The following pages contain the final 2025 PREA audit report for MacLaren Youth Correctional Facility.

This report includes fields that are populated from information entered into the online system during the pre-audit process. Personnel changed during the audit period, but it was not possible for the auditors to update the online system. For that reason, OYA wishes to update the organizational structure on pages 2-4.

In February 2025, Jana McLellan became OYA's interim director. In August 2025, Mike Tessean took over from McLellan and became OYA's director. Both of these directors would be listed under "Agency Chief Executive" on pg.3.

Kristine Meany became the superintendent of Oak Creek Youth Correctional Facility and Jackie Winters Youth Transition Program on September 1, 2025. She should be listed for both facilities as "Superintendent/Director/Administrator."

Oak Creek and Jackie Winters's compliance manager during the duration of the 2025 audits was Drew Reynolds.

PREA Facility Audit Report: Final

Name of Facility: Jackie Winters Transition Program
Facility Type: Juvenile
Date Interim Report Submitted: 07/18/2025
Date Final Report Submitted: 02/17/2026

Auditor Certification	
The contents of this report are accurate to the best of my knowledge.	☑
No conflict of interest exists with respect to my ability to conduct an audit of the agency under review.	☑
I have not included in the final report any personally identifiable information (PII) about any inmate/resident/detainee or staff member, except where the names of administrative personnel are specifically requested in the report template.	☑
Auditor Full Name as Signed: D. Will Weir	**Date of Signature:** 02/17/2026

AUDITOR INFORMATION	
Auditor name:	Weir, Will
Email:	prea.america@gmail.com
Start Date of On-Site Audit:	06/04/2025
End Date of On-Site Audit:	06/04/2025

FACILITY INFORMATION	
Facility name:	Jackie Winters Transition Program
Facility physical address:	4400 Lochner Road Southeast, Albany, Oregon - 97322
Facility mailing address:	530 Center St. NE, Suite 500, Salem, - 97301

Primary Contact

Name:	Alisha Goodwin
Email Address:	alisha.r.goodwin@oya.oregon.gov
Telephone Number:	5034004426

Superintendent/Director/Administrator	
Name:	Kevin Nelson
Email Address:	kevin.nelson@oya.oregon.gov
Telephone Number:	5417915906

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

Facility Health Service Administrator On-Site	
Name:	Ann Hingson
Email Address:	ann.hingson@oya.oregon.gov
Telephone Number:	503-981-2548

Facility Characteristics	
Designed facility capacity:	12
Current population of facility:	10
Average daily population for the past 12 months:	10
Has the facility been over capacity at any point in the past 12 months?	No
What is the facility's population designation?	Women/girls

Age range of population:	12-24
Facility security levels/resident custody levels:	Closed
Number of staff currently employed at the facility who may have contact with residents:	14
Number of individual contractors who have contact with residents, currently authorized to enter the facility:	6
Number of volunteers who have contact with residents, currently authorized to enter the facility:	19

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

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

Agency-Wide PREA Coordinator Information			
Name:	Alisha Goodwin	**Email Address:**	alisha.r.goodwin@oya.oregon.gov

Facility AUDIT FINDINGS

Summary of Audit Findings

The OAS automatically populates the number and list of Standards exceeded, the number of Standards met, and the number and list of Standards not met.

Auditor Note: In general, no standards should be found to be "Not Applicable" or "NA." A compliance determination must be made for each standard. In rare instances where an auditor determines that a standard is not applicable, the auditor should select "Meets Standard" and include a comprehensive discussion as to why the standard is not applicable to the facility being audited.

Number of standards exceeded:	
0	
Number of standards met:	
43	
Number of standards not met:	
0	

POST-AUDIT REPORTING INFORMATION

Please note: Question numbers may not appear sequentially as some questions are omitted from the report and used solely for internal reporting purposes.

GENERAL AUDIT INFORMATION

On-site Audit Dates

1. Start date of the onsite portion of the audit:	2025-06-04
2. End date of the onsite portion of the audit:	2025-06-04

Outreach

10. Did you attempt to communicate with community-based organization(s) or victim advocates who provide services to this facility and/or who may have insight into relevant conditions in the facility?	(●) Yes ( ) No
a. Identify the community-based organization(s) or victim advocates with whom you communicated:	Center Against Rape and Domestic Violence

AUDITED FACILITY INFORMATION

14. Designated facility capacity:	14
15. Average daily population for the past 12 months:	10
16. Number of inmate/resident/detainee housing units:	3
17. Does the facility ever hold youthful inmates or youthful/juvenile detainees?	( ) Yes ( ) No (●) Not Applicable for the facility type audited (i.e., Community Confinement Facility or Juvenile Facility)

Audited Facility Population Characteristics on Day One of the Onsite Portion of the Audit	
Inmates/Residents/Detainees Population Characteristics on Day One of the Onsite Portion of the Audit	
23. Enter the total number of inmates/ residents/detainees in the facility as of the first day of onsite portion of the audit:	12
25. Enter the total number of inmates/ residents/detainees with a physical disability in the facility as of the first day of the onsite portion of the audit:	1
26. Enter the total number of inmates/ residents/detainees with a cognitive or functional disability (including intellectual disability, psychiatric disability, or speech disability) in the facility as of the first day of the onsite portion of the audit:	3
27. Enter the total number of inmates/ residents/detainees who are Blind or have low vision (visually impaired) in the facility as of the first day of the onsite portion of the audit:	0
28. Enter the total number of inmates/ residents/detainees who are Deaf or hard-of-hearing in the facility as of the first day of the onsite portion of the audit:	1
29. Enter the total number of inmates/ residents/detainees who are Limited English Proficient (LEP) in the facility as of the first day of the onsite portion of the audit:	0
30. Enter the total number of inmates/ residents/detainees who identify as lesbian, gay, or bisexual in the facility as of the first day of the onsite portion of the audit:	2

31. Enter the total number of inmates/ residents/detainees who identify as transgender or intersex in the facility as of the first day of the onsite portion of the audit:	0
32. Enter the total number of inmates/ residents/detainees who reported sexual abuse in the facility as of the first day of the onsite portion of the audit:	9
33. Enter the total number of inmates/ residents/detainees who disclosed prior sexual victimization during risk screening in the facility as of the first day of the onsite portion of the audit:	9
34. Enter the total number of inmates/ residents/detainees who were ever placed in segregated housing/isolation for risk of sexual victimization in the facility as of the first day of the onsite portion of the audit:	0
35. Provide any additional comments regarding the population characteristics of inmates/residents/detainees in the facility as of the first day of the onsite portion of the audit (e.g., groups not tracked, issues with identifying certain populations):	This is a transitional program so residents are busy with plans and commitments. The person with hearing difficulty did not have severe hearing loss.
Staff, Volunteers, and Contractors Population Characteristics on Day One of the Onsite Portion of the Audit	
36. Enter the total number of STAFF, including both full- and part-time staff, employed by the facility as of the first day of the onsite portion of the audit:	71
37. Enter the total number of VOLUNTEERS assigned to the facility as of the first day of the onsite portion of the audit who have contact with inmates/residents/detainees:	19

38. Enter the total number of CONTRACTORS assigned to the facility as of the first day of the onsite portion of the audit who have contact with inmates/residents/detainees:	20
39. Provide any additional comments regarding the population characteristics of staff, volunteers, and contractors who were in the facility as of the first day of the onsite portion of the audit:	The staff, contractor and volunteer numbers are the same as for Oak Creek YCF because, even if they are assigned to only one facility, they may go to both facilities, or see residents from both facilities, in the course of their work. ***Additional comments regarding agency and facility administrators: The Online Audit System (OAS) collects the names of agency and facility administrators at the beginning of the audit process. The names listed in this report are the names of OYA leadership from early 2025 when data collection for this audit began.***

INTERVIEWS

Inmate/Resident/Detainee Interviews

Random Inmate/Resident/Detainee Interviews

40. Enter the total number of RANDOM INMATES/RESIDENTS/DETAINEES who were interviewed:	3
41. Select which characteristics you considered when you selected RANDOM INMATE/RESIDENT/DETAINEE interviewees: (select all that apply)	☑ Age ☑ Race ☑ Ethnicity (e.g., Hispanic, Non-Hispanic) ☐ Length of time in the facility ☑ Housing assignment ☐ Gender ☑ Other ☐ None

If "Other," describe:	The residents' stature was also considered.
42. How did you ensure your sample of RANDOM INMATE/RESIDENT/DETAINEE interviewees was geographically diverse?	The Audit Team attempted to interview all 12 residents of the facility. However four residents declined. All of the residents who declined to be interviewed met one-on-one with the Auditor very briefly, took a business card, and offered plausible reasons for not choosing to participate. In general, they had other things to do and did not think they knew anything that would help the Audit one way or another.
43. Were you able to conduct the minimum number of random inmate/ resident/detainee interviews?	(●) Yes ( ) No
44. Provide any additional comments regarding selecting or interviewing random inmates/residents/detainees (e.g., any populations you oversampled, barriers to completing interviews, barriers to ensuring representation):	8 of 12 residents (67%) is an appropriate percentage of residents to interview. However, the Auditor attempted to interview all of the residents, offering to do the interview at a convenient time or to make the interview brief. Additionally, some residents interviewed next door at Oak Creek YCF have been residents of JWTP in the past. Some had been to JWTP multiple times and some had been there in the past year. The information they provided about JWTP was consistent with the information provided by current residents at JWTP.
Targeted Inmate/Resident/Detainee Interviews	
45. Enter the total number of TARGETED INMATES/RESIDENTS/DETAINEES who were interviewed:	5

As stated in the PREA Auditor Handbook, the breakdown of targeted interviews is intended to guide auditors in interviewing the appropriate cross-section of inmates/residents/detainees who are the most vulnerable to sexual abuse and sexual harassment. When completing questions regarding targeted inmate/resident/detainee interviews below, remember that an interview with one inmate/resident/detainee may satisfy multiple targeted interview requirements. These questions are asking about the number of interviews conducted using the targeted inmate/resident/detainee protocols. For example, if an auditor interviews an inmate who has a physical disability, is being held in segregated housing due to risk of sexual victimization, and disclosed prior sexual victimization, that interview would be included in the totals for each of those questions. Therefore, in most cases, the sum of all the following responses to the targeted inmate/resident/detainee interview categories will exceed the total number of targeted inmates/residents/detainees who were interviewed. If a particular targeted population is not applicable in the audited facility, enter "0".

47. Enter the total number of interviews conducted with inmates/residents/detainees with a physical disability using the "Disabled and Limited English Proficient Inmates" protocol:	1
48. Enter the total number of interviews conducted with inmates/residents/detainees with a cognitive or functional disability (including intellectual disability, psychiatric disability, or speech disability) using the "Disabled and Limited English Proficient Inmates" protocol:	3
49. Enter the total number of interviews conducted with inmates/residents/detainees who are Blind or have low vision (i.e., visually impaired) using the "Disabled and Limited English Proficient Inmates" protocol:	0
a. Select why you were unable to conduct at least the minimum required number of targeted inmates/residents/detainees in this category:	■ Facility said there were "none here" during the onsite portion of the audit and/or the facility was unable to provide a list of these inmates/residents/detainees. ☐ The inmates/residents/detainees in this targeted category declined to be interviewed.

b. Discuss your corroboration strategies to determine if this population exists in the audited facility (e.g., based on information obtained from the PAQ; documentation reviewed onsite; and discussions with staff and other inmates/residents/detainees).	The Audit Team was provided with access to information about each resident, and met each resident. Additionally, during the interviews that were conducted, with both residents and staff, the Audit Team tried to learn whether residents with any disabilities (or other risk factors) are, or have been, at the facility, and how they might fare.
50. Enter the total number of interviews conducted with inmates/residents/detainees who are Deaf or hard-of-hearing using the "Disabled and Limited English Proficient Inmates" protocol:	1
51. Enter the total number of interviews conducted with inmates/residents/detainees who are Limited English Proficient (LEP) using the "Disabled and Limited English Proficient Inmates" protocol:	0
a. Select why you were unable to conduct at least the minimum required number of targeted inmates/residents/detainees in this category:	■ Facility said there were "none here" during the onsite portion of the audit and/or the facility was unable to provide a list of these inmates/residents/detainees. ☐ The inmates/residents/detainees in this targeted category declined to be interviewed.
b. Discuss your corroboration strategies to determine if this population exists in the audited facility (e.g., based on information obtained from the PAQ; documentation reviewed onsite; and discussions with staff and other inmates/residents/detainees).	The Audit Team was provided with access to information about each resident, and met each resident. Additionally, during the interviews that were conducted, with both residents and staff, the Audit Team tried to learn whether residents with limited English proficiency are, or have been, at the facility, and how they might fare. Also, since the interpreter services are the same for all facilities, and another facility being audited had multiple LEP residents, the Auditor was able to test that system at the other facility.

52. Enter the total number of interviews conducted with inmates/residents/ detainees who identify as lesbian, gay, or bisexual using the "Transgender and Intersex Inmates; Gay, Lesbian, and Bisexual Inmates" protocol:	2
53. Enter the total number of interviews conducted with inmates/residents/ detainees who identify as transgender or intersex using the "Transgender and Intersex Inmates; Gay, Lesbian, and Bisexual Inmates" protocol:	0
a. Select why you were unable to conduct at least the minimum required number of targeted inmates/residents/ detainees in this category:	■ Facility said there were "none here" during the onsite portion of the audit and/or the facility was unable to provide a list of these inmates/residents/detainees. ☐ The inmates/residents/detainees in this targeted category declined to be interviewed.
b. Discuss your corroboration strategies to determine if this population exists in the audited facility (e.g., based on information obtained from the PAQ; documentation reviewed onsite; and discussions with staff and other inmates/ residents/detainees).	The Audit Team was provided with access to information about each resident, and met each resident. Additionally, during the interviews that were conducted, with both residents and staff, the Audit Team tried to learn opinions from diverse points of view about how transgender and intersex residents would fare at the facility.
54. Enter the total number of interviews conducted with inmates/residents/ detainees who reported sexual abuse in this facility using the "Inmates who Reported a Sexual Abuse" protocol:	5
55. Enter the total number of interviews conducted with inmates/residents/ detainees who disclosed prior sexual victimization during risk screening using the "Inmates who Disclosed Sexual Victimization during Risk Screening" protocol:	5

56. Enter the total number of interviews conducted with inmates/residents/ detainees who are or were ever placed in segregated housing/isolation for risk of sexual victimization using the "Inmates Placed in Segregated Housing (for Risk of Sexual Victimization/Who Allege to have Suffered Sexual Abuse)" protocol:	0
a. Select why you were unable to conduct at least the minimum required number of targeted inmates/residents/ detainees in this category:	■ Facility said there were "none here" during the onsite portion of the audit and/or the facility was unable to provide a list of these inmates/residents/detainees. ☐ The inmates/residents/detainees in this targeted category declined to be interviewed.
b. Discuss your corroboration strategies to determine if this population exists in the audited facility (e.g., based on information obtained from the PAQ; documentation reviewed onsite; and discussions with staff and other inmates/ residents/detainees).	Information from all sources, including interviews, indicates that isolation does not and cannot occur at this facility.
57. Provide any additional comments regarding selecting or interviewing targeted inmates/residents/detainees (e.g., any populations you oversampled, barriers to completing interviews):	No targeted category was missed due to the residents who declined interviews. Because of the low number of residents, residents for targeted interviews were oversampled.
Staff, Volunteer, and Contractor Interviews	
Random Staff Interviews	
58. Enter the total number of RANDOM STAFF who were interviewed:	12

59. Select which characteristics you considered when you selected RANDOM STAFF interviewees: (select all that apply)	☐ Length of tenure in the facility ☑ Shift assignment ☑ Work assignment ☑ Rank (or equivalent) ☑ Other (e.g., gender, race, ethnicity, languages spoken) ☐ None
If "Other," describe:	The Audit Team strives to consider all areas of diversity.
60. Were you able to conduct the minimum number of RANDOM STAFF interviews?	◉ Yes ○ No
61. Provide any additional comments regarding selecting or interviewing random staff (e.g., any populations you oversampled, barriers to completing interviews, barriers to ensuring representation):	Staff often provided information about both facilities. ***Additional comments regarding agency and facility administrators: The Online Audit System (OAS) collects the names of agency and facility administrators at the beginning of the audit process. The names listed in this report are the names of OYA leadership from early 2025 when data collection for this audit began.***
Specialized Staff, Volunteers, and Contractor Interviews	
Staff in some facilities may be responsible for more than one of the specialized staff duties. Therefore, more than one interview protocol may apply to an interview with a single staff member and that information would satisfy multiple specialized staff interview requirements.	
62. Enter the total number of staff in a SPECIALIZED STAFF role who were interviewed (excluding volunteers and contractors):	14

63. Were you able to interview the Agency Head?	(●) Yes ( ) No
64. Were you able to interview the Warden/Facility Director/Superintendent or their designee?	(●) Yes ( ) No
65. Were you able to interview the PREA Coordinator?	(●) Yes ( ) No
66. Were you able to interview the PREA Compliance Manager?	(●) Yes ( ) No ( ) NA (NA if the agency is a single facility agency or is otherwise not required to have a PREA Compliance Manager per the Standards)

67. Select which SPECIALIZED STAFF roles were interviewed as part of this audit from the list below: (select all that apply)	☑ Agency contract administrator ☑ Intermediate or higher-level facility staff responsible for conducting and documenting unannounced rounds to identify and deter staff sexual abuse and sexual harassment ☐ Line staff who supervise youthful inmates (if applicable) ☐ Education and program staff who work with youthful inmates (if applicable) ☑ Medical staff ☑ Mental health staff ☐ Non-medical staff involved in cross-gender strip or visual searches ☑ Administrative (human resources) staff ☐ Sexual Assault Forensic Examiner (SAFE) or Sexual Assault Nurse Examiner (SANE) staff ☑ Investigative staff responsible for conducting administrative investigations ☐ Investigative staff responsible for conducting criminal investigations ☑ Staff who perform screening for risk of victimization and abusiveness ☐ Staff who supervise inmates in segregated housing/residents in isolation ☑ Staff on the sexual abuse incident review team ☑ Designated staff member charged with monitoring retaliation ☑ First responders, both security and non-security staff ☑ Intake staff

	☐ Other
68. Did you interview VOLUNTEERS who may have contact with inmates/ residents/detainees in this facility?	○ Yes ◉ No
69. Did you interview CONTRACTORS who may have contact with inmates/ residents/detainees in this facility?	○ Yes ◉ No
70. Provide any additional comments regarding selecting or interviewing specialized staff.	Although the facility has numerous contractors and volunteers, none are are at the facility regularly during business hours. They typically come in after hours and on weekends for special groups or church, and are supervised. The Audit Team interviewed staff who coordinate and work with them.

SITE REVIEW AND DOCUMENTATION SAMPLING

Site Review

PREA Standard 115.401 (h) states, "The auditor shall have access to, and shall observe, all areas of the audited facilities." In order to meet the requirements in this Standard, the site review portion of the onsite audit must include a thorough examination of the entire facility. The site review is not a casual tour of the facility. It is an active, inquiring process that includes talking with staff and inmates to determine whether, and the extent to which, the audited facility's practices demonstrate compliance with the Standards. Note: As you are conducting the site review, you must document your tests of critical functions, important information gathered through observations, and any issues identified with facility practices. The information you collect through the site review is a crucial part of the evidence you will analyze as part of your compliance determinations and will be needed to complete your audit report, including the Post-Audit Reporting Information.

71. Did you have access to all areas of the facility?	◉ Yes ○ No

Was the site review an active, inquiring process that included the following:	
72. Observations of all facility practices in accordance with the site review component of the audit instrument (e.g., signage, supervision practices, cross-gender viewing and searches)?	(●) Yes ( ) No
73. Tests of all critical functions in the facility in accordance with the site review component of the audit instrument (e.g., risk screening process, access to outside emotional support services, interpretation services)?	( ) Yes (●) No
a. Explain which critical functions you were unable to test per the site review component of the audit instrument and why:	There was no intake for the Audit Team to observe.
74. Informal conversations with inmates/residents/detainees during the site review (encouraged, not required)?	(●) Yes ( ) No
75. Informal conversations with staff during the site review (encouraged, not required)?	(●) Yes ( ) No
76. Provide any additional comments regarding the site review (e.g., access to areas in the facility, observations, tests of critical functions, or informal conversations).	The Audit Team had access to all areas of the facility. Administrators were open to answering all questions and addressing all concerns.

Documentation Sampling

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

77. In addition to the proof documentation selected by the agency or facility and provided to you, did you also conduct an auditor-selected sampling of documentation?	(●) Yes ( ) No

78. Provide any additional comments regarding selecting additional documentation (e.g., any documentation you oversampled, barriers to selecting additional documentation, etc.).	The Audit Team oversampled resident records and investigations. Contractor and volunteer training records were not provided until during the Corrective Action Plan (CAP).

SEXUAL ABUSE AND SEXUAL HARASSMENT ALLEGATIONS AND INVESTIGATIONS IN THIS FACILITY

Sexual Abuse and Sexual Harassment Allegations and Investigations Overview

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

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

	# of sexual abuse allegations	# of criminal investigations	# of administrative investigations	# of allegations that had both criminal and administrative investigations
Inmate-on-inmate sexual abuse	2	0	2	0
Staff-on-inmate sexual abuse	1	0	1	0
Total	3	0	3	0

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

	# of sexual harassment allegations	# of criminal investigations	# of administrative investigations	# of allegations that had both criminal and administrative investigations
Inmate-on-inmate sexual harassment	1	0	1	0
Staff-on-inmate sexual harassment	1	0	1	0
Total	2	0	2	0

Sexual Abuse and Sexual Harassment Investigation Outcomes

Sexual Abuse Investigation Outcomes

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

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

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

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

	Ongoing	Unfounded	Unsubstantiated	Substantiated
Inmate-on-inmate sexual abuse	0	1	1	0
Staff-on-inmate sexual abuse	0	0	1	0
Total	0	1	2	0

Sexual Harassment Investigation Outcomes

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

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

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

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

	Ongoing	Unfounded	Unsubstantiated	Substantiated
Inmate-on-inmate sexual harassment	0	0	1	0
Staff-on-inmate sexual harassment	0	0	1	0
Total	0	0	2	0

Sexual Abuse and Sexual Harassment Investigation Files Selected for Review

Sexual Abuse Investigation Files Selected for Review

85. Enter the total number of SEXUAL ABUSE investigation files reviewed/ sampled:	18

86. Did your selection of SEXUAL ABUSE investigation files include a cross-section of criminal and/or administrative investigations by findings/outcomes?	(●) Yes ( ) No ( ) NA (NA if you were unable to review any sexual abuse investigation files)
Inmate-on-inmate sexual abuse investigation files	
87. Enter the total number of INMATE-ON-INMATE SEXUAL ABUSE investigation files reviewed/sampled:	13
88. Did your sample of INMATE-ON-INMATE SEXUAL ABUSE investigation files include criminal investigations?	(●) Yes ( ) No ( ) NA (NA if you were unable to review any inmate-on-inmate sexual abuse investigation files)
89. Did your sample of INMATE-ON-INMATE SEXUAL ABUSE investigation files include administrative investigations?	(●) Yes ( ) No ( ) NA (NA if you were unable to review any inmate-on-inmate sexual abuse investigation files)
Staff-on-inmate sexual abuse investigation files	
90. Enter the total number of STAFF-ON-INMATE SEXUAL ABUSE investigation files reviewed/sampled:	5
91. Did your sample of STAFF-ON-INMATE SEXUAL ABUSE investigation files include criminal investigations?	(●) Yes ( ) No ( ) NA (NA if you were unable to review any staff-on-inmate sexual abuse investigation files)

92. Did your sample of STAFF-ON-INMATE SEXUAL ABUSE investigation files include administrative investigations?	(●) Yes ( ) No ( ) NA (NA if you were unable to review any staff-on-inmate sexual abuse investigation files)
Sexual Harassment Investigation Files Selected for Review	
93. Enter the total number of SEXUAL HARASSMENT investigation files reviewed/sampled:	16
94. Did your selection of SEXUAL HARASSMENT investigation files include a cross-section of criminal and/or administrative investigations by findings/outcomes?	(●) Yes ( ) No ( ) NA (NA if you were unable to review any sexual harassment investigation files)
Inmate-on-inmate sexual harassment investigation files	
95. Enter the total number of INMATE-ON-INMATE SEXUAL HARASSMENT investigation files reviewed/sampled:	10
96. Did your sample of INMATE-ON-INMATE SEXUAL HARASSMENT files include criminal investigations?	(●) Yes ( ) No ( ) NA (NA if you were unable to review any inmate-on-inmate sexual harassment investigation files)
97. Did your sample of INMATE-ON-INMATE SEXUAL HARASSMENT investigation files include administrative investigations?	(●) Yes ( ) No ( ) NA (NA if you were unable to review any inmate-on-inmate sexual harassment investigation files)

Staff-on-inmate sexual harassment investigation files	
98. Enter the total number of STAFF-ON-INMATE SEXUAL HARASSMENT investigation files reviewed/sampled:	6
99. Did your sample of STAFF-ON-INMATE SEXUAL HARASSMENT investigation files include criminal investigations?	(●) Yes ( ) No ( ) NA (NA if you were unable to review any staff-on-inmate sexual harassment investigation files)
100. Did your sample of STAFF-ON-INMATE SEXUAL HARASSMENT investigation files include administrative investigations?	(●) Yes ( ) No ( ) NA (NA if you were unable to review any staff-on-inmate sexual harassment investigation files)
101. Provide any additional comments regarding selecting and reviewing sexual abuse and sexual harassment investigation files.	Since all sexual abuse and sexual harassment investigations are completed at the agency level, investigations were selected from a log of all sexual abuse and sexual harassment investigations. During the CAP, some selections were made from lists that assisted in determining how well the agency was addressing specific issues. For example, under the old system, some investigations went into backlog status due to being "suspended" to give law enforcement time to conduct criminal investigations, when in reality, no criminal investigation was occurring in many of those cases. Selections were made during the CAP to confirm that the agency has verified that a criminal investigation was occuring in the case of suspended cases.

SUPPORT STAFF INFORMATION	
DOJ-certified PREA Auditors Support Staff	
102. Did you receive assistance from any DOJ-CERTIFIED PREA AUDITORS at any point during this audit? REMEMBER: the audit includes all activities from the pre-onsite through the post-onsite phases to the submission of the final report. Make sure you respond accordingly.	○ Yes ◉ No
Non-certified Support Staff	
103. Did you receive assistance from any NON-CERTIFIED SUPPORT STAFF at any point during this audit? REMEMBER: the audit includes all activities from the pre-onsite through the post-onsite phases to the submission of the final report. Make sure you respond accordingly.	◉ Yes ○ No
a. Enter the TOTAL NUMBER OF NON-CERTIFIED SUPPORT who provided assistance at any point during this audit:	1
AUDITING ARRANGEMENTS AND COMPENSATION	
108. Who paid you to conduct this audit?	○ The audited facility or its parent agency ○ My state/territory or county government employer (if you audit as part of a consortium or circular auditing arrangement, select this option) ○ A third-party auditing entity (e.g., accreditation body, consulting firm) ◉ Other
Identify the entity by name:	PREA America, LLC. I own the company.

Standards
Auditor Overall Determination Definitions
• Exceeds Standard (Substantially exceeds requirement of standard) • Meets Standard (substantial compliance; complies in all material ways with the stand for the relevant review period) • Does Not Meet Standard (requires corrective actions)
Auditor Discussion Instructions
Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

115.311	Zero tolerance of sexual abuse and sexual harassment; PREA coordinator
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	This first PREA Standard overlaps with the other Standards requiring a minimum structure, or framework, for sexual safety (aka PREA compliance) while also necessitating the development, implementation, and oversight of measures that ensure sustained compliance. There have been periods of public scrutiny in recent years, as some Oregon Youth Authority (OYA) administrators were relieved of duty or resigned, backlogs were identified, and the State Legislature called for accountability. Morale has been affected by staffing shortages and allegations in the press dating back decades. Officials from the Oregon Department of Corrections and other agencies were called in to help, and numerous changes were announced. This Audit came at a time of change in the agency. Nevertheless, an audit is a snapshot of what is found at the point in time that information is collected and reviewed. Documentation for PREA Audits must be collected by the agency and facility and uploaded into the Pre-Audit Questionnaire (PAQ). The records are from the 12 months (or more) preceding the completion of the PAQ. The PAQ must be completed 4 to 8 weeks in advance of the On-Site Review. This gives the Auditor time to review the information and request additional details or clarification. Then, as

	inconsistencies and compliance issues are found, newer materials are collected. These are more likely to reflect new ways of doing things when an agency or facility is making changes or is under new leadership. CORRECTIVE ACTION: The July 18, 2025, PREA Audit Interim Report stated that, "this PREA Audit indicates that when actual investigative files and other documents are reviewed, they do not provide proof of compliant practice. There are numerous inconsistencies between practices, policies, PREA Standards, and agency paperwork." During the Corrective Action Period (CAP), the facility needed to show stronger or sustained proof of compliance for about half of the Standards. Change management challenges were anticipated by those who contributed to the development of the PREA Standards. Standard 115.388 requires "corrective action on an ongoing basis." The reason that corrective actions can always be ongoing is that the Standards, starting with this first one, and leading up to 115.388, require various kinds of documentation that constantly flows toward, or includes, PREA administrators (and their superiors) who must review, critically analyze, and categorize/contextualize the data points in ways that give a clear picture of the health of each aspect of PREA compliance. The 180-day CAP required monitoring and analysis of these processes from different perspectives and found solid evidence of sustained compliance. Specific areas of review, requiring documentation and/or proof of practice for this Standard during the CAP included: Organization Charts reflecting permanent positions for both the Agency and facility levels; Facility PREA Compliance Manager Role update of training process and checklists to include the ongoing role of setting the culture of sexual safety; records of the Safety Advisory Committee that began meeting in May 2025 and continues to meet regularly and includes the new Agency Director, Youth and Family Advocate, Chief Investigator, Policy Coordinator, Communication Director, and various external partners; Sexual Abuse Response Plan (SARP) reviews conducted including comprehensive review teams; PREA Coordinator and Chief Investigator regular meetings with the Youth and Family Advocate; PREA Coordinator participation in weekly PSO Huddles with standing agenda items; and investigations showing proof of improved and sustained practices provided in advance of the end of the CAP. Analysis: Evidence used to determine compliance with this Standard Includes: Interviews with PREA Coordinator and Compliance Managers; Policy 1I-A-10.0 Preventing Youth Sexual Abuse and Harassment; Agency and Facility organizational charts and Management Structure; Sexual Abuse Response Plans; Agency Policy Part 1 Administrative Services Preventing, Detecting, and Responding to Youth Sexual Abuse and Sexual Harassment (pp 4-14) Sections III and IV; Policy II-B-2.1 Behavior Management - Attachment 1: OYA Youth Behavior Refocus Options (pp 6-7); Department of Administrative Services Harassment Free Workplace Training; Time and Authority Acknowledgement letter of PCM; and emails regarding numerous administrative changes. Additionally, onboarding plans and PCM Duties were provided, along with acknowledgements that it is difficult to keep detailed organizational charts current. The website was reviewed: https://www.oregon.gov/oya/pages/pso/prea.aspx. Additionally, staffing plans and deviations were reviewed, along with numerous documents, news stories, and press releases regarding the agency's handling of a backlog of PSO investigations. Finally, as the Auditor

	reviewed documentation and proofs of practice provided during the CAP, it was determined that sustained compliance has been demonstrated through the completion of the CAP.

115.312	Contracting with other entities for the confinement of residents
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	This Standard requires that if an agency contracts for the confinement of its residents, it shall require the contractor to adopt and comply with the PREA Standards, and it shall monitor the contractor to ensure that the contractor is complying with the PREA Standards. Analysis: Interviews with the PREA Coordinator, Contracts Monitor, documentation showing where youth are placed, and a memo regarding contracts indicate that no contracts are utilized for the placement of Oregon Youth Authority (OYA) youth in any facility not operated by OYA. A triangulation of evidence indicates that the agency is compliant with this Standard.

115.313	Supervision and monitoring
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	This Standard requires the agency to ensure that every correctional facility it operates has “adequate levels of staffing, and, where applicable, video monitoring, to protect residents against sexual abuse.” In calculating what is considered an adequate level of staffing, the following must be considered: “(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.” Then, the Standard requires agency compliance with its own staffing plan “except during limited and discrete exigent circumstances, and shall fully document deviations from the plan during such circumstances.” In some facilities, the above-mentioned factors may require a very high staff-to-resident ratio in order to protect

	residents against sexual abuse. When the above-enumerated factors do not indicate a higher ratio, secure juvenile facilities must “maintain staff ratios of a minimum of 1:8 during resident waking hours and 1:16 during resident sleeping hours, except during limited and discrete exigent circumstances, which shall be fully documented. Only security staff shall be included in these ratios.” The Standard goes on to require that, “whenever necessary” to protect residents against sexual abuse, “the agency shall assess, determine, and document whether adjustments are needed to” the staffing plan as established above. Adding to the enumerated factors already mentioned, reviews must also consider “Prevailing staffing patterns;” “The facility’s deployment of video monitoring systems and other monitoring technologies; and” “The resources the facility has available to commit to ensure adherence to the staffing plan.” If no necessity has required a review of the Staffing Plan, it must be reviewed at least once each year. Finally, the Standard requires that “Each secure facility shall implement 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. Such policy and practice shall be implemented for night shifts as well as day shifts. Each secure facility shall have a policy to prohibit 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.” Corrective Action: The PREA Audit Interim Report noted that issues identified through interviews and observations during the On-Site Review included a belief among some that nothing could be done about policy violations. Some window blinds were used in such a way that hindered visual observation by staff who were supposed to be supervising residents. Allegedly, these issues had been raised before, but persisted because they were not addressed in a way that effectively resolved the problem. During the On-Site Review, some youth lacked direct supervision. When procedures at the sally ports were not followed, administrators acknowledged the issue but did not appear to know how to address it effectively. Staff reported that youth feel unsupported when they report something. These issues and violations were raised during the top ten trainings last year, but persisted, as if unaddressed. A laundry room was not appropriately secure during the Review. The CAP sought to address the issues both culturally and specifically. Window blinds were removed from the classroom windows where they impeded direct supervision; supervision and sally port protocols and obligations were reviewed, updated where needed, and verified in practice; the laundry room had a new lock installed; and refreshers were provided regarding applicable Top Ten issues. Signs were posted in areas where youth are not permitted, and doors must be secured. Random video checks are conducted at least twice a month during peak traffic periods to verify compliance. Analysis: Evidence reviewed includes: Interviews with the Superintendent designee, facility administrators, PREA Coordinator, staff, and residents. Documentation includes 2025 Oak Creek staffing plan; 2025 JWTP staffing plan; Oak Creek Staffing Plan Deviations; JWTP Staffing Deviations; Staffing Plan Reviews; Policy II-A-3.0 Interactive Supervision of Youth; PREA Walkthrough at Oak Creek and JWTP; Top 10 Policy Training and Rosters 2025; and After-Action Youth Support Response

	Takeaways. Photos, emails, and documents were provided to demonstrate the implementation of changes required during the CAP. Additionally, the agency PREA Coordinator now spends time at Oakcreek and JWTP every week to support the continuity of sensible change and to assist with ongoing corrective actions that support a safe environment and a workforce and resident population that is empowered to know they will be heard when they speak up. With these improvements, Oakcreek YCF and JWTP demonstrate compliance with this Standard by successfully completing their CAP.

115.315	**Limits to cross-gender viewing and searches**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	OYA does not conduct searches of residents by staff of a different sex* absent exigent circumstances. The facility has implemented policies and procedures that enable residents to shower, perform bodily functions, and change clothing without non-medical different sex* staff viewing their breasts, buttocks, or genitalia, except in exigent circumstances or when such viewing is incidental to routine room checks (this includes viewing via video camera). Policies and procedures require different sex* staff to announce their presence when entering a resident housing unit or area where residents are likely to be showering, performing bodily functions, or changing clothing. CORRECTIVE ACTION: The On-Site review raised concerns that there was no protocol or method for different-sex* announcements, should there be residents with hearing impairments. Finally, although already trained, some staff expressed interest in additional training on certain types of searches. There was inadequate supervision in the classroom during the On-Site review. During the CAP, training was updated (including in the New Employee Orientation, as applicable) and delivered on searches, supervision in school, and different-sex* announcements. The handouts used and sign-in sheets were provided. Also related to Standard 115.313, the JWTP laundry room door needed a lock. The blinds in the school office obstructed supervision. Additionally, there was a need to determine whether to install a mirror or otherwise address the difficulty for staff to observe the area behind the cubby in the laundry room on the units. Pictures verifying that blinds were removed and that all areas are now observable by staff were provided during the CAP. Analysis: Evidence used to determine compliance with this Standard includes: interviews with staff who supervise residents and conduct searches; interviews with randomly selected staff and residents; policies and procedures governing searches; training curricula on searches; and staff training logs. Policy citations included II-A-2.0 Searches of Youth and Youth Property in OYA Facilities; Policy II-A-3.0 Interactive Supervision of Youth (pg. 4); Training Academy Follow-up regarding searches; Lesson Plan: Contraband and Searches (pp. 5, 6 & 9); and Local Operating

	Protocol, Youth Privacy, and Staff Announcement sections. Additionally, verification was provided during the CAP that the corrective actions had been implemented. Upon completion of the CAP, the facility has demonstrated compliance with this Standard. *The PREA Standards use the term "gender." "Gender" is more germane for use in this report because the Audit Team does not view or otherwise verify the status of anyone's biological sex. Nevertheless, the federal government of the United States is currently officially discouraging the use of the term "gender." On December 2, 2025, the US DOJ PREA Management Office instructed DOJ Certified PREA Auditors to comply with Presidential Executive Order 14168. The Presidential Executive Order states, in Section 3(c), "When administering or enforcing sex-based distinctions, every agency and all Federal employees acting in an official capacity on behalf of their agency shall use the term 'sex' and not 'gender' in all applicable Federal policies and documents." PREA Auditors are not federal employees but were told to adopt these federal guidelines, "effective immediately."

115.316	**Residents with disabilities and residents who are limited English proficient**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	This Standard requires that the agency take appropriate steps to ensure that residents with disabilities (including, for example, residents who are deaf or hard of hearing, those who are blind or have low vision, or those who have intellectual, psychiatric, or speech disabilities), and residents with limited English proficiency, have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment. OYA policies address the identification of needs and the provision of appropriate services during Intake and throughout the resident's time in care. Policy prohibits the use of 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. CORRECTIVE ACTION: All PREA Materials are available in both English and Spanish, as these are the two most commonly used languages at OYA facilities. Although JWTP and Oakcreek did not have LEP residents at the time of the On-Site Review, some improvements were identified that can help the facilities serve these residents when they are present. Also, the On-Site Review brought up concerns that there was no established protocol or method for different-sex announcements, should there be residents with hearing impairments. The CAP required that administrators be informed of OYA's requirements for residents with disabilities and those with limited

	English proficiency, and be aware of which residents have been identified as needing assistance, the amount required, and the type of assistance needed. The administrators were informed regarding the instances when they should instruct staff to use the language line. Policy was updated, and protocols were developed outlining considerations for youth needs and examples of strategies. Analysis: Evidence used to determine compliance with this Standard includes: Interviews with agency and facility administrators, residents, and staff; training; and policies. Citations include Policy I-D-2.1 Use of Language Services; Policy II-E-2.4 English Plus – Facility; Request for Interpretation Services; Policy 1I-A-10.0 Preventing Youth Sexual Abuse and Harassment; Contract with LinguaLinx; Contract with Call Interpreting Translations; and Language Interpreter Services LOP and checklist. Documentation of staff training on PREA-compliant practices for residents with disabilities. Although Oakcreek and JWTP did not have current LEP residents, MacLaren YCF had a number of residents with LEP. At that facility, the Auditor asked the line staff who were assigned the task of bringing residents for Audit interviews to use their contracted translation service. They had never used it before. Administrators quickly pointed out the information about the language line that was posted. The staff, who were on the spot, remembered having been told about the language line and read (and followed) the instructions. It was a success in every case. The Auditor used the examples from MacLaren YCF as proof of practice for Oakcreek YCF and JWTP because the identical language line numbers and instructions were posted for Oakcreek and JWTP staff as well, and they are equally capable of reading and following the instructions. The documentation of CAP completion described above demonstrates compliance with this Standard.

115.317	**Hiring and promotion decisions**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	OYA policy prohibits hiring or promoting anyone who may have contact with residents, and it prohibits enlisting the services of any contractor who may have contact with residents, who: Has engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility, or other institution (as defined in 42 USC 1997); Has been convicted of engaging or attempting to engage in sexual activity in the community facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse; or Has been civilly or administratively adjudicated to have engaged in the activity described. Policy requires the consideration of any incidents of sexual harassment in determining whether to hire or promote anyone, or to enlist the services of any contractor, who may have contact with residents. Policy requires that, before it hires any new employees who may have contact with residents, OYA conducts criminal background record checks; consults the Child Abuse Registry; and attempts to contact all prior institutional employers for information on substantiated allegations

	of sexual abuse, or any resignation during a pending investigation of an allegation of sexual abuse. The Agency policy states that material omissions regarding such misconduct, or the provision of materially false information, shall be grounds for termination. The agency provides information on substantiated allegations of sexual abuse or sexual harassment involving a former employee upon receiving a request from an institutional employer for whom such employee has applied to work. CORRECTIVE ACTION: At the time of the PREA Audit Interim Report, Oakcreek YCF and JWTP had still not provided their records regarding volunteers and contractors. The agency identified issues with training and record-keeping early in the process, but did not implement corrective actions before the Interim Report. Documentation for the new system was provided, along with background checks and training records for the volunteers and contractors. Analysis: Evidence used to determine compliance with this Standard includes: Interviews with Human Resources staff. Policies on promotions and hiring of employees and contractors, including policies governing criminal background checks and checks of child abuse registries for current employees and contractors who may have contact with residents. Files of persons hired or promoted in the last 12 months, to determine whether proper criminal record background checks and checks of child abuse registries have been conducted, and whether questions regarding past conduct were asked and answered. Policy and procedure citations include I-A-10.0 Preventing, Detecting, and Responding to Youth Sexual Abuse & Sexual Harassment, pg. 6. Records regarding volunteers and contractors were provided during the CAP. The facility demonstrated compliance with this Standard by completing the CAP.

115.318	**Upgrades to facilities and technologies**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	When designing or acquiring any new facility, and in planning any substantial expansion or modification of existing facilities, this Standard requires the agency to consider the effect of the design, acquisition, expansion, or modification upon its ability to protect residents from sexual abuse. When installing or updating a video monitoring system, electronic surveillance system, or other monitoring technology, the agency is required to consider how such technology may enhance the agency’s ability to protect residents from sexual abuse. Analysis: Interviews and documentation indicate that a remodel of the Medical Clinic was completed in 2024. Remodeling of the Control Room began in April 2025. A server upgrade for cameras was completed in November 2023. The facility includes the PREA Coordinator in any major camera additions or updates. Evidence used to determine compliance with this Standard includes the Site Review and interviews with the Agency Head, PREA Coordinator, and facility administrators. The PAQ

	documentation indicates that sexual safety is considered when modifications are made in compliance with this Standard.

115.321	Evidence protocol and forensic medical examinations
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	For agencies such as OYA that conduct their own administrative investigations of allegations of sexual abuse, this Standard requires the agency to "follow a uniform evidence protocol that maximizes the potential for obtaining usable physical evidence for administrative proceedings and criminal prosecutions." The Standard includes specific rules regarding how this is to be done and how to care for alleged abuse survivors. For example, it requires the agency to "offer all residents who experience sexual abuse access to forensic medical examinations whether on-site or at an outside facility, without financial cost, where evidentiarily or medically appropriate. Such examinations shall be performed by Sexual Assault Forensic Examiners (SAFEs) or Sexual Assault Nurse Examiners (SANEs) where possible. If SAFEs or SANEs cannot be made available, the examination can be performed by other qualified medical practitioners. The agency shall document its efforts to provide SAFEs or SANEs." In addition, it requires the agency to "attempt to make available to the victim a victim advocate from a rape crisis center." The Standard acknowledges that these services are not always available in every locality and provides provisions that take into account various circumstances. For example, it states that "If a rape crisis center is not available to provide victim advocate services, the agency shall make available to provide these services a qualified staff member from a community-based organization or a qualified agency staff member. Agencies shall document efforts to secure services from rape crisis centers." The requirement for victims to be allowed to have advocates present extends far beyond their inclusion in forensic exams. The Standard states, "As requested by the victim, the victim advocate, qualified agency staff member, or qualified community-based organization staff member shall accompany and support the victim through the forensic medical examination process and investigatory interviews and shall provide emotional support, crisis intervention, information, and referrals." In addition to what is required in this Standard, Standard 115.353 requires that all residents have a level of access to advocates. Standard 115.353 states that facilities shall provide residents "access to outside victim advocates for emotional support services related to sexual abuse, by providing, posting, or otherwise making accessible mailing addresses and telephone numbers, including toll-free hotline numbers where available, of local, State, or national victim advocacy or rape crisis organizations . . . ." CORRECTIVE ACTION: Upon reviewing the investigations that were provided early in the Audit, as well as the purported reasons for the delay in their completion, the Audit Team found that some investigations had been "suspended" while waiting for

	OSP to conduct an investigation, despite no indication that OSP had accepted the case for investigation. The PREA Audit Interim Report stated that "Policy and procedures must change so that an administrative investigation is never 'suspended' unless there is a reasonable reason. For example, if there is no police report, a criminal investigation will not be conducted. Sexual harassment by an OYA resident has never been known to have been prosecuted in these jurisdictions, so it is not appropriate to suspend sexual harassment cases without word from OSP. OYA is working on updating the IAA with OSP to clarify the working relationship. Additionally, victim advocates have not been a part of investigative interviews with alleged victims." The CAP required a review of the PSO process to identify the best steps to verify that youth are receiving the required information and access to advocacy. Meetings were held with the OYA Victim Engagement Program Director and representatives of advocacy organizations. Documentation of change was received, and proof of practice was in investigative materials for the most recent investigations and a review of open and suspended investigations. Continual improvement in the relationship between OSP and PSO was noted in the documentation of quick and thorough OSP responses, the reduction in investigations pending OSP, and the few remaining suspended cases having clear reasoning regarding delays. PSO recognizes that work can continue even when specific elements are paused for OSP. The IAA between OSP and PSO was updated. Analysis: The evidence used to determine compliance with this Standard includes Interviews with randomly selected staff and a SANE Nurse. Evidence Protocol governing how to obtain usable physical Analysis and Evidence in allegations of sexual abuse. Documentation of efforts to provide SAFEs or SANEs. Documentation that forensic medical exams are offered for free. Documentation of agreement with the rape crisis center for services. Documentation of staff qualifications. Policy and Procedure citations include all of HS I-A-10.0 policy, but especially sections addressing Preventing Youth Sexual Abuse and Harassment, and Responding to and Monitoring Offender Sexual Abuse; I-A-10 Sexual Abuse Response Plan; Qualified agency staff; Victim Advocate MOUs; I-D-4.0 Professional Standards Office Investigations; MOU with Oregon State Police (OSP) regarding criminal investigations; II-A-1.2 Preserving Chain of Evidence; YA 1958 First Responder Checklist; YA 1959 Sexual Abuse Incident Response Checklist; and Facility SARRT Sexual Abuse Incident Checklist. The agency came into compliance with this Standard through the completion of the CAP.

115.322	**Policies to ensure referrals of allegations for investigations**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	This Standard is clear and direct in its requirement that “The agency shall ensure that an administrative or criminal investigation is completed for all allegations of sexual abuse and sexual harassment.” The Standard further requires that agencies

	have a policy that ensures compliance and that the policy be published. Agencies must provide their referrals and investigative records to demonstrate compliance. CORRECTIVE ACTION: The PREA Audit Interim Report stated, “PSO is in the process of updating to a new system, Benchmark. At the time of this report, the new system is not being used for PREA cases. This is an ongoing development into a new system. At the time of this PREA Audit Interim Report, OYA cannot be found in compliance with this Standard due to investigations that do not appear to be addressing all allegations as per all the provisions of Standard 115.371 that make an investigation ‘complete.’” The Audit Team reviewed lists of investigations several times during the CAP and twice selected cases for review. The agency requested feedback from the Audit Team in September 2025 to verify compliance or determine whether additional corrections were required. The quality of the investigations improved with each review, with only best practice issues remaining prior to the final set of selections. But more importantly, the Auditor sought evidence that compliant investigative practices were sustained over time. The review of the last set of investigations demonstrated full compliance with this Standard within well-organized reports that clearly identified what findings applied to which allegations. Analysis: Evidence used to determine compliance with this Standard includes: Interviews with the Agency Head and Investigative staff; policies and procedures governing investigations of allegations of sexual abuse and sexual harassment; Investigative policy; documentation of reports of sexual abuse and sexual harassment; and documentation of investigations of these referrals/allegations, including full investigative reports with findings. I-D-4.0 Professional Standards Office Investigations, pg. 3, IV. A.2. & 8. pg. 10, Attachment A: OYA Investigations Decision Tree. Spreadsheets tracking investigations. Oregon State Police MOU. https://www.oregon.gov/oya/pso/Pages/prea.aspx. Screenshots from AIM and JJIS. The agency demonstrated compliance with this Standard by successfully completing the CAP.

115.331	**Employee training**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	OYA trains all employees who may have contact with residents regarding all the topics required by this Standard. The training is tailored to the unique needs and attributes of the residents at the facility. Between trainings, the agency provides employees who may have contact with residents with refresher information about current policies regarding sexual abuse and sexual harassment. Analysis: Evidence used to determine compliance with this Standard includes: Interviews with randomly selected staff; training policy and/or procedures; staff training curricula; and samples of records documenting staff training regarding compliance with this Standard. Documentation includes Policy 1I-A-10.0 Preventing

	Youth Sexual Abuse and Harassment; 3330 LP - PREA Scenarios Training for NEO; Annual Employee PREA Acknowledgement and Understanding; 2025 OYA PREA Refresher Workday; Staff Training Random Samples Requested by Auditor; Online Course - Relationship with Youth and Their Families; LGBTQIA+ Youth Training v2; Policy 1 0-2.3 Mandatory Reporting of Abuse; Workday Mandatory Reporting Training; PREA NEO Scenarios Worksheet Review; FS Top 10 Policy Presentation; Training Update dated September and October, 2024; PREA updates in unit meetings; and Email Reaffirming Reporting Requirements for all Staff. In December 2025, just over one month prior to the conclusion of this Audit, the DOJ PREA Management Office told PREA Auditors to “immediately” cease determining compliance with the provision of this Standard that requires employees to be trained in “How to communicate effectively and professionally with residents, including lesbian, gay, bisexual, transgender, intersex, or gender nonconforming residents.” Nevertheless, providing this training remains best practice. A triangulation of evidence demonstrates that the facility has followed all applicable provisions and/or best practices of this Standard.

115.332	**Volunteer and contractor training**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Volunteers and contractors who will have contact with residents are required to have been trained on their responsibilities, under OYA policies and procedures, regarding sexual abuse and sexual harassment prevention, detection, reporting, and response. The level and type of training provided to volunteers and contractors should be based on the services they will provide, taking into account the level of contact they will have with residents. All contractors who will have contact with residents should have been notified of the agency and facility’s zero-tolerance policy regarding sexual abuse and sexual harassment, as well as informed of how to report such incidents. The agency is responsible for maintaining documentation confirming that its contractors and volunteers understand the training they have received. CORRECTIVE ACTION: At the time of the Interim Report, JWTP and Oakcreek YCF were not able to produce training records for their volunteers. This problem had been identified by OYA prior to the audit and an agencywide system update was in process to assist with uniformity while also giving facilities leeway regarding local volunteers. The updated system was verified, and the missing records were provided during the CAP. Analysis: Evidence used to determine compliance with this Standard includes: Interviews with contractors (including teachers) and volunteers; and training curriculum for volunteers and contractors who have contact with residents. This consists of the following: PREA Standards on Volunteers; Volunteer Training on YouTube; YA 6030 - Volunteer Agreement; Policy I-D-3.16 Volunteer Services; Create

	Extended Enterprise Learner Account - OYA 3-15-23; Facility Access Level 1 - Youth Visitors and Facility Guest; Facility Access Level 2 - Volunteers and Interns; and Facility Access Level 3 - Employees and Contracted Providers. Oakcreek YCF and JWTP demonstrated compliance by completing their CAP, updating their training and record-keeping systems, and providing verification.

115.333	**Resident education**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Residents are to receive information at the time of Intake about the zero-tolerance policy and how to report incidents or suspicions of sexual abuse or sexual harassment. Additionally, the Standard requires that, "Within 10 days of intake, the agency shall provide comprehensive age-appropriate education to residents either in person or through video regarding their rights to be free from sexual abuse and sexual harassment and to be free from retaliation for reporting such incidents, and regarding agency policies and procedures for responding to such incidents." The facility is required to provide education in formats accessible to all residents, including those who have limited English proficiency and/or are deaf, visually impaired, and/or otherwise disabled, as well as to residents who have limited reading skills. The agency is also to ensure that key information is continuously and readily available or visible to residents through posters, resident handbooks, or other written formats. Analysis: Evidence used to determine compliance with this Standard includes interviews with Intake Staff and selected residents. Resident interviews included interviews utilizing the staff's ability to use the language interpreter line. Staff called the number, connected with an interpreter, then left the room so the Auditor could conduct a private interview with the resident with the interpreter's help. These demonstrations only occurred at MacLaren YCF, as Oakcreek YCF and JWTP had no current residents with limited English proficiency. Also reviewed to determine compliance with this Standard was Policy I-A-10.0 Preventing Youth Sexual Abuse pp. 8-9, IV.D.; intake records, randomly selected by the Auditor, of residents entering the facility in the past 12 months; logs and other records corroborating that residents received comprehensive, age-appropriate PREA education within ten days of Intake; and education and informational materials (posters, resident handbook, etc.) in compliance with the Standard. Some materials reviewed include the Reporting Line Poster – English; Reporting Line Poster – Spanish; Youth Sexual Safety Education – Spanish and English; Victim Advocate Flyer – Bilingual; Reporting Line Card in English and Spanish; Close Custody Youth Sexual Safety Education for Intake in English and Spanish; Service Order Contract between Oregon Youth Authority and Cal Interpreting & Translations, Inc.; Service Order Contract # between Oregon Youth Authority and LinguaLinx Language Solutions, Inc; emails; curricula documenting that Ways to Report Abuse are reviewed semiannually in the facilities;

	and the Hearing Impaired Interpreter Request Form for all State Agencies. The facility has provided a triangulation of evidence of compliance with this Standard.

115.334	Specialized training: Investigations
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The Standard states that “the agency shall ensure that, to the extent the agency itself conducts sexual abuse investigations, its investigators have received training in conducting such investigations in confinement settings.” The training “shall include techniques for interviewing juvenile sexual abuse victims, proper use of Miranda and Garrity warnings, sexual abuse evidence collection in confinement settings, and the criteria and evidence required to substantiate a case for administrative action or prosecution referral.” Further, “The agency shall maintain documentation that agency investigators have completed the required specialized training in conducting sexual abuse investigations.” PREA Standard 115.331: Employee training also related to agency investigators and administrators because they are employees who have contact with residents. Standard 115.331 states, “(a) The agency shall train all employees who may have contact with residents on: (1) Its zero-tolerance policy for sexual abuse and sexual harassment; (2) How to fulfill their responsibilities under agency sexual abuse and sexual harassment prevention, detection, reporting, and response policies and procedures . . . .” CORRECTIVE ACTION: The agency had a new Chief Investigator, secured through an agreement with the Oregon Department of Corrections. A transcript from DOC of his training was provided, but not the curriculum. The PREA Audit Interim Report pointed out that, for his work in OYA, he must be trained in “techniques for interviewing juvenile sexual abuse victims” as well as the other PREA training that all OYA employees and investigators are required to receive. Additionally, interviews with the Chief Investigator and other investigators did not indicate that they understand that, as they come across information in the course of their fact-finding duties, they must also consider how to help the agency strengthen its systems for preventing, detecting, and reporting. During the CAP, the Chief Investigator completed the missing specialized training. The PSO team and the PREA Coordinator attended the Sexual Assault Task Force Training “Trauma Informed Interview Practices Training - Sexual Assault: Ready and Resilient” and provided verification. In addition, they attended numerous training sessions and meetings to update their skills, onboard new investigators, and address concerns raised in the audit and elsewhere. Analysis: Evidence used to determine compliance with this Standard includes: interviews with Investigative staff and agency administrators; Agency training policy (1-A-10.0 Preventing Youth Sexual Abuse pg. 8, IV.C.3.b.); Investigator training curriculum; and documentation that Agency Investigators have completed the required training. The agency demonstrated compliance with this Standard by

	completing the CAP.

115.335	Specialized training: Medical and mental health care
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	This Standard requires that 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; How to preserve physical evidence of sexual abuse; How to respond effectively and professionally to juvenile victims of sexual abuse and sexual harassment; and How and to whom to report allegations or suspicions of sexual abuse and sexual harassment. The agency maintains documentation that medical and mental health practitioners have received the training referenced in this Standard, either from the agency or elsewhere. Medical and mental health care practitioners 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. OYA's in-house medical professionals are not required to have training to perform forensic sexual abuse exams because they do not perform forensic exams. Analysis: Evidence used to determine compliance with this Standard includes: Interviews with medical and mental health Staff; interviews with youth who receive care from these professionals; documentation completed by these staff in relation to numerous PREA Standards; policy (I-A-10.0 Preventing Youth Sexual Abuse, pg. 8) and procedures governing training of medical and mental health care practitioners around sexual abuse and sexual harassment; and documentation showing that medical and mental health care practitioners have completed the required training. Audit documents indicate that all medical and mental health care practitioners who work regularly at this facility received the training required by agency policy. National Institute of Corrections (NIC) Training Certificates were provided for randomly selected practitioners. The Auditor has reviewed the NIC training curricula. In the Pre-Audit Phase, the audit team found that the role of OYA medical and mental health care practitioners in active responses to allegations of sexual assault was not entirely up to date and accurately explained in the facility's coordinated response plan, known as the Sexual Abuse Response Plan (SARP). For example, the way the Plan was worded might have led an inexperienced OYA staff member, or even an administrator, to inaccurately believe that an OYA RN approval is required before a resident is taken for a forensic exam. This did not affect compliance with Standard 115.335 since it was addressed more appropriately under Standard 115.365. This was addressed within 30 days after the On-Site Review and resolved with changes that were fully updated and distributed during the CAP under Standard 115.365. A triangulation of evidence demonstrates that the facility is fully compliant with this Standard.

115.341	Obtaining information from residents
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	OYA has a policy consistent with this Standard requiring that, upon admission to the facility or transfer from another facility, all residents must receive screening for risk of sexual abuse victimization or sexual abusiveness toward other residents. This information, collected as part of the screening process, is to be ascertained through conversations with the resident during the Intake process, medical and mental health screenings, and classification assessments, and by reviews of court records, case files, facility behavioral records, and other relevant documentation from the resident’s files. Analysis: Evidence used to determine compliance with this Standard includes: Interviews that were conducted with Risk Screening staff, with randomly selected residents, with the PREA Coordinator, and with the Compliance Manager. Agency policy I-A-10.0 Preventing Youth Sexual Abuse, pg. 12, IV.I; Procedure: Vulnerability to Victimization and Sexually Aggressive Behavior (VSAB) Placement Tool; and Summary VSAB Placement Tool Document governing screening of residents upon admission to a facility or transfer to another facility and during reassessments. Records for residents admitted to the facility within the past 12 months have been reviewed for evidence of appropriate screening within 72 hours and compliance with the other provisions of this Standard. By a triangulation of evidence, the facility has demonstrated compliance with this Standard.

115.342	Placement of residents
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	OYA uses information from the risk screening required by ß115.341 to inform housing, bed, work, education, and program assignments to keep all residents safe and free from sexual abuse. Residents may be isolated from others only as a last resort, only when less restrictive measures are inadequate to keep them and other residents safe, and then only until an alternative means of keeping all residents safe can be arranged. OYA policy states that residents may not be isolated for more than five days. Additionally, OYA does not place youth in Isolation for risk of sexual victimization because it does not meet OYA's threshold for Isolation. Analysis: Evidence used to determine compliance with this Standard includes: Interviews conducted with the PREA Coordinator and the Compliance Manager, with Risk Screening Staff, and with LGBTI residents. Documentation of screening information to inform housing, bed, work, education, and program assignments to keep all residents safe and free from sexual abuse. Facility policies and procedures

	(I-A-10.0 Preventing Youth Sexual Abuse, pg. 12, IV.I; Procedure: Vulnerability to Victimization and Sexually Aggressive Behavior (VSAB) Placement Tool; Samples of JJIS VSAB usage with notes for placement; II-B-1.2 Use of Time-out, Room-lock Other, Isolation, and Safety Programs; and I-A-10.1 Meeting LGBTQ+ Needs, page 7) applicable to the provisions of this Standard. Additionally, documentation of 30-day Reviews was examined for compliance with the Standard. By a triangulation of evidence, the facility has verified compliance with this Standard.

115.351	**Resident reporting**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	This Standard requires the agency to provide multiple internal ways for residents to privately report sexual abuse and sexual harassment, retaliation by other residents or staff for reporting sexual abuse and sexual harassment, and staff neglect or violation of responsibilities that may have contributed to such incidents. Also, the agency is to provide a way for residents to report abuse or harassment to an entity that can receive and immediately forward resident reports of sexual abuse and sexual harassment to agency officials, allowing the resident to remain anonymous upon request. Staff are to accept reports made verbally, in writing, anonymously, and from third parties, and promptly document verbal reports. Facilities are to provide residents with access to the necessary tools to create a written report. The agency is also to provide a method for staff to privately report sexual abuse and sexual harassment of residents. CORRECTIVE ACTION: Most compliance concerns regarding this Standard were at the agency level. The Governor's Constituent Services office (State Capital, RM 254; 900 Court Street, Salem, Oregon 97301) was sent a test complaint. Although the test letter was received and processed in a timely manner, the letter requested that the name be kept anonymous; however, this request was not honored when the test complaint was forwarded. When testing the address for the Professional Standards Office (530 Center Street NE, Suite 500, Salem, OR 97301), which is located in OYA's Central Office, the Auditor encountered significant difficulty. The Auditor had to send six (6) letters before they started being received and processed in a timely manner. Once the problem was identified, it was addressed comprehensively, even before the CAP was developed. The PSO office is now staffed full-time, and mail is checked daily. During the CAP, the MOU with the Governor's Constituent Services office was updated, and their reporting system has since been successfully tested. The PSO website was updated and the online reporting option tested again. Additionally, changes were made and verified at the PSO, with additional tests mailed through USPS being successful. Out of an abundance of caution, JWTP and Oakcreek administrators and staff were retrained on reporting requirements and on MOU updates. Analysis: Evidence used to determine compliance with this Standard includes: (1)

	Interviews with all of the following people: randomly selected staff and residents; the PREA Compliance Manager; and residents who reported sexual abuse. (2) Reviews of all of the following policies and agreements: resident reporting policy; documentation on resident reporting; documentation of agreement with an outside entity responsible for taking reports; resident reporting policy relevant to reporting to an outside public or private entity; policy mandating that staff accept reports of sexual abuse and sexual harassment made verbally, in writing, anonymously, and from third parties; and policy and documentation outlining procedures for staff to privately report sexual abuse and sexual harassment of residents. Policy and Procedure citations include I-A-10.0 Preventing Youth Sexual Abuse, pp. 9-10, IV.F. Resident Education materials and forms. OYA does not hold youth solely for civil immigration purposes. Facility-wide procedure: FAC I-E-4.0 Youth Incident Reports, pg. 3, Step 3. II-F-1.1 Youth Grievance Process, pp. 3-4, IV.E. Staff may use the third-party reporting process described in I-A-10.0, pg. 11, IV.G.1-3. Link to the online complaint form: https://www.oregon.gov/oya/pso/Pages/OnlineComplaintForm.aspx. Test of the complaint form. Annual Training Slides and instructions to access them. Resident reporting - agreement, process, and test. Annual and New Employee Training Slides. During the CAP, additional verification was received as described in the "Corrective Action" section above. The culmination of evidence provided verification of compliance with this Standard.

115.352	**Exhaustion of administrative remedies**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	OYA has an administrative procedure for dealing with resident grievances regarding sexual abuse. The facility policy allows a resident to submit a grievance regarding an allegation of sexual abuse at any time, regardless of when the incident is alleged to have occurred. There is no time limit for a resident to submit a grievance regarding an allegation of sexual abuse, and the resident is not required to use an informal grievance process, nor to otherwise attempt to resolve with staff an alleged incident of sexual abuse. Policy allows a resident to submit a grievance alleging sexual abuse without submitting it to the staff member who is the subject of the complaint. The facility's procedure requires that a resident grievance alleging sexual abuse not be referred to the staff member who is the subject of the complaint. CORRECTIVE ACTION: At the time of the PREA Audit Interim Report, the agency was still under corrective action following the grievance system audit conducted by ODOC and ODAS auditors. Some corrections appeared to have been successfully implemented. Grievance boxes have been installed, although they were not all properly labeled. A designated staff member who does not have routine contact with residents must collect all forms from the locked boxes. The report made 12 recommendations to OYA management. The On-Site Review by the PREA Audit Team, which included interviews, observation of grievance boxes, and review of

	relevant emails and other documentation, indicated that the changes triggered by the ODOC/ODAS audit had not been fully institutionalized within the agency's culture. The PREA Audit Interim Report stated that sustained compliance is optimal in these determinations, and additional system tests would be helpful. Additionally, since grievances may be mailed to OYA, the failure of OYA's Central Office to receive and process, in a timely manner, 6 test letters from the Auditor (mailed on different days) also affected the reliability of the agency's grievance system. The Audit Team tested the online form for filing a grievance. It was received and processed in a timely manner for a regular grievance, but not for an emergency grievance. These forms were reviewed Monday through Friday, excluding holidays. The form now provides instructions on contacting facilities directly for urgent matters. Additionally, the CAP required updated Grievance audit tracking and additional system tests. Analysis: Evidence used to determine compliance with this Standard includes: interviews with residents who reported Sexual Abuse and those familiar with the grievance process; interviews with administrators and staff familiar with the grievance process; Policy 1I-A-10.0 Preventing Youth Sexual Abuse and Harassment; Samples of grievances with outcomes; Policy II-F-1.1 Youth Grievance Process-Facility; Grievance Box Samples; posted instructions for youth regarding grievances; Grievance form and instructions; Grievance system tests; and the July 2024 OYA Youth Grievance Process Report by an internal Auditor from the Oregon Department of Corrections and with contributions and supervision by an Audit Executive with the Oregon Department of Administrative Services. Completion of the CAP culminated in a triangulation of evidence of compliance with this Standard.

115.353	**Resident access to outside confidential support services and legal representation**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The facility provides residents with access to outside victim advocates for emotional support services related to sexual abuse. It provides residents with reasonable and confidential access to their attorneys or other legal representation, as well as reasonable access to parents and legal guardians. OYA does not have the authority to have custody of residents detained solely for civil immigration purposes. Analysis: Evidence used to determine compliance with this Standard includes: Interviews with randomly selected residents, with residents who reported sexual abuse, with the PREA Compliance Manager, and with the Superintendent or designee; Policies and procedures governing resident access to outside victim advocates for emotional support services related to sexual abuse and the other provisions of this Standard; Resident handbooks and written materials prepared for residents, pertinent to reporting sexual abuse and access to support services; and MOUs with community service providers who provide residents with emotional support services related to sexual abuse. The Audit Team called the community

	service providers and verified the services they provide. Policy and Procedure citations include I-A-10.0, Preventing Youth Sexual Abuse, page 9, IV.D.6; the annual check of the advocacy phone number; and the flyer for the advocacy provider. Residents may visit with, mail letters to, and telephone advocacy organizations. Screenshots of documentation of this access were provided as proof of practice. Related policy includes I-A-9.0 Parent-Guardian Involvement; III-E-5.0 Notification to Parents/Guardians; II-E-2.5 Visits with Youth; II-F-1.0 Youth Rights (Facilities); II-F-3.0 Youth Mail in Facilities; II-F-3.6 Youth Legal Materials and Assistance; II-F-3.4 Youth Use of Telephone; I-A-10.0 Preventing Youth Sexual Abuse, pg. 9; IV.E Confidentiality; and I-F-3.6 Youth Legal Materials and Assistance. Also reviewed were the documentation of youth access to an attorney and the completed 4033 youth education forms. Concerns that victim advocates were not being included in investigative interviews were addressed under Standard 115.371 during the CAP. By a triangulation of evidence, the facility has demonstrated compliance with this Standard.

115.354	**Third-party reporting**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	According to OYA policy, they provide methods to receive third-party reports of resident sexual abuse or sexual harassment. All staff members are required to take complaints. Complaints can be anonymous. Information is supposed to be distributed on how to report resident sexual abuse or sexual harassment on behalf of residents. This Standard states that, "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." CORRECTIVE ACTION: At the time of the PREA Audit Interim Report, the Audit Team had had success verifying the email, grievance box, and phone reporting systems through observation and tests. However, issues arose when test letters were sent via the United States Postal Service. The Governor's Constituent Services office (State Capital, RM 254; 900 Court Street; Salem, Oregon 97301) received and processed their test letter in a timely manner, but the test letter requested that the (fictitious) name of the resident be kept anonymous, and this request was not honored. When testing the address for the Professional Standards Office (530 Center Street NE, Suite 500; Salem, OR 97301), which is in the OYA's Central Office, the Auditor had to send seven letters before they started being received and processed in a timely manner. Posters displayed in facility visitation areas were written for residents, not for families or visitors. Community-facing language is more useful on these postings. Corrections made within 30 days of the On-Site Audit, along with those made during the CAP, addressed all of these issues. The agency and the Governor's Constituent Services office responded quickly with well-received

	reminders for their staff about the importance and option of anonymity around sexual abuse. The Professional Standards Office (PSO) assigned staff and backup staff to mailroom duties, and all staff, including the Chief Investigator, began participating in checking and double-checking the mail. Testing of the PSO address continued during the CAP. Additional letters were processed appropriately, with verifications recorded. New posters were designed by OYA Communications and installed in the facility's visitation areas. Analysis: Evidence used to determine compliance with this Standard includes: publicly distributed information on how to report sexual abuse or sexual harassment on behalf of residents. OYA provides information on how to report abuse or harassment on its public website and in brochures and flyers distributed to families and others. The public site is https://www.oregon.gov/oya/pso/Pages/abuse.aspx. During the CAP, protocols were reinforced and verified to accommodate Third-Party Reporting as required by this Standard.

115.361	**Staff and agency reporting duties**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	All staff are required to report, immediately and according to agency policy: any knowledge, suspicion, or information they receive regarding an incident of sexual abuse or sexual harassment that occurred; any retaliation against residents or staff who reported such an incident; and any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation. OYA requires all staff to comply with any applicable mandatory child abuse reporting laws, as well as reporting, as (and when) appropriate, to licensing agencies and Adult Protective Services. Other than when reporting to designated supervisors or officials and designated state or local service agencies, OYA policy prohibits staff from revealing any information related to a sexual abuse report to anyone, beyond what is necessary to make treatment, investigation, and other security and management decisions. Medical and Mental Health practitioners are mandated reporters; therefore, they are required to inform residents at the initiation of services of their duty to report and the limitations of confidentiality. Upon receiving any allegation of sexual abuse, OYA is to promptly report the allegation to the appropriate agency office and to the alleged victim's parents or legal guardians, unless the facility has official documentation showing that the parents or legal guardians should not be notified. If the alleged victim is under the guardianship of the child welfare system, the report shall be made to the alleged victim's caseworker rather than to the parents or legal guardians. If a juvenile court retains jurisdiction over the alleged victim, the facility head or designee shall also report the allegation to the juvenile's attorney or other legal representative of record, within 14 days of receiving the allegation. Analysis: Evidence used to determine compliance with this Standard includes:

	Interviews with randomly selected staff, with medical staff, with mental health staff, with selected residents, with the PREA Compliance Manager, and with the Superintendent or designee. Policy I-A-10.0, Preventing Youth Sexual Abuse, and Policy 0-2.4, Mandatory Reporting of Abuse, were reviewed. Also reviewed were the Notification to PREA Coordinator process, Workday training on this Standard, and the PREA semiannual refresher training regarding reporting. A triangulation of evidence indicates that the agency and facility are compliant with this Standard.

115.362	**Agency protection duties**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The Standard in its entirety is this: "When an agency learns that a resident is subject to a substantial risk of imminent sexual abuse, it shall take immediate action to protect the resident." Analysis: Evidence used to determine compliance with this Standard includes: Interviews with the Agency Head, with the Superintendent or designee, other administrators, and with randomly selected staff; and relevant policy governing the agency's protection duties when residents are subject to a substantial risk of imminent sexual abuse which is I-A-10.0 Preventing Youth Sexual Abuse and Harassment, p.14, IV.I.5 and 0-2.3 Mandatory Reporting of Abuse. A documented agency example was provided of a resident who was considered at risk of harm being moved for safety from the perceived threat of sexual victimization, as well as for safety planning. In general, the residents interviewed indicated they believe staff will take immediate action to protect them when they are aware of a threat. There is less confidence in staff's long-term follow-up and in responses regarding verbal abuse. Still, they say that the vast majority of staff act immediately to protect residents from harassment and inappropriate comments. They shared numerous examples of staff using wisdom and skill to prevent problems and to intervene and redirect when needed. The content of the information gathered from the interviews conducted for this audit, along with the policies and procedures in place, and the documentation of immediate responses to various concerns and incidents, collectively indicate that the facility is fully compliant with this Standard.

115.363	**Reporting to other confinement facilities**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The Standard states that, “Upon receiving an allegation that a resident was sexually

	abused while confined at another facility, the head of the facility that received the allegation shall notify the head of the facility or appropriate office of the agency where the alleged abuse occurred and shall also notify the appropriate investigative agency.” The Standard also requires the notification be made within 72 hours, be documented, and that “The facility head or agency office that receives such notification shall ensure that the allegation is investigated in accordance with these standards.” Analysis: Evidence used to determine compliance with this Standard includes: Interviews with the Agency Head and the Superintendent or designee; Agency policy regarding reporting of allegations of sexual abuse of residents while confined at another facility; and Agency policy requiring that allegations of sexual abuse of residents received from other agencies or facilities are investigated in accordance with the PREA Standards. These policies are I-A-10.0, Preventing Youth Sexual Abuse and Sexual Harassment, on page 17, and I-D-4.0, Professional Standards Office Investigations, on page 3. Examples of receiving reports and reporting to other confinement facilities, applicable to this Standard, were provided as proof of practice. The PREA Standards define full compliance as “compliance with all material requirements of each standard except for de minimis violations, or discrete and temporary violations during otherwise sustained periods of compliance.” Although OYA has demonstrated adherence to the spirit of this Standard, it appears that the facility head has not always made the notifications. A triangulation of evidence verifies compliance with this Standard.

115.364	**Staff first responder duties**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Policy requires that, upon learning of an allegation that a resident was sexually abused, the first staff to respond to the report shall: (1) separate the alleged victim and abuser; and (2) preserve and protect any crime scene until appropriate steps can be taken to collect any evidence. If the abuse occurred within a time period that still allows for the collection of physical evidence, those appropriate steps shall be as follows: (1) The First Responder requests that the alleged victim not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating; and (2) The First Responder should ensure that the alleged abuser does not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating. Additional notifications are required, as in ß115.361 above. Analysis: Evidence used to determine compliance with this Standard includes: Interviews with residents who reported sexual abuse; interviews with staff who have acted as First Responders; and interviews with randomly selected staff, along with the Agency's policy governing staff First Responder duties. These policies and

	procedures are in I-A-10.0 Preventing Youth Sexual Abuse and Harassment; I-A-10 Sexual Abuse Response Plan; Facility First Responders to Sexual Abuse Checklist; Facility SARRT Sexual Abuse Incident Checklist; First Responder Cards for Staff; and training content related to this Standard. These sources, along with investigative documentation consistent with policy and training, provide a triangulation of evidence of compliance with this Standard.

115.365	**Coordinated response**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The Standard states that "The facility shall develop a written institutional plan to coordinate actions taken in response to an incident of sexual abuse among staff first responders, medical and mental health practitioners, investigators, and facility leadership." CORRECTIVE ACTION: The Sexual Abuse Response Plan (SARP) had a phone number for a "Nurse Manager" that was not in use and an outdated number for the Chief Investigator that was also not in use. Improvements and updates were needed to the wording of the plans. For example, it should be clear that residents can be taken for a forensic exam without approval from any investigator or nurse. Each facility must designate someone responsible for PREA compliance to ensure these plans remain up to date and accessible to new or inexperienced staff and administrators when other staff and administrators are unavailable. During the CAP, to demonstrate full compliance, the plan was made clear and accurate and shown to be part of a reliable system for ongoing review and update. Analysis: Evidence used to determine compliance with this Standard includes interviews with the Superintendent or designee, a review of the Facility's Sexual Abuse Response Plan, and interviews conducted to check the information provided on the SARP. Evidence of CAP completion and compliance with the Standard included the updated SARP, with notes and documentation showing the review and involvement of the agency and the facility SARP team, including the PCM, Superintendent, Medical, Supervisors, and Providers. Additionally, requirements for regular plan reviews and updates are documented.

115.366	**Preservation of ability to protect residents from contact with abusers**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion

	The agency has not made 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. Analysis: The evidence used to determine compliance with this Standard includes an interview with the Agency Head and a review of collective bargaining agreements. This included the SEIU Master Agreement Collective Bargaining Agreement 2023-2025. Interviews and documentation verified compliance with this Standard with no evidence to the contrary.

115.367	**Agency protection against retaliation**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	This Standard requires that the agency 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." The Standard describes minimum practices to protect against retaliation. These measures include designating "which staff members or departments are charged with monitoring retaliation." The agency must "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." "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, negative performance reviews, or staff reassignments. The agency shall continue such monitoring beyond 90 days if the initial monitoring indicates a continuing need." The monitoring of residents must "include periodic status checks." "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." The monitoring begins as soon as an allegation of sexual abuse or sexual harassment is made. "An agency's obligation to monitor shall terminate if the agency determines that the allegation is unfounded." CORRECTIVE ACTION: The agency's policy definition of retaliation fell short of meeting the PREA Standard. Policy said, "Retaliation: When a youth or staff injures, harms, or intimidates a person who has reported sexual abuse/harassment, or is the alleged victim of the sexual abuse/harassment; or any attempts to do so." However,

	the Standard requires the agency to include not only the reporting person and the alleged victim but also all who "cooperate with sexual abuse or sexual harassment investigations" in retaliation monitoring efforts when applicable. This omission was consistent with statements in interviews and with the documented retaliation monitoring, which did not include witnesses or others who feared retaliation. Additionally, the retaliation monitoring of staff was not fully compliant with the PREA Standard. Interviews indicated that concerns about retaliation among staff were underreported, particularly when compared to other state agencies. A code of silence, particularly among new staff, was suspected to be the cause. Retaliation Monitoring relies on face-to-face meetings with the person being monitored. Other monitoring methods, such as file reviews of write-ups, housing transfers, shift changes, and Incident reports, had not been fully implemented for staff, witnesses, reporting persons, or youth. Interviews indicated a lack of awareness of these expectations. For example, one interviewee stated that OYA can only protect staff if they report retaliation, suggesting that OYA is not taking adequate steps to proactively check for it. During the CAP, Policy and practice were changed to comply with the Standard. Analysis: Evidence used to determine compliance with this Standard includes: (1) Interviews with each of the following: the Agency Head, the Superintendent or designee, staff responsible for retaliation monitoring, residents who have been in isolation, and residents who reported sexual abuse or sexual harassment. (2) Agency policy (I-A-10.0 Preventing Youth Sexual Abuse, pg. 10, IV.F.2.; pg. 12, H; Staff Monitoring Process document; and FAC I-A-10.0 Monitoring retaliation of youth) protecting all residents and staff who report sexual abuse or sexual harassment, or who cooperate with sexual abuse or sexual harassment investigations, from retaliation by other residents or staff, including policies on the monitoring of residents and staff following a report and the Agency response to suspected retaliation. (3) Documentation of monitoring efforts, including retaliation monitoring of staff and youth. During the CAP, evidence was provided that the definition of retaliation in Policy and other areas was updated to match the PREA definition. Current practices were reviewed to determine process adjustments. This included facility PCM, QMHPs, and other affected individuals, as appropriate. Evidence of sustained change was provided through submitted investigations and other materials, including templates, JJIS notes, emails, and training records. Proof of CAP completion verifies compliance with this Standard.

115.368	**Post-allegation protective custody**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The Standard requires that, "Any use of segregated housing to protect a resident

	who is alleged to have suffered sexual abuse shall be subject to the requirements of § 115.342." Analysis: Evidence used to determine compliance with this Standard includes: (1) Interviews with each of the following: the Superintendent or designee; staff who supervise residents in Isolation for any reason; medical staff; mental health staff; and any residents in Isolation [not applicable in JWTP] specifically related to the risk of sexual victimization/who allege to have suffered sexual abuse. (2) Facility policy that residents who allege to have suffered sexual abuse may only be placed in Isolation as a last resort, only if less restrictive measures are inadequate to keep them and other residents safe, and only until an alternative means of keeping all residents safe can be arranged. (3) Documentation of monitoring. Isolation for those who allege sexual abuse does not meet OYA's threshold for use of Isolation. See OYA policy II-B-1.2 Use of Time-out, Room-lock Other, Isolation, and Safety Programs in OYA Facilities; pg. 6, IV.E.1. Youth who allege to have suffered sexual abuse may not be placed in Isolation. However, youth placed in Isolation for other reasons have access to the listed activities and services, and their placement is reviewed. A triangulation of evidence indicates full compliance with this Standard with no indications to the contrary.

115.371	**Criminal and administrative agency investigations**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	This Standard contains numerous provisions regarding how investigations are to be conducted. It starts by saying, "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." CORRECTIVE ACTION: The review found that not all allegations were investigated "promptly" and "thoroughly." Phone calls were substituting for face-to-face interviews as a matter of standard practice. Specific findings were not made for every resident who was allegedly victimized, for every person who was an alleged perpetrator, or for every allegation related to each alleged victim and alleged perpetrator. Not all new allegations that came in during investigations were investigated. Not all leads were followed, and not all or enough witnesses were interviewed. A few narratives were unclear and seemed to imply evidence that was not otherwise documented. Some investigations were not timely and were coded as "suspended," allegedly to await a criminal investigation, even though there was no evidence they would be pursued by law enforcement. Of the selected cases prior to the On-Site Review, the Auditor found no examples of adequate credibility statements, despite a heading for these assessments in the narratives. When an

	employee was the alleged perpetrator, no credibility assessment was conducted, possibly implying that staff are assumed to be credible. In the case of residents, the credibility assessment narratives sometimes read more like character assassinations than legitimate assessments. Victim advocates had not been included in investigative interviews. During the 30 days following the On-Site Review, one case with appropriate credibility assessments was submitted. Also, during those 30 days, evidence was provided that the agency intended to take the concerns seriously. Face-to-face interviews became the norm, training in conducting credibility statements was implemented, policy updates were considered, and new investigators were hired to increase the agency's ability to investigate promptly, thoroughly, and objectively into all allegations. Yet, at the time of the PREA Audit Interim Report, the agency had not yet demonstrated compliance with the Standard. The CAP required that compliance be verified by proof of sustained, institutionalized investigative practices. This included updating the PSO investigation format to address each specific allegation. PSO investigators completed additional investigative training, including credibility assessment. Assessments of their work from different sources were reviewed at meetings. Although not required by the CAP, investigators are now stationed at the MacLaren facility. Analysis: Evidence used to determine compliance with this Standard includes: Interviews with Investigative staff, with residents and staff who have been involved in investigations, with agency and facility administrators, with the PREA Coordinator, and with the Compliance Manager; Policies related to criminal and administrative investigations; Training records for Investigators; and investigative records/reports for allegations of sexual abuse or sexual harassment regarding the three facilities being audited during this round of PREA Audits. Since agency investigators from the Professional Standards Office were used rather than facility-level investigators, all facilities being audited had the same level of compliance. Interviews with residents involved in the investigations yielded mixed responses. When asked specific questions about whether standard investigative practices were followed, they did not indicate much confidence in, or knowledge of, OYA's investigative work. However, most expressed confidence that OYA is doing its best and that the decisions made are often sound. Some residents provided examples of what they considered good outcomes from investigations, such as residents being relocated or required to stay apart. Several expressed the belief that staff members' word is taken as the truth simply because they are staff. The documentation reviewed to assess the quality of investigations included AIM (investigator database) terminology; Policy I-D-4.0, Professional Standards Office Investigations, pages 4, IV.A.7, and 9, IV.I.3; and spreadsheets of allegations & investigations, as well as Oregon State Police (OSP)-referred cases. During the CAP, the new PSO formats were reviewed, along with additional randomly selected investigations, which were reviewed after the changes had been implemented in practice. The Audit Team was provided proof of credibility assessment training, assessments that were reviewed at meetings, meeting minutes, PSO PREA Weekly Meeting Agenda Samples, PSO YFA PREA Meeting Minutes, OYA Safety Advisory Committee Documents, updated Organization Charts, logs of all sexual abuse and sexual harassment investigations, SARP Team Reviews of the Sex Abuse Response Plans, and the Top 10 policy training materials and rosters of attendees. OYA's research

	team now has full access to PSO data and the authority to verify its accuracy and produce public-facing reports upon request. As PSO works to complete investigations into aged cases, it has published weekly figures showing progress and status. New coding enables the agency to examine a range of factors, including the type of allegation, who is involved, the site to which the allegation pertains, the time elapsed from complaint to resolution, and any referrals. Regular audits by research staff identify anomalies. Agency performance metrics are fully transparent, so department failures cannot be masked. Triangulation of evidence verifies that the agency has demonstrated compliance with this Standard following completion of the CAP.

115.372	**Evidentiary standard for administrative investigations**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The entire Standard is as follows: “The agency shall impose no standard higher than a preponderance of the evidence in determining whether allegations of sexual abuse or sexual harassment are substantiated.” CORRECTIVE ACTION: Although interviews indicated that investigators understood this Standard, the PSO practice of lumping allegations together, even when there are multiple alleged incidents, perpetrators, and/or victims, and assigning only one finding for the case, made it difficult to track which evidence was applied to which allegation. Therefore, at the time of this Interim Report, the agency has not yet demonstrated full compliance with this Standard to the level required by the PREA Auditor’s Handbook. The CAP for this Standard was the same as for Standard 115.371 because resolving other investigative issues would serve to resolve the compliance issues with this Standard. Analysis: Evidence used to determine compliance with this Standard includes: Interviews with Investigative staff; Policy I-D-4.0 Professional Standards Office Investigations, pg. 8, IV.I.1.d; and a review of selected investigations. Also, the Audit Team interviewed staff and residents who had been involved in investigations. The training, along with most of the narratives and interviews conducted, indicated an understanding of the preponderance of evidence. A finding of full compliance with this Standard requires adherence to it even in complex investigations, as demonstrated during the CAP.

115.373	**Reporting to residents**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion

	Any resident who alleges that they suffered sexual abuse is to be informed, verbally or in writing, as to whether the allegation has been determined to be substantiated, unsubstantiated, or unfounded. The Standard provides additional rules that outline the work of informing residents. For example, it requires that all notifications described under this Standard are documented. Additionally, in some cases, notifications are required to inform a resident whether an alleged perpetrator remains at the facility or has had charges filed or convictions entered. CORRECTIVE ACTION: The PREA Audit Interim Report documented that, in every investigation reviewed, PREA administrators documented their attempts to comply with this Standard and their efforts to do so. However, the Report also stated that, “But, since some investigations have not been completed promptly, and with allegations being lumped together, three barriers arise that keep this Standard from working the way it was intended: 1) Residents who need to be notified are often long gone from the facility by the time the time a facility is ready to notify them; 2) Even when residents are still at the facility, they may not remember or understand what investigation they are being notified about especially if they have been involved in several cases; and 3) They are not being notified about all allegations because not all allegations are connected with separate findings. Information pertinent to complex investigations involving multiple alleged perpetrators with varying statuses at the facility and/or in the courts may be outdated or confusing.” Since, with just a few exceptions, the process for reporting to residents was reliable and timely once PREA officials were notified by investigators or other sources of information that an alleged victim needed to be informed of, the corrective actions for this Standard were closely tied to Standard 115.371. The CAP required that the After Actions Committee and/or TIC Committee develop a protocol for supports, including the process for youth notifications for the aged cases (note this committee reviews the process for all case types, not only investigations of sexual abuse and sexual harassment). The Protocol and meeting minutes, applicable to all facilities, were provided. Additionally, proof of practice was provided in the form of the documentation of actual resident notifications, when applicable, for all investigations reviewed during the CAP. Analysis: Evidence used to determine compliance with this Standard includes: Interviews with the Superintendent or designee and with Investigative staff; Agency policy requiring that any resident who alleges that they suffered sexual abuse in an agency facility is informed, verbally or in writing, as to whether the allegation has been determined to be substantiated, unsubstantiated, or unfounded, following an investigation by the agency (1I-A-10.0 Preventing Youth Sexual Abuse and Harassment); Sexual abuse investigations completed by the agency; Agency policy requiring documentation of notifications (1I-A-10.0 Preventing Youth Sexual Abuse and Harassment); and documentation of notifications for completed investigations related to all three facilities being audited. Additionally, as described above, the Audit Team reviewed progress made during the CAP and the After Action Response Protocols. Compliance with the Standard was achieved through the successful completion of the CAP.

115.376	Disciplinary sanctions for staff
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Facility staff are to be subject to disciplinary sanctions, up to and including termination, for violating agency sexual abuse or sexual harassment policies. Disciplinary sanctions for violations of agency policies relating to sexual abuse or sexual harassment (other than actually engaging in sexual abuse) are to be commensurate with the nature and circumstances of the acts committed, the staff member's disciplinary history, and the sanctions imposed for comparable offenses by other staff with similar histories. All terminations for violations of agency sexual abuse or sexual harassment policies, or resignations by staff who would have been terminated if not for their resignation, are to be reported to law enforcement agencies, unless the activity was clearly not criminal, and to any relevant licensing bodies. Within the 30 days following the On-Site Review, the Auditor requested and received additional proof of practice and an explanation regarding how substantiated allegations of conduct that appear to be criminal are referred for criminal prosecution. Analysis: Evidence used to determine compliance with this Standard includes: Staff disciplinary policy regarding violations of Agency sexual abuse or sexual harassment policies, including Policy I-A-10.0 Preventing Youth Sexual Abuse and Harassment, pg. 5, III., and Policy I-D-4.0 Professional Standards Office Investigations, pg. 9, J. Also, the Audit Team conducted numerous interviews with staff, residents who made complaints against staff, investigators, HR officials, and administrators. To provide additional evidence of their commitment to the spirit of this Standard, the agency provided letters of expectation (LOE) to employees, which are not disciplinary actions but outline and document expectations for employee performance and conduct. The investigations reviewed and the sample paperwork, including emails, provided by the agency to demonstrate its practices, all appeared to be consistent with this Standard. Concerns about investigations not complying with all provisions relating to staff were addressed under Standard 115.371 during the CAP. Through a triangulation of evidence, the agency demonstrated compliance with this Standard.

115.377	Corrective action for contractors and volunteers
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	This Standard requires that “Any contractor or volunteer who engages in sexual abuse shall be prohibited from contact with residents and shall be reported to law enforcement agencies, unless the activity was clearly not criminal, and to relevant

	licensing bodies." It also requires that "The facility shall take appropriate remedial measures, and shall consider whether to prohibit further contact with residents, in the case of any other violation of agency sexual abuse or sexual harassment policies by a contractor or volunteer." Analysis: Evidence used to determine compliance with this Standard includes interviews with facility and agency administrators, and reviews of policies (I-D-4.0 Professional Standards Office Investigations, pg. 9; and I-A-10.0 Preventing Youth Sexual Abuse pp. 5, 19). No contractors or volunteers have been subject to disciplinary sanctions for violating agency sexual abuse or sexual harassment policies in the previous 12 months. The agency provided documentation of one instance in which a volunteer was suspended and removed from an agency facility due to boundary concerns. No Sex abuse was alleged or identified, but the volunteer was determined to have violated policy and was dealt with according to policy. The facility has shown compliance with this Standard.

115.378	**Interventions and disciplinary sanctions for residents**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Residents are to be subject to disciplinary sanctions only pursuant to a formal disciplinary process following an administrative finding that the resident engaged in resident-on-resident sexual abuse. This Standard provides guidelines for disciplinary sanctions for sexual abuse. It prohibits disciplinary action for a report of sexual abuse made in good faith, based upon a reasonable belief that the alleged conduct occurred, even if an investigation does not establish evidence sufficient to substantiate the allegation. Sexual activity between residents is not held to constitute sexual abuse unless the activity is coerced. The use of Isolation as a sanction is prohibited by OYA, as outlined in Oregon Administrative Rules (OAR 416-490-0032); however, youth in Isolation for any reason must still receive basic services. Analysis: Evidence used to determine compliance with this Standard includes: Interviews with medical staff and mental health staff; a review of selected investigations; Policy II-B-2.1 Behavior Management - Youth Refocus Options; Samples of "refocus" options given to youth; Policy HS I-A-10.0 Preventing, Responding to and Monitoring Youth Sexual Abuse; Policy 1I-A-10.0 Preventing Youth Sexual Abuse and Harassment; and Policy II-B-1.2 Use of Time-out Room-lock Other Isolation and Safety Programs, Pg 11, IV.G.3. Documentation and policy reviews, along with interviews, indicate that youth are being refocused in a manner consistent with this Standard and agency policy. Isolation has not been used as a sanction for Sexual Abuse. A triangulation of evidence indicates compliance with this Standard.

115.381	Medical and mental health screenings; history of sexual abuse
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	This Standard relates to the screening conducted for Standard 115.341. When residents have experienced prior sexual victimization, or if residents have previously perpetrated sexual abuse, staff are required to ensure that the residents are offered a follow-up meeting with a Mental Health practitioner within 14 days of the screening. The Standard also provides rules regarding information related to sexual victimization or abusiveness. CORRECTIVE ACTION: Interviews and documentation reviewed during the first phases of the audit indicate that all residents have visits with a qualified mental health professional. However, at the time of the PREA Audit Interim Report, the agency had not yet shown that the screening documentation and referral system facilitated a follow-up meeting with a Mental Health practitioner within 14 days of the screening that references prior sexual victimization or abusiveness. In other words, QMHPs might have been meeting with residents without knowing that there was an issue related to prior victimization or abusiveness. The agency began working on a revision to the screening documentation system immediately after the On-Site Review. They developed a communication process to track this work. In cases where prior sexual abuse or abusiveness reveals information about a resident's behavior or risk of victimization, this must be considered in the VSAB. In some cases, OYA facilitates ongoing care. Standard 115.383 requires that all residents who have been victimized by sexual abuse in any prison, jail, lockup, or juvenile facility receive evaluation and treatment, as appropriate, to include 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. The tracking system and reinforced compliance with Standards 115.381 and 115.371 increase the likelihood that OYA identifies residents who qualify for the ongoing care required under Standard 115.383. During the CAP, a training refresher was provided with the QMHP staff, and the Training Roster was provided to the Audit Team. The updated FAC was provided, and the tracking mechanism was demonstrated as Proof of Practice. Analysis: Evidence used to determine compliance with this Standard includes interviews with each of the following: residents who disclosed sexual victimization at Risk Screening; medical staff; mental health staff; and staff who perform Risk Screening. Samples of medical and mental health secondary materials were also provided with sample VSABs and the Initial Mental Health Assessment and the corresponding Mental Health Check-in. The policy reference is I-A-10.0 Preventing Youth Sexual Abuse, pg. 14, IV.I., and FAC I-A-10.0(b) VSAB Procedure, pg. 2.F. Additionally, proof was provided to verify completion of the CAP. Compliance with this Standard was demonstrated through the completion of the CAP.

115.382	Access to emergency medical and mental health services
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Resident victims of sexual abuse are to receive timely, unimpeded access to emergency medical treatment and crisis intervention services. The nature and scope of such services are to be determined by Medical and Mental Health practitioners, in accordance with their professional judgment. Medical and Mental Health staff are to maintain secondary materials documenting the timeliness of emergency medical treatment and crisis intervention services that were provided; the appropriate response by non-health staff in the event health staff are not present at the time the incident is reported; and the provision of appropriate and timely information and services concerning sexually transmitted infection prophylaxis. Treatment services are to be provided to every victim without financial cost, and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident. Analysis: Evidence used to determine compliance with this Standard includes: interviews with medical staff, with mental health staff, and with residents who reported sexual abuse. A documented agency example of access to emergency services was provided. Policies and procedures regarding access to treatment services by resident victims of sexual abuse are found in Policy II-D-1.0 Facility Health Services, pg. 3, III; pg. 9, IV.M; Policy 1I-A-10.0 Preventing Youth Sexual Abuse and Harassment and Policy HS I-A-10.0 Preventing, Responding to and Monitoring Youth Sexual Abuse Assault, pg. 2, B. The information provided in policy, documentation, and interviews indicates compliance with this Standard.

115.383	Ongoing medical and mental health care for sexual abuse victims and abusers
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The facility is required to offer medical and mental health evaluations and, as appropriate, treatment to all residents who have been victimized by sexual abuse in any prison, jail, lockup, or juvenile facility. Resident victims of sexual abuse while incarcerated are to be offered tests for sexually transmitted infections, as medically appropriate. Treatment services are to be provided to the victim at no financial cost, regardless of whether the victim names the abuser or cooperates with any investigation arising from the incident. Within 60 days of learning of such abuse history, the facility is to attempt to conduct a mental health evaluation of all known resident-on-resident abusers, and it is to offer treatment, when deemed appropriate by mental health practitioners.

	Analysis: Evidence used to determine compliance with this Standard includes: interviews with medical staff, mental health staff, and residents who reported sexual abuse; Policy 1I-A-10.0 Preventing Youth Sexual Abuse and Harassment; Policy HS I-A-10.0 Preventing, Responding to and Monitoring Youth Sexual Abuse Assault; Policy II-D-1.0 Facility Health Services; and samples of medical and mental health secondary materials. Concerns relating to the documentation and referral of residents to follow-up mental health visits, if they have been sexually abused or have been sexually abusive, were addressed in Standard 115.381 during the CAP. Evidence triangulation demonstrates compliance with this Standard.

115.386	**Sexual abuse incident reviews**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The facility conducts a sexual abuse incident review within 30 days after the conclusion of every sexual abuse investigation, unless the allegation has been determined to be unfounded. The sexual abuse incident review team includes upper-level management officials and allows for input from line supervisors, investigators, and medical or mental health practitioners. The review team considers all provisions of this Standard, including whether the incident and investigation revealed any motivations, group dynamics, staffing issues, and needed changes. They assess whether monitoring technology should be deployed or augmented. They report their findings and any recommendations for improvement to the facility head and the PCM. The facility must implement the recommendations for improvement or document its reasons for not doing so. CORRECTIVE ACTION: The PREA Audit Interim Report gave a mixed rating for the agency’s compliance with this Standard, saying, “The form used for AIRRs, which was revised in 2023, has turned into a checklist with narrative sections, and with errors in its wording. It does not generate much information that is useful in correcting the agency when its investigators go off course. Several AIRRs did provide observations that were useful for facility improvements. It also should be said that in the past 12 months, the agency has held meetings regarding these reports and improved the completion rates.” The CAP required the development of a review team to review the Administrative Incident Review (AIR) documentation. This team focused on developing stronger narratives and including opportunities for feedback or process critique beyond initial facility responses. Information from these reviews must be used for compliance with PREA Standards 115.387, 115.388, and 115.389, so OYA and facility administrators needed to understand how these PREA Standards fit together. This included many of the moving parts of the processes, such as investigations, PREA Coordinator notifications, access to resources, and communication between teams. The CAP required updating the AIR form and training core AIR team members on the new form.

	Analysis: Evidence used to determine compliance with this Standard includes: interviews with the Superintendent or designee, with the PREA Compliance Manager, and with other members of the Incident Review Team (called Administrative Incident Reviews [AIRs] at OYA); Policy I-A-10.0 Preventing Youth Sexual Abuse pg. 17; Policy I-E-4.0 Incident Reviews, pg. 5; and sample AIRRs (Administrative Incident Review Reports). During the CAP, additional documentation was received, including meeting minutes and verifications, updated & improved AIR templates, and completed, fully compliant AIRs. Improvements in investigative reports (see Standard 115.371) provided AIR teams with better information for review and increased the usefulness of AIRs. As with some provisions in other Standards, Auditors have recently been ordered by the DOJ PREA Management Office to cease making compliance determinations for a provision of this Standard. The DOJ Memorandum states that it is about the "National PREA Standards Alignment with Executive Order 14168." Executive Order 14168 states that "'Sex' shall refer to an individual's immutable biological classification as either male or female. 'Sex' is not a synonym for and does not include the concept of 'gender identity.'" The Executive Order also states that "'Gender identity' reflects a fully internal and subjective sense of self, disconnected from biological reality and sex and existing on an infinite continuum, that does not provide a meaningful basis for identification . . . ." The Executive Order goes on to order that "Agencies shall remove all statements, policies, regulations, forms, communications, or other internal and external messages that promote or otherwise inculcate gender ideology, and shall cease issuing such statements, policies, regulations, forms, communications or other messages. Agency forms that require an individual's sex shall list male or female, and shall not request gender identity. . . ." However, the longstanding PREA provision in Standard 115.386, which is subject to possible reversal, is not about sex or gender but about motivations for abuse that occur in correctional facilities. The provision advises facility administrators to "Consider whether the incident or allegation [of sexual abuse] 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." This audit complies with the new DOJ requirement that auditors not make a compliance determination regarding this provision, while also making clear that the provision remains a best practice. The targeted provision in no way supports any notions about what gender(s) are or ought to be. It is instead a piece of tested wisdom for learning what perceptions are part of a dynamic that gets people hurt. The provision helps facilities know if someone is identified or perceived in some way that makes them a potential target of violence. When facility administrators consider the background, rumors, stories, relationships, labels, insults, and slurs that are part of the context for a particular incident of violence, it does not mean that the administrators believe any of the rumors or notions that any of the parties hold about the labels. Many violence-producing interactions include sexual comments and behaviors as part of stances of power and domination. Ignoring these age-old dynamics of violent incidents, if and when they are applicable, would be inefficient and naive. Violence in correctional facilities must be directly and effectively addressed: it harms the

	active participants of the violence, and the ripple effects also harm other youth, staff, families, and communities. Gang membership, or perceived membership, like gender, cannot be biologically proven but is also still a significant factor in many violent incidents in some facilities across the country, and is essential to consider when applicable. Upon completion of the CAP, the agency and facility have demonstrated compliance with this Standard.

115.387	**Data collection**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	This Standard requires the agency to “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 Standard further states that “The agency shall aggregate the incident-based sexual abuse data at least annually.” “The incident-based data collected shall include, at a minimum, the data necessary to answer all questions from the most recent version of the Survey of Sexual Violence conducted by the Department of Justice.” The Survey of Sexual Violence is now called the Survey of Sexual Victimization. The data comes “from all available incident-based documents, including reports, investigation files, and sexual abuse incident reviews.” CORRECTIVE ACTION: The agency and its partners produced numerous reports to explain what happened and provide updates on the ongoing resolution of the backlog problem. The data was migrated to a better system that came online during the audit. In the process, spreadsheets have been used to interpret and track information. Many steps were taken to get to the point where the agency could “collect accurate, uniform data for every allegation of sexual abuse at facilities under its direct control using a standardized instrument and set of definitions” as required by this Standard. The CAP required the “2024 Annual Report to include narrative and updated data to accurately reflect investigation information.” Analysis: The audit team reviewed the agency website (https://www.oregon.gov/oya/pso/Pages/prea.aspx) and screenshots of OYA’s internal reports. Policy I-E-4.0 Incident Reviews, Policy 1I-A-10.0 Preventing Youth Sexual Abuse and Harassment, and Surveys of Sexual Victimization were reviewed. Reports compiled after the agency discovered a backlog of investigations were reviewed early in the Audit process. Interviews were conducted with the agency head and other staff and administrators. OYA’s PREA administrators can be commended for identifying the backlog problem, despite apparent attempts by a PSO administrator to conceal it. (This administrator is no longer with the agency.) An additional hurdle for every data report is the fact that OYA was tracking its investigations using a computer application that was not designed for the kinds of investigations it was tracking. The

	software was for human resources investigations. This created barriers to understanding the data and reports generated. For example, in the coding of the system, the word “employee” was used instead of “perpetrator.” In cases where a resident was named as a perpetrator, the reader had to know to substitute “alleged perpetrator” when the text generated by the system in the report said “employee.” Had PREA been functioning as it should have, with an appropriate computer system and built-in accountability, every backlog would likely have been documented and reported all along, because administrators outside the Professional Standards Office would have been able to review it and understand it. Investigative backlogs and partially complete investigations added further complications to data interpretation. Reviewers lacked the data needed to craft corrective actions. These issues were not mentioned in OYA’s Annual Reports, and could not have been, because OYA’s PREA administrators were being misled. Yet, if reports do not include the data that needs to be understood and that should trigger reforms, the reports are not serving their purpose. The PREA Audit Interim Report stated, “Although the issues are clear in hindsight, and the agency claims to be accurately tracking its data now, it has not yet demonstrated full compliance with this Standard.” As discussed in the “Corrective Action” section above, the agency has addressed and repaired many problems and issued an Annual Report for 2024 that contains information as accurate as possible under the circumstances. A triangulation of evidence verifies compliance with this Standard.

115.388	**Data review for corrective action**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The fact that the PREA Standards devote several Standards to the work of collecting data, using it to make course corrections, and publishing it, is another way to demonstrate the intention of the Standards’ crafters to have a system of integrity with built-in fail-safes to keep correctional facilities as safe as possible from sexual abuse. This Standard requires the agency to “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. (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.”

	CORRECTIVE ACTION: The agency and its partners produced numerous reports to explain what occurred and to provide updates on the ongoing resolution of the backlog. The data was migrated to a better system that came online during the audit. In the process, and in the meantime, spreadsheets have been used to interpret and track information. Many steps were taken to get to the point where the agency could use information collected pursuant to Standard 115.387 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.” as required by this Standard. The CAP required the “2024 Annual Report to include narrative and updated data to accurately reflect investigation information.” Analysis: The Audit Team interviewed administrators, reviewed relevant policies, and examined the Annual Reports from previous years. As mentioned in the analysis narrative for the previous Standard, if reports do not include the data that needs to be understood and that should trigger reforms, the reports are not serving their purpose. The PREA Audit Interim Report stated, “Although the issues are clear in hindsight, and the agency claims to be accurately tracking its data now, it has not yet demonstrated full compliance with this Standard.” By completing the Corrective Action Plan (CAP), the agency has shown compliance with this Standard.

115.389	**Data storage, publication, and destruction**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	This Standard requires that the agency ensure the secure retention of data collected pursuant to §115.387. This Standard requires that the agency make all aggregated sexual abuse data from facilities under its direct control readily available to the public at least annually. When the Standard says "data," it means accurate data that is not misleading. The agency must maintain sexual abuse data for at least 10 years after the date of its initial collection unless Federal, State, or local law requires otherwise. The Annual Reports, along with various other provisions of the PREA Standards, are required as part of a system of accountability to propel the agency toward continual compliance through corrective actions that keep it on course. These reports are an annual opportunity for the agency to provide transparency, both to receive credit for the work they do day after day and to express the challenges they face. CORRECTIVE ACTION: The agency and its partners produced numerous reports explaining what led to the backlog and providing updates on the ongoing resolution. The data was migrated to a better system that came online during the audit. In the process, and in the meantime, regularly updated spreadsheets have been used to interpret and track information. Many steps were taken to reach the point at which

	the agency could use information collected under Standard 115.387 to prepare a report under Standard 115.388, which is published under Standard 115.389. Analysis: Although the agency has faithfully published Annual Reports on its website, at the time of the PREA Audit Interim Report, the Auditor did not consider the agency fully compliant with this Standard because the Reports contained incomplete data vital to youth safety. The PREA Audit Interim Report pointed out that "There is evidence that the administrators who worked on the Reports were not aware of the extent of the backlogs and were misled by an administrator . . . ." It is essential to note that OYA agency officials were the ones who discovered and reported the backlogs and other issues that required attention. Additionally, due to their practice of data retention, they were able to revisit and reanalyze the data from previous years, identifying errors in the way it had been represented to them. The documentation reviewed includes numerous news reports and agency press releases, and also includes Policy 1I-A-10.0 Preventing Youth Sexual Abuse and Harassment; Policy I-E-3.2 Information Asset Classification – Protection; 2023 PREA Annual Report; other previous reports; the website where the reports are published; Policy I-E-2.0 Records Retention, Destruction and Archiving; and Policy I-D-4.0 Professional Standards Office Investigations. A triangulation of evidence demonstrates compliance with this Standard.

115.401	**Frequency and scope of audits**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	This Standard requires that all correctional facilities operated by the agency be audited at least once during each 3-year audit cycle. These audit cycles started on August 20, 2013. The Standard also states that “The agency shall bear the burden of demonstrating compliance with the standards.” Auditors are instructed to “review all relevant agency-wide policies, procedures, reports, internal and external audits, and accreditations for each facility type.” Auditors are required to sample relevant documents and other records and information for the most recent one-year period. The list of other requirements includes that “The auditor shall have access to, and shall observe, all areas of the audited facilities” and that “The auditor shall be permitted to conduct private interviews with inmates, residents, and detainees.” Analysis: For the purposes of this Standard, PREA Audits are considered to be complete when the Interim Reports are issued. Although this Final Report is issued after the end of the audit cycle, the PREA Audits of MacLaren YCF, Oakcreek YCF, and JWTP are considered to have been completed during the third year of the 4th audit cycle. The other facilities operated by OYA had audits during the same 3-year cycle as required. The agency is compliant with this Standard.

115.403	Audit contents and findings
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	This Standard provides rules and guidelines for Audits and Auditors. Additionally, this Standard requires that the agency "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." Analysis: The Audit Team has reviewed the agency's website and found that previous PREA Final Audit Reports have been published as required, thereby fulfilling the requirements of 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	yes

	staffing levels and determining the need for video monitoring: Any findings of inadequacy from internal or external oversight bodies?	
	Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: All components of the facility's physical plant (including "blind-spots" or areas where staff or residents may be isolated)?	yes
	Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: The composition of the resident population?	yes
	Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: The number and placement of supervisory staff?	yes
	Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: Institution programs occurring on a particular shift?	yes
	Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: Any applicable State or local laws, regulations, or standards?	yes
	Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: Any other relevant factors?	yes
115.313 (b)	**Supervision and monitoring**	
	Does the agency comply with the staffing plan except during limited and discrete exigent circumstances?	yes
	In circumstances where the staffing plan is not complied with, does the facility fully document all deviations from the plan? (N/A if no deviations from staffing plan.)	yes
115.313 (c)	**Supervision and monitoring**	
	Does the facility maintain staff ratios of a minimum of 1:8 during resident waking hours, except during limited and discrete exigent circumstances? (N/A only until October 1, 2017.)	yes

	Does the facility maintain staff ratios of a minimum of 1:16 during resident sleeping hours, except during limited and discrete exigent circumstances? (N/A only until October 1, 2017.)	yes
	Does the facility fully document any limited and discrete exigent circumstances during which the facility did not maintain staff ratios? (N/A only until October 1, 2017.)	yes
	Does the facility ensure only security staff are included when calculating these ratios? (N/A only until October 1, 2017.)	yes
	Is the facility obligated by law, regulation, or judicial consent decree to maintain the staffing ratios set forth in this paragraph?	yes
115.313 (d)	**Supervision and monitoring**	
	In the past 12 months, has the facility, in consultation with the agency PREA Coordinator, assessed, determined, and documented whether adjustments are needed to: The staffing plan established pursuant to paragraph (a) of this section?	yes
	In the past 12 months, has the facility, in consultation with the agency PREA Coordinator, assessed, determined, and documented whether adjustments are needed to: Prevailing staffing patterns?	yes
	In the past 12 months, has the facility, in consultation with the agency PREA Coordinator, assessed, determined, and documented whether adjustments are needed to: The facility’s deployment of video monitoring systems and other monitoring technologies?	yes
	In the past 12 months, has the facility, in consultation with the agency PREA Coordinator, assessed, determined, and documented whether adjustments are needed to: The resources the facility has available to commit to ensure adherence to the staffing plan?	yes
115.313 (e)	**Supervision and monitoring**	
	Has the facility implemented a policy and practice of having intermediate-level or higher-level supervisors conduct and document unannounced rounds to identify and deter staff sexual abuse and sexual harassment? (N/A for non-secure facilities)	yes
	Is this policy and practice implemented for night shifts as well as day shifts? (N/A for non-secure facilities)	yes
	Does the facility have a policy prohibiting staff from alerting other staff members that these supervisory rounds are occurring, unless such announcement is related to the legitimate operational	yes

	functions of the facility? (N/A for non-secure facilities)	
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**	
	This provision is no longer applicable to your compliance finding, please select N/A.	yes
	This provision is no longer applicable to your compliance finding, please select N/A.	yes

115.315 (f)	**Limits to cross-gender viewing and searches**	
	This provision is no longer applicable to your compliance finding, please select N/A.	yes
	This provision is no longer applicable to your compliance finding, please select N/A.	yes
115.316 (a)	**Residents with disabilities and residents who are limited English proficient**	
	Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Residents who are deaf or hard of hearing?	yes
	Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Residents who are blind or have low vision?	yes
	Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Residents who have intellectual disabilities?	yes
	Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Residents who have psychiatric disabilities?	yes
	Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Residents who have speech disabilities?	yes
	Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Other? (if "other," please explain in overall determination notes.)	yes
	Do such steps include, when necessary, ensuring effective	yes

	communication with residents who are deaf or hard of hearing?	
	Do such steps include, when necessary, providing access to interpreters who can interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary?	yes
	Does the agency ensure that written materials are provided in formats or through methods that ensure effective communication with residents with disabilities including residents who: Have intellectual disabilities?	yes
	Does the agency ensure that written materials are provided in formats or through methods that ensure effective communication with residents with disabilities including residents who: Have limited reading skills?	yes
	Does the agency ensure that written materials are provided in formats or through methods that ensure effective communication with residents with disabilities including residents who: Who are blind or have low vision?	yes
115.316 (b)	**Residents with disabilities and residents who are limited English proficient**	
	Does the agency take reasonable steps to ensure meaningful access to all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment to residents who are limited English proficient?	yes
	Do these steps include providing interpreters who can interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary?	yes
115.316 (c)	**Residents with disabilities and residents who are limited English proficient**	
	Does the agency always refrain from relying on resident interpreters, resident readers, or other types of resident assistants except in limited circumstances where an extended delay in obtaining an effective interpreter could compromise the resident's safety, the performance of first-response duties under §115.364, or the investigation of the resident's allegations?	yes
115.317 (a)	**Hiring and promotion decisions**	
	Does the agency prohibit the hiring or promotion of anyone who may have contact with residents who: Has engaged in sexual	yes

	abuse in a prison, jail, lockup, community confinement facility, juvenile facility, or other institution (as defined in 42 U.S.C. 1997)?	
	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	yes

	maintained by the State or locality in which the employee would work?	
	Before hiring new employees who may have contact with residents, does the agency: Consistent with Federal, State, and local law, make its best efforts to contact all prior institutional employers for information on substantiated allegations of sexual abuse or any resignation during a pending investigation of an allegation of sexual abuse?	yes
115.317 (d)	**Hiring and promotion decisions**	
	Does the agency perform a criminal background records check before enlisting the services of any contractor who may have contact with residents?	yes
	Does the agency consult applicable child abuse registries before enlisting the services of any contractor who may have contact with residents?	yes
115.317 (e)	**Hiring and promotion decisions**	
	Does the agency either conduct criminal background records checks at least every five years of current employees and contractors who may have contact with residents or have in place a system for otherwise capturing such information for current employees?	yes
115.317 (f)	**Hiring and promotion decisions**	
	Does the agency ask all applicants and employees who may have contact with residents directly about previous misconduct described in paragraph (a) of this section in written applications or interviews for hiring or promotions?	yes
	Does the agency ask all applicants and employees who may have contact with residents directly about previous misconduct described in paragraph (a) of this section in any interviews or written self-evaluations conducted as part of reviews of current employees?	yes
	Does the agency impose upon employees a continuing affirmative duty to disclose any such misconduct?	yes
115.317 (g)	**Hiring and promotion decisions**	

	Does the agency consider material omissions regarding such misconduct, or the provision of materially false information, grounds for termination?	yes
115.317 (h)	**Hiring and promotion decisions**	
	Unless prohibited by law, does the agency provide information on substantiated allegations of sexual abuse or sexual harassment involving a former employee upon receiving a request from an institutional employer for whom such employee has applied to work? (N/A if providing information on substantiated allegations of sexual abuse or sexual harassment involving a former employee is prohibited by law.)	yes
115.318 (a)	**Upgrades to facilities and technologies**	
	If the agency designed or acquired any new facility or planned any substantial expansion or modification of existing facilities, did the agency consider the effect of the design, acquisition, expansion, or modification upon the agency's ability to protect residents from sexual abuse? (N/A if agency/facility has not acquired a new facility or made a substantial expansion to existing facilities since August 20, 2012, or since the last PREA audit, whichever is later.)	yes
115.318 (b)	**Upgrades to facilities and technologies**	
	If the agency installed or updated a video monitoring system, electronic surveillance system, or other monitoring technology, did the agency consider how such technology may enhance the agency's ability to protect residents from sexual abuse? (N/A if agency/facility has not installed or updated a video monitoring system, electronic surveillance system, or other monitoring technology since August 20, 2012, or since the last PREA audit, whichever is later.)	yes
115.321 (a)	**Evidence protocol and forensic medical examinations**	
	If the agency is responsible for investigating allegations of sexual abuse, does the agency follow a uniform evidence protocol that maximizes the potential for obtaining usable physical evidence for administrative proceedings and criminal prosecutions? (N/A if the agency/facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations.)	yes
115.321	**Evidence protocol and forensic medical examinations**	

(b)		
	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	**Evidence protocol and forensic medical examinations**	

(e)		
	As requested by the victim, does the victim advocate, qualified agency staff member, or qualified community-based organization staff member accompany and support the victim through the forensic medical examination process and investigatory interviews?	yes
	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 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

	The subsection of this provision is no longer applicable to your compliance finding, please select N/A.	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	yes

	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?	
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	yes

	video regarding: Agency policies and procedures for responding to such incidents?	
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	yes

	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).)	
115.334 (b)	**Specialized training: Investigations**	
	Does this specialized training include: Techniques for interviewing juvenile sexual abuse victims? (N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.321(a).)	yes
	Does this specialized training include: Proper use of Miranda and Garrity warnings? (N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.321(a).)	yes
	Does this specialized training include: Sexual abuse evidence collection in confinement settings? (N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.321(a).)	yes
	Does this specialized training include: The criteria and evidence required to substantiate a case for administrative action or prosecution referral? (N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.321(a).)	yes
115.334 (c)	**Specialized training: Investigations**	
	Does the agency maintain documentation that agency investigators have completed the required specialized training in conducting sexual abuse investigations? (N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.321(a).)	yes
115.335 (a)	**Specialized training: Medical and mental health care**	
	Does the agency ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in: How to detect and assess signs of sexual abuse and sexual harassment? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners who work regularly in its facilities.)	yes
	Does the agency ensure that all full- and part-time medical and	yes

	mental health care practitioners who work regularly in its facilities have been trained in: How to preserve physical evidence of sexual abuse? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners who work regularly in its facilities.)	
	Does the agency ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in: How to respond effectively and professionally to juvenile victims of sexual abuse and sexual harassment? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners who work regularly in its facilities.)	yes
	Does the agency ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in: How and to whom to report allegations or suspicions of sexual abuse and sexual harassment? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners who work regularly in its facilities.)	yes
115.335 (b)	**Specialized training: Medical and mental health care**	
	If medical staff employed by the agency conduct forensic examinations, do such medical staff receive appropriate training to conduct such examinations? (N/A if agency medical staff at the facility do not conduct forensic exams or the agency does not employ medical staff.)	na
115.335 (c)	**Specialized training: Medical and mental health care**	
	Does the agency maintain documentation that medical and mental health practitioners have received the training referenced in this standard either from the agency or elsewhere? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners who work regularly in its facilities.)	yes
115.335 (d)	**Specialized training: Medical and mental health care**	
	Do medical and mental health care practitioners employed by the agency also receive training mandated for employees by §115.331? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners who work regularly in its facilities.)	yes
	Do medical and mental health care practitioners contracted by	yes

	and volunteering for the agency also receive training mandated for contractors and volunteers by §115.332? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners contracted by or volunteering for the agency.)	
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
	The subsection of this provision is no longer applicable to your compliance finding, please select N/A.	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**	
	This provision is no longer applicable to your compliance finding, please select N/A.	yes
	This provision is no longer applicable to your compliance finding, please select N/A.	yes
	This provision is no longer applicable to your compliance finding, please select N/A.	yes
	This provision is no longer applicable to your compliance finding, please select N/A.	yes

115.342 (d)	**Placement of residents**	
	This provision is no longer applicable to your compliance finding, please select N/A.	yes
	This provision is no longer applicable to your compliance finding, please select N/A.	yes
115.342 (e)	**Placement of residents**	
	This provision is no longer applicable to your compliance finding, please select N/A.	yes
115.342 (f)	**Placement of residents**	
	This provision is no longer applicable to your compliance finding, please select N/A.	yes
115.342 (g)	**Placement of residents**	
	This provision is no longer applicable to your compliance finding, please select N/A.	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?)	yes
	If a resident is isolated pursuant to paragraph (b) of this section, does the facility clearly document: The reason why no alternative means of separation can be arranged? (N/A for h and i if facility doesn't use isolation?)	yes
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	**Resident reporting**	

(a)		
	Does the agency provide multiple internal ways for residents to privately report: Sexual abuse and sexual harassment?	yes
	Does the agency provide multiple internal ways for residents to privately report: 2. Retaliation by other residents or staff for reporting sexual abuse and sexual harassment?	yes
	Does the agency provide multiple internal ways for residents to privately report: Staff neglect or violation of responsibilities that may have contributed to such incidents?	yes
115.351 (b)	**Resident reporting**	
	Does the agency also provide at least one way for residents to report sexual abuse or sexual harassment to a public or private entity or office that is not part of the agency?	yes
	Is that private entity or office able to receive and immediately forward resident reports of sexual abuse and sexual harassment to agency officials?	yes
	Does that private entity or office allow the resident to remain anonymous upon request?	yes
	Are residents detained solely for civil immigration purposes provided information on how to contact relevant consular officials and relevant officials at the Department of Homeland Security to report sexual abuse or harassment?	yes
115.351 (c)	**Resident reporting**	
	Do staff members accept reports of sexual abuse and sexual harassment made verbally, in writing, anonymously, and from third parties?	yes
	Do staff members promptly document any verbal reports of sexual abuse and sexual harassment?	yes
115.351 (d)	**Resident reporting**	
	Does the facility provide residents with access to tools necessary to make a written report?	yes
115.351 (e)	**Resident reporting**	

	Does the agency provide a method for staff to privately report sexual abuse and sexual harassment of residents?	yes
115.352 (a)	**Exhaustion of administrative remedies**	
	Is the agency exempt from this standard? NOTE: The agency is exempt ONLY if it does not have administrative procedures to address resident grievances regarding sexual abuse. This does not mean the agency is exempt simply because a resident does not have to or is not ordinarily expected to submit a grievance to report sexual abuse. This means that as a matter of explicit policy, the agency does not have an administrative remedies process to address sexual abuse.	no
115.352 (b)	**Exhaustion of administrative remedies**	
	Does the agency permit residents to submit a grievance regarding an allegation of sexual abuse without any type of time limits? (The agency may apply otherwise-applicable time limits to any portion of a grievance that does not allege an incident of sexual abuse.) (N/A if agency is exempt from this standard.)	yes
	Does the agency always refrain from requiring an resident to use any informal grievance process, or to otherwise attempt to resolve with staff, an alleged incident of sexual abuse? (N/A if agency is exempt from this standard.)	yes
115.352 (c)	**Exhaustion of administrative remedies**	
	Does the agency ensure that: A resident who alleges sexual abuse may submit a grievance without submitting it to a staff member who is the subject of the complaint? (N/A if agency is exempt from this standard.)	yes
	Does the agency ensure that: Such grievance is not referred to a staff member who is the subject of the complaint? (N/A if agency is exempt from this standard.)	yes
115.352 (d)	**Exhaustion of administrative remedies**	
	Does the agency issue a final agency decision on the merits of any portion of a grievance alleging sexual abuse within 90 days of the initial filing of the grievance? (Computation of the 90-day time period does not include time consumed by residents in preparing any administrative appeal.) (N/A if agency is exempt from this	yes

	standard.)	
	If the agency determines that the 90 day timeframe is insufficient to make an appropriate decision and claims an extension of time (the maximum allowable extension of time to respond is 70 days per 115.352(d)(3)) , does the agency notify the resident in writing of any such extension and provide a date by which a decision will be made? (N/A if agency is exempt from this standard.)	yes
	At any level of the administrative process, including the final level, if the resident does not receive a response within the time allotted for reply, including any properly noticed extension, may a resident consider the absence of a response to be a denial at that level? (N/A if agency is exempt from this standard.)	yes
115.352 (e)	**Exhaustion of administrative remedies**	
	Are third parties, including fellow residents, staff members, family members, attorneys, and outside advocates, permitted to assist residents in filing requests for administrative remedies relating to allegations of sexual abuse? (N/A if agency is exempt from this standard.)	yes
	Are those third parties also permitted to file such requests on behalf of residents? (If a third party, other than a parent or legal guardian, files such a request on behalf of a resident, the facility may require as a condition of processing the request that the alleged victim agree to have the request filed on his or her behalf, and may also require the alleged victim to personally pursue any subsequent steps in the administrative remedy process.) (N/A if agency is exempt from this standard.)	yes
	If the resident declines to have the request processed on his or her behalf, does the agency document the resident’s decision? (N/A if agency is exempt from this standard.)	yes
	Is a parent or legal guardian of a juvenile allowed to file a grievance regarding allegations of sexual abuse, including appeals, on behalf of such juvenile? (N/A if agency is exempt from this standard.)	yes
	If a parent or legal guardian of a juvenile files a grievance (or an appeal) on behalf of a juvenile regarding allegations of sexual abuse, is it the case that those grievances are not conditioned upon the juvenile agreeing to have the request filed on his or her behalf? (N/A if agency is exempt from this standard.)	yes
115.352	**Exhaustion of administrative remedies**	

(f)		
	Has the agency established procedures for the filing of an emergency grievance alleging that a resident is subject to a substantial risk of imminent sexual abuse? (N/A if agency is exempt from this standard.)	yes
	After receiving an emergency grievance alleging a resident is subject to a substantial risk of imminent sexual abuse, does the agency immediately forward the grievance (or any portion thereof that alleges the substantial risk of imminent sexual abuse) to a level of review at which immediate corrective action may be taken? (N/A if agency is exempt from this standard.)	yes
	After receiving an emergency grievance described above, does the agency provide an initial response within 48 hours? (N/A if agency is exempt from this standard.)	yes
	After receiving an emergency grievance described above, does the agency issue a final agency decision within 5 calendar days? (N/A if agency is exempt from this standard.)	yes
	Does the initial response and final agency decision document the agency's determination whether the resident is in substantial risk of imminent sexual abuse? (N/A if agency is exempt from this standard.)	yes
	Does the initial response document the agency's action(s) taken in response to the emergency grievance? (N/A if agency is exempt from this standard.)	yes
	Does the agency's final decision document the agency's action(s) taken in response to the emergency grievance? (N/A if agency is exempt from this standard.)	yes
115.352 (g)	**Exhaustion of administrative remedies**	
	If the agency disciplines a resident for filing a grievance related to alleged sexual abuse, does it do so ONLY where the agency demonstrates that the resident filed the grievance in bad faith? (N/A if agency is exempt from this standard.)	yes
115.353 (a)	**Resident access to outside confidential support services and legal representation**	
	Does the facility provide residents with access to outside victim advocates for emotional support services related to sexual abuse by providing, posting, or otherwise making accessible mailing addresses and telephone numbers, including toll-free hotline	yes

	numbers where available, of local, State, or national victim advocacy or rape crisis organizations?	
	Does the facility provide persons detained solely for civil immigration purposes mailing addresses and telephone numbers, including toll-free hotline numbers where available of local, State, or national immigrant services agencies?	yes
	Does the facility enable reasonable communication between residents and these organizations and agencies, in as confidential a manner as possible?	yes
115.353 (b)	**Resident access to outside confidential support services and legal representation**	
	Does the facility inform residents, prior to giving them access, of the extent to which such communications will be monitored and the extent to which reports of abuse will be forwarded to authorities in accordance with mandatory reporting laws?	yes
115.353 (c)	**Resident access to outside confidential support services and legal representation**	
	Does the agency maintain or attempt to enter into memoranda of understanding or other agreements with community service providers that are able to provide residents with confidential emotional support services related to sexual abuse?	yes
	Does the agency maintain copies of agreements or documentation showing attempts to enter into such agreements?	yes
115.353 (d)	**Resident access to outside confidential support services and legal representation**	
	Does the facility provide residents with reasonable and confidential access to their attorneys or other legal representation?	yes
	Does the facility provide residents with reasonable access to parents or legal guardians?	yes
115.354 (a)	**Third-party reporting**	
	Has the agency established a method to receive third-party reports of sexual abuse and sexual harassment?	yes
	Has the agency distributed publicly information on how to report sexual abuse and sexual harassment on behalf of a resident?	yes

115.361 (a)	**Staff and agency reporting duties**	
	Does the agency require all staff to report immediately and according to agency policy any knowledge, suspicion, or information they receive regarding an incident of sexual abuse or sexual harassment that occurred in a facility, whether or not it is part of the agency?	yes
	Does the agency require all staff to report immediately and according to agency policy any knowledge, suspicion, or information they receive regarding retaliation against residents or staff who reported an incident of sexual abuse or sexual harassment?	yes
	Does the agency require all staff to report immediately and according to agency policy any knowledge, suspicion, or information they receive regarding any staff neglect or violation of responsibilities that may have contributed to an incident of sexual abuse or sexual harassment or retaliation?	yes
115.361 (b)	**Staff and agency reporting duties**	
	Does the agency require all staff to comply with any applicable mandatory child abuse reporting laws?	yes
115.361 (c)	**Staff and agency reporting duties**	
	Apart from reporting to designated supervisors or officials and designated State or local services agencies, are staff prohibited from revealing any information related to a sexual abuse report to anyone other than to the extent necessary, as specified in agency policy, to make treatment, investigation, and other security and management decisions?	yes
115.361 (d)	**Staff and agency reporting duties**	
	Are medical and mental health practitioners required to report sexual abuse to designated supervisors and officials pursuant to paragraph (a) of this section as well as to the designated State or local services agency where required by mandatory reporting laws?	yes
	Are medical and mental health practitioners required to inform residents of their duty to report, and the limitations of confidentiality, at the initiation of services?	yes

115.361 (e)	**Staff and agency reporting duties**	
	Upon receiving any allegation of sexual abuse, does the facility head or his or her designee promptly report the allegation to the appropriate office?	yes
	Upon receiving any allegation of sexual abuse, does the facility head or his or her designee promptly report the allegation to the alleged victim’s parents or legal guardians unless the facility has official documentation showing the parents or legal guardians should not be notified?	yes
	If the alleged victim is under the guardianship of the child welfare system, does the facility head or his or her designee promptly report the allegation to the alleged victim’s caseworker instead of the parents or legal guardians? (N/A if the alleged victim is not under the guardianship of the child welfare system.)	yes
	If a juvenile court retains jurisdiction over the alleged victim, does the facility head or designee also report the allegation to the juvenile’s attorney or other legal representative of record within 14 days of receiving the allegation?	yes
115.361 (f)	**Staff and agency reporting duties**	
	Does the facility report all allegations of sexual abuse and sexual harassment, including third-party and anonymous reports, to the facility’s designated investigators?	yes
115.362 (a)	**Agency protection duties**	
	When the agency learns that a resident is subject to a substantial risk of imminent sexual abuse, does it take immediate action to protect the resident?	yes
115.363 (a)	**Reporting to other confinement facilities**	
	Upon receiving an allegation that a resident was sexually abused while confined at another facility, does the head of the facility that received the allegation notify the head of the facility or appropriate office of the agency where the alleged abuse occurred?	yes
	Does the head of the facility that received the allegation also notify the appropriate investigative agency?	yes

115.363 (b)	**Reporting to other confinement facilities**	
	Is such notification provided as soon as possible, but no later than 72 hours after receiving the allegation?	yes
115.363 (c)	**Reporting to other confinement facilities**	
	Does the agency document that it has provided such notification?	yes
115.363 (d)	**Reporting to other confinement facilities**	
	Does the facility head or agency office that receives such notification ensure that the allegation is investigated in accordance with these standards?	yes
115.364 (a)	**Staff first responder duties**	
	Upon learning of an allegation that a resident was sexually abused, is the first security staff member to respond to the report required to: Separate the alleged victim and abuser?	yes
	Upon learning of an allegation that a resident was sexually abused, is the first security staff member to respond to the report required to: Preserve and protect any crime scene until appropriate steps can be taken to collect any evidence?	yes
	Upon learning of an allegation that a resident was sexually abused, is the first security staff member to respond to the report required to: Request that the alleged victim not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating, if the abuse occurred within a time period that still allows for the collection of physical evidence?	yes
	Upon learning of an allegation that a resident was sexually abused, is the first security staff member to respond to the report required to: Ensure that the alleged abuser does not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating, if the abuse occurred within a time period that still allows for the collection of physical evidence?	yes
115.364 (b)	**Staff first responder duties**	

	If the first staff responder is not a security staff member, is the responder required to request that the alleged victim not take any actions that could destroy physical evidence, and then notify security staff?	yes
115.365 (a)	**Coordinated response**	
	Has the facility developed a written institutional plan to coordinate actions among staff first responders, medical and mental health practitioners, investigators, and facility leadership taken in response to an incident of sexual abuse?	yes
115.366 (a)	**Preservation of ability to protect residents from contact with abusers**	
	Are both the agency and any other governmental entities responsible for collective bargaining on the agency's behalf prohibited from entering into or renewing any collective bargaining agreement or other agreement that limits the agency's ability to remove alleged staff sexual abusers from contact with any residents pending the outcome of an investigation or of a determination of whether and to what extent discipline is warranted?	yes
115.367 (a)	**Agency protection against retaliation**	
	Has the agency established a policy to protect all residents and staff who report sexual abuse or sexual harassment or cooperate with sexual abuse or sexual harassment investigations from retaliation by other residents or staff?	yes
	Has the agency designated which staff members or departments are charged with monitoring retaliation?	yes
115.367 (b)	**Agency protection against retaliation**	
	Does the agency employ multiple protection measures for residents or staff who fear retaliation for reporting sexual abuse or sexual harassment or for cooperating with investigations, such as housing changes or transfers for resident victims or abusers, removal of alleged staff or resident abusers from contact with victims, and emotional support services?	yes
115.367 (c)	**Agency protection against retaliation**	

	Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor the conduct and treatment of residents or staff who reported the sexual abuse to see if there are changes that may suggest possible retaliation by residents or staff?	yes
	Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor the conduct and treatment of residents who were reported to have suffered sexual abuse to see if there are changes that may suggest possible retaliation by residents or staff?	yes
	Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Act promptly to remedy any such retaliation?	yes
	Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor: Any resident disciplinary reports?	yes
	Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor: Resident housing changes?	yes
	Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor: Resident program changes?	yes
	Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor: Negative performance reviews of staff?	yes
	Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor: Reassignments of staff?	yes
	Does the agency continue such monitoring beyond 90 days if the initial monitoring indicates a continuing need?	yes
115.367 (d)	**Agency protection against retaliation**	

	In the case of residents, does such monitoring also include periodic status checks?	yes
115.367 (e)	**Agency protection against retaliation**	
	If any other individual who cooperates with an investigation expresses a fear of retaliation, does the agency take appropriate measures to protect that individual against retaliation?	yes
115.368 (a)	**Post-allegation protective custody**	
	Is any and all use of segregated housing to protect a resident who is alleged to have suffered sexual abuse subject to the requirements of § 115.342?	yes
115.371 (a)	**Criminal and administrative agency investigations**	
	When the agency conducts its own investigations into allegations of sexual abuse and sexual harassment, does it do so promptly, thoroughly, and objectively? (N/A if the agency does not conduct any form of administrative or criminal investigations of sexual abuse or harassment. See 115.321(a).)	yes
	Does the agency conduct such investigations for all allegations, including third party and anonymous reports? (N/A if the agency does not conduct any form of administrative or criminal investigations of sexual abuse or harassment. See 115.321(a).)	yes
115.371 (b)	**Criminal and administrative agency investigations**	
	Where sexual abuse is alleged, does the agency use investigators who have received specialized training in sexual abuse investigations involving juvenile victims as required by 115.334?	yes
115.371 (c)	**Criminal and administrative agency investigations**	
	Do investigators gather and preserve direct and circumstantial evidence, including any available physical and DNA evidence and any available electronic monitoring data?	yes
	Do investigators interview alleged victims, suspected perpetrators, and witnesses?	yes
	Do investigators review prior reports and complaints of sexual abuse involving the suspected perpetrator?	yes

115.371 (d)	**Criminal and administrative agency investigations**	
	Does the agency always refrain from terminating an investigation solely because the source of the allegation recants the allegation?	yes
115.371 (e)	**Criminal and administrative agency investigations**	
	When the quality of evidence appears to support criminal prosecution, does the agency conduct compelled interviews only after consulting with prosecutors as to whether compelled interviews may be an obstacle for subsequent criminal prosecution?	yes
115.371 (f)	**Criminal and administrative agency investigations**	
	Do agency investigators assess the credibility of an alleged victim, suspect, or witness on an individual basis and not on the basis of that individual’s status as resident or staff?	yes
	Does the agency investigate allegations of sexual abuse without requiring a resident who alleges sexual abuse to submit to a polygraph examination or other truth-telling device as a condition for proceeding?	yes
115.371 (g)	**Criminal and administrative agency investigations**	
	Do administrative investigations include an effort to determine whether staff actions or failures to act contributed to the abuse?	yes
	Are administrative investigations documented in written reports that include a description of the physical evidence and testimonial evidence, the reasoning behind credibility assessments, and investigative facts and findings?	yes
115.371 (h)	**Criminal and administrative agency investigations**	
	Are criminal investigations documented in a written report that contains a thorough description of the physical, testimonial, and documentary evidence and attaches copies of all documentary evidence where feasible?	yes
115.371 (i)	**Criminal and administrative agency investigations**	
	Are all substantiated allegations of conduct that appears to be	yes

	criminal referred for prosecution?	
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	yes

	responsible for conducting administrative and criminal investigations.)	
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	yes

	within the facility?	
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	**Interventions and disciplinary sanctions for residents**	

(c)		
	When determining what types of sanction, if any, should be imposed, does the disciplinary process consider whether a resident's mental disabilities or mental illness contributed to his or her behavior?	yes
115.378 (d)	**Interventions and disciplinary sanctions for residents**	
	If the facility offers therapy, counseling, or other interventions designed to address and correct underlying reasons or motivations for the abuse, does the facility consider whether to offer the offending resident participation in such interventions?	yes
	If the agency requires participation in such interventions as a condition of access to any rewards-based behavior management system or other behavior-based incentives, does it always refrain from requiring such participation as a condition to accessing general programming or education?	yes
115.378 (e)	**Interventions and disciplinary sanctions for residents**	
	Does the agency discipline a resident for sexual contact with staff only upon a finding that the staff member did not consent to such contact?	yes
115.378 (f)	**Interventions and disciplinary sanctions for residents**	
	For the purpose of disciplinary action, does a report of sexual abuse made in good faith based upon a reasonable belief that the alleged conduct occurred NOT constitute falsely reporting an incident or lying, even if an investigation does not establish evidence sufficient to substantiate the allegation?	yes
115.378 (g)	**Interventions and disciplinary sanctions for residents**	
	Does the agency always refrain from considering non-coercive sexual activity between residents to be sexual abuse? (N/A if the agency does not prohibit all sexual activity between residents.)	yes
115.381 (a)	**Medical and mental health screenings; history of sexual abuse**	
	If the screening pursuant to § 115.341 indicates that a resident has experienced prior sexual victimization, whether it occurred in an institutional setting or in the community, do staff ensure that	yes

	the resident is offered a follow-up meeting with a medical or mental health practitioner within 14 days of the intake screening?	
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	yes

	medical and mental health practitioners?	
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 §	yes

	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.)	
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	yes

	investigation indicates a need to change policy or practice to better prevent, detect, or respond to sexual abuse?	
	The subsection of this provision is no longer applicable to your compliance finding, please select N/A.	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	yes

	addressing sexual abuse?	
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?	yes

	(Note: The response here is purely informational. A "no" response does not impact overall compliance with this standard.)	
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.)	no
	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.)	na
	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	yes

	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.)	