PREA AUDIT REPORT ☐ INTERIM ☒ FINAL

JUVENILE FACILITIES

Date of report: 08/28/2016

Auditor Information			
Auditor name: G. Peter Zeegers			
Address: 6302 Benjamin Rd. Suite 400 Tampa, Fl. 33634			
Email: pete.zeegers@us.g4s.com			
Telephone number: 863-441-2495			
Date of facility visit: July 27-28, 2016			
Facility Information			
Facility name: Camp Riverbend Youth Transitional Facility			
Facility physical address: 58231 Oregon Highway 244 La Grande, Oregon 97850			
Facility mailing address: *(if different from above)* Click here to enter text.			
Facility telephone number: (541) 663-8801			
The facility is:	☐ Federal	☒ State	☐ County
	☐ Military	☐ Municipal	☐ Private for profit
	☐ Private not for profit		
Facility type:	☒ Correctional	☐ Detention	☐ Other
Name of facility's Chief Executive Officer: Superintendent Greg Westbrooks			
Number of staff assigned to the facility in the last 12 months: 27			
Designed facility capacity: 25			
Current population of facility: 30			
Facility security levels/inmate custody levels: Close Custody			
Age range of the population: 16-24			
Name of PREA Compliance Manager: Gary Lillard		**Title:** Treatment Manager	
Email address: Gary.lillard@oya.state.or.us		**Telephone number:** (503) 663-8801	
Agency Information			
Name of agency: Oregon Youth Authority			
Governing authority or parent agency: *(if applicable)* Click here to enter text.			
Physical address: 530 Center Street NE; Suite 500; Salem, Oregon 97301			
Mailing address: *(if different from above)* Click here to enter text.			
Telephone number: (503) 373-7205			
Agency Chief Executive Officer			
Name: Fariborz Pakseresht		**Title:** Director	
Email address: Fariborz.Pakseresht@oya.state.or.us		**Telephone number:** (503) 373-7212	
Agency-Wide PREA Coordinator			
Name: Dallas Tully		**Title:** PREA Coordinator	
Email address: Dallas.Tully@oya.state.or.us		**Telephone number:** (503) 373-7203	

AUDITFINDINGS

NARRATIVE

Camp Riverbend Youth Transitional Facility (CRYTF) is a thirty-two (32) bed male residential facility governed by the Oregon Youth Authority (OYA). CRYTF is staffed with twenty seven (27) full-time and part-time employees. The on-site audit was conducted on July 27th and 28th, 2016 by certified PREA Auditor G. Peter Zeegers. The mission of the Oregon Youth Authority (OYA) is to protect the public and reduce crime by holding youth offenders accountable and providing opportunities for reformation in safe environments. The vision of the Oregon Youth Authority is that youth who leave CRYTF go on to lead productive, crime-free lives. The values that guide the agency's decisions, actions and priorities are: integrity, professionalism, accountability, and respect.

The state's most delinquent youth offenders, ages 12 – 24 are committed to the Oregon Youth Authority. Crimes include murder, rape, arson, robbery, other violent crimes, and substance abuse. OYA maintains legal and physical custody of youth offenders adjudicated by juvenile courts. OYA has physical custody of youth offenders committed to DOC by adult courts and placed with OYA due to their age. CRYTF was opened in 1979 as a work-study camp known as Camp Hilgard. A newer facility was built on the site in 2002 and the camp was renamed. The facility design, which provides living units around an enclosed courtyard, is similar to that of the other regional close-custody facilities. Today, Camp Riverbend serves up to 25 male youth in one unit. The treatment programs at Camp Riverbend YTF focus on serving youth with alcohol, tobacco, and other drug problems. A small accredited on-site high school serves youth who still need to acquire high school diplomas or GEDs. On-line college courses also are offered. Youth may take free courses provided by some colleges or may pay for courses if they have the money. Youth may apply for Pell grants and if not eligible for Pell grants may apply for scholarships through New Beginnings, a private OYA grant program funded by donations. Vocational programs at Riverbend include: building maintenance (e.g., custodial skills); culinary skills (e.g., food service worker); grounds maintenance; industrial laundry skills; waste water treatment; wildland fire fighting, community service and volunteer opportunities; and other trades. Certificates are available in many of these programs. Through treatment, classroom education and vocational education, CRYTF helps youth succeed in reforming their lives. CRYTF offers building better lives through: treatment, accountability, empathy, mental health treatment, drug and alcohol treatment, offense-specific treatment, violent offender treatment, restitution and community service, gang intervention, functional life skills, and transition services.

Prior to the on-site visit, the facility provided a completed PREA Questionnaire and a flash-drive with the requested documents. The auditor reviewed the same documents prior to the on-site visit. The auditor contacted the facility one week prior to the audit to review the on-site audit process, time lines, and to request additional information be made available on the first day of the audit. These documents included inmate rosters and staff assignments. There were no resident letters received before the on-site audit.

The on-site audit began with a meeting between the PREA Auditor, Greg Westbrooks, Superintendent, Gary Lillard, Facility PREA Compliance Manager, Dallas Tully, Statewide PREA Coordinator, and via tele-conference video; Dave Manley, Chief Investigator; Fariborz Pakseresht, Director; Bret Blanca, Treatment Manager, Winifred Skinner, Rules and Policy Coordinator, and Jodi Cochran, Internal Auditor. The discussion focused on the audit process, the interim/final 30-day report, Corrective Action Plan period, and the final report. The meeting was followed by a tour of the program.

During the tour, the auditor observed PREA notices and Zero Tolerance posters in the facility where both youth and staff had access to the information. The tour included administration, visitation, programming offices, intake/receiving, medical/dental, recreation areas, education, laundry, central control, dining hall, kitchen/food service, maintenance, vocational classrooms, and housing units. Interviewees were randomly selected for both inmates and staff. There were a total of 10 random youth interviewed. A total of 10 random staff were interviewed, as well as 13 specialized interviews were conducted. There were no allegations of sexual abuse or sexual harassment during the 12 months prior to the on-site audit.

DESCRIPTION OF FACILITY CHARACTERISTICS

The on-site audit was conducted on July 27-28, 2016. An entrance briefing was conducted with the PREA Auditor; Gary Lillard, PREA Compliance Manager, Bret Blanca, Treatment Manager, Greg Westbrooks, Superintendent, Dallas Tully, Statewide PREA Coordinator, and via tele-conference video; Dave Manley, Chief Investigator; Winifred Skinner, Rules and Policy Coordinator, Fariborz Pakseresht, Director; and Jodi Cochran, Internal Auditor (via phone). During the briefing, it was explained the audit process and a tentative schedule for the two (2) days to include conducting interviews with the staff and residents and reviewing the documentation. A complete guided tour of the entire facility was conducted including the administrative area, kitchen and dining area, dormitory areas, vocational and educational areas including school offices and classrooms, medical area, gym and maintenance building. During the tour, residents were observed to be under constant supervision of the staff while involved in school and other activities. The facility was clean and well maintained. Notification of the PREA audit was posted in all locations throughout the facility as well as postings informing residents of the telephone numbers to call against sexual abuse and harassment and to call the victim advocate. Cameras and video surveillance system enhance their capabilities to assist in monitoring blind spots and the review of incidents. There were no cameras installed in the resident's rooms or shower/toileting area so residents are not seen on the surveillance system while showering or toileting, but can be viewed by same sex staff as they supervise the shower area. During the tour, it was observed the shower/toilet areas in the male unit/dorm areas did allow for privacy. Emergency medical services and forensic exams are conducted at Grande Ronde Hospital located in La Grande, Oregon. There is an MOU with "Shelter from the Storm", in order to offer victim advocacy should a youth need it.

SUMMARY OF AUDIT FINDINGS

The notification of the on-site audit was posted six weeks prior to the date of the on-site audit. The posting of the notices was verified by photographs received electronically from the OYA PREA Coordinator. The photographs indicated notices were posted in various locations throughout the facility including the clinic, dining area/visitation, and units/dormitories. This auditor did not receive any communications from the staff or the residents as a result of the posted notices. The Pre-Audit Questionnaire, policies, procedures, and supporting documentation were reviewed by this auditor. The documents, which were uploaded to a UBS flash drive, were organized and easy to navigate. Also, several documents were provided during the on-site visit.

During the two (2) day on-site visit, there were a total of thirty (30) residents in the facility. There are two (2) living unit/dorms and residents were randomly selected from each dorm for the interview process. A total of ten (10) residents were interviewed on the second day of the audit. Residents were well informed of their right to be free from sexual abuse and harassment and how to report sexual abuse and harassment using several ways of communication such as trusted staff, administration, the hot line, and the grievance process. The community victims' advocacy service and telephone number is available to the residents. There is evidence of the OYA obtaining a Memorandum of Understanding with "Shelter from the Storm" to provide confidential emotional support to residents who are victims of sexual abuse.

Twenty-three (23) staff including those from all shifts, administrative and supervisory staff, medical and mental health/substance abuse staff, youth corrections unit coordinator, group life coordinators, contracted staff (teachers), the Superintendent/PREA Compliance Manager and Treatment Services Manager were interviewed. Additionally, the OYA Director (representative), OYA PREA Coordinator, OYA Human Resources, OYA Agency Contract Administrators, and OYA Chief Investigator were interviewed during a prior OYA facility audit conducted by G4S PREA Auditor Dorothy Xanos. Overall, the interviews revealed the staff is knowledgeable of the PREA standards and were able to articulate their responsibilities and their mandated duty to report. At the end of the second day, an exit briefing with a summary of the findings was conducted.

Number of standards exceeded: 2

Number of standards met: 37

Number of standards not met: 0

Number of standards not applicable: 2

Standard 115.311 Zero tolerance of sexual abuse and sexual harassment; PREA Coordinator

☒ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The initial review of the Oregon Youth Authority (OYA) Policy 1-A-10.0 [General Administration (Preventing, Detecting and Responding to Offender Sexual Abuse and Sexual Harassment)] revised 6/18/2015, outlines how the facility implements its approach to preventing, detecting and responding to sexual abuse and harassment, includes definitions of prohibited behaviors as well as sanctions for staff, contractors, volunteers and residents who had violated those prohibitions. Additionally, the policy provided guidelines for implementing the facility's approach to include the zero tolerance towards reducing and preventing sexual abuse and harassment of residents. It is evident the executive administration has taken the PREA Standards to another level and it is reflected in their commitment to protecting the residents in their care throughout the State of Oregon.

OYA has a designated juvenile PREA Coordinator who works statewide to implement the PREA Standards and who indicated she has sufficient time and authority to develop, implement and oversee compliance efforts of ten (10) residential facilities. She is also a certified PREA Auditor. The Treatment Manager is designated as the facility PREA Compliance Manager who also indicated that he has sufficient time to oversee the facility's PREA compliance efforts and perform other duties as assigned. It was evident during the staff interviews, staff had been trained and were knowledgeable of OYA Agency's Zero Tolerance Policy including all aspects of sexual abuse, sexual harassment and sexual misconduct in accordance with the requirements.

Standard 115.312 Contracting with other entities for the confinement of residents

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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.

A review of the documentation revealed OYA does not contract for the confinement of residents with private entities or other entities, including other government agencies. This standard is not applicable to this facility.

Standard 115.313 Supervision and monitoring

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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.

OYA Policy II-A-3.0 [Security (Supervision of Offenders)] required each facility to develop a staffing plan to provide for adequate staffing levels to ensure the safety and custody of residents, account for departmental resident to staff ratios, physical plant, video monitoring, and federal standards. In addition, to comply with staffing requirements including exigent circumstances and supervisory staff conducting unannounced rounds during all shifts on a quarterly basis. The facility reported that there have been no deviations from the minimum staffing levels during the past 12 months. In addition, minimum staff ratios are always maintained, the facility has a mechanism in place for call outs and staff volunteer to stay over if needed. Unannounced rounds are conducted quarterly on every shift and documented on JJIS/unit logs that contains observations of all areas of the facility. Staff interviews confirmed the process takes place in the facility. The Superintendent created a rotating schedule for himself and assigned the Treatment Services Manager and Supervisors to conduct and document unannounced rounds on all shifts and in all areas of the facility to monitor and deter staff sexual abuse and harassment.

Standard 115.315 Limits to cross-gender viewing and searches

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The initial review of the OYA Policy II-A-2.0 [Security (Searches of Offenders and Offender Property in OYA Facilities)] revealed policy and procedures on limited pat-down searches to same gender staff absent exigent circumstances, shower procedures, female staff announcing when entering housing area, and prohibiting the search of a transgender or intersex resident solely for the purpose of determining the resident's genital status. There were no cross-gender pat-down searches conducted during the past 12 months. Staff and resident interviews indicated that female staff entering the housing area consistently announce themselves. Staff and resident interviews confirmed residents are able to shower, perform bodily functions and change clothing without non-medical staff of the opposite gender viewing them. Additionally, staff and resident interviews indicated that female staff are prohibited from entering the bathroom/shower area while residents are showering. All residents stated that they had never been searched by a staff member of the opposite sex nor had they ever seen a staff conduct a cross gender pat down search. A review of the training documentation and staff interviews confirmed training on pat down searches, cross-gender pat searches and searches of transgender and intersex residents, and prohibiting cross-gender strip or cross-gender visual body cavity searches of residents.

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

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance

determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

An initial review of the OYA Policy 1-A-10.0 [General Administration (Preventing, Detecting and Responding to Offender Sexual Abuse and Sexual Harassment)] and 1-D-2.1 (Use of Language Services; English Plus) contained procedures to be taken to ensure residents with disabilities or who are limited English proficient are provided meaningful access to all aspects of the facility's efforts to prevent, protect and respond to sexual abuse and harassment. Additionally, the policy states the facility will not rely on resident interpreters, resident readers or any kind of resident assistants except when a delay in obtaining interpreters services could jeopardize a residents' safety. There are postings throughout the facility in English and Spanish and intake staff have access to several lists for interpreter services and OYA's Deaf and Hard of Hearing services. Staff training documentation, pamphlet and resident handbook contained information on providing appropriate explanations regarding PREA to residents based upon the individual needs of the youth. Also the resident handbook is available in Spanish. Some staff and resident interviews confirmed the facility does not use resident assistance and there were no instances of resident interpreters or readers being used in the past 12 months.

Standard 115.317 Hiring and promotion decisions

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

An initial review of the OYA Policy 1-A-10.0 [General Administration (Preventing, Detecting and Responding to Offender Sexual Abuse and Sexual Harassment)] contained all the elements required by this standard and all background checks are conducted initially on new employees and promotion decisions of the agency. The initial background checks include the screening for criminal record checks, possible checks on criminal convictions and pending criminal charges, access to state and federal criminal databases to conduct background checks, child abuse registry checks (ORKids) and best efforts to contact all prior institutional employers for information on substantiated allegations of sexual abuse and any resignation during a pending investigation or an allegation of sexual abuse. The agency conducts 5-year background checks for all employees and contractors. Material omissions by an employee is subject to termination. Additionally, contractors who have contact with residents have documented criminal background checks. A sampled review of staff HR records contained the documented criminal background checks and the questions regarding past misconduct (application and PREA Acknowledgement form) were asked and responded to during the hiring process.

Standard 115.318 Upgrades to facilities and technologies

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These

recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

There have been no upgrades tofacilities and/ortechnologies in the last 12 months. This standard is N/A.

Standard 115.321 Evidence protocol and forensic medical examinations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Initial documentation review of CRYTF Policy 1-A-10.0 (Sexual Abuse Response Plan) contained the elements of the standard and identified that all allegations of sexual abuse and sexual harassment be referred to the appropriate investigative agency based upon the victim's age. Additionally, it requires protocols for informed consent, confidentiality, reporting to law enforcement, and reporting to child abuse investigative agencies. Documentation and staff interviews confirmed Oregon State Police (OSP) & Professional Standard Office (PSO) conducts the administrative and criminal investigations of allegations of sexual abuse, sexual harassment and sexual misconduct. Residents 18 years of age are referred to the appropriate law enforcement agency to investigate allegations of sexual abuse and sexual harassment. There is evidence of OYA obtaining Memorandum of Understanding with "Shelter from the Storm" to provide confidential emotional support to residents who are victims of sexual abuse. Documentation was provided that the medical examiners at Grande Ronde Hospital is SANE certified. All residents are offered a forensic medical examinations at no financial cost to the victim.

Standard 115.322 Policies to ensure referrals of allegations for investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

OYA Policy 1-D-4.0 (Professional Standards Office Administrative Investigations) requires an administrative and/or criminal investigation for all allegations of sexual abuse or sexual harassment. All staff are required to report all allegations, knowledge and suspicions of sexual abuse, sexual harassment, retaliation, staff neglect and/or violations of responsibilities that may have contributed to an incident or retaliation. All staff are required to refer all alleged incidents of sexual abuse, harassment or misconduct to the Professional Standard Office (PSO) for investigation. The PREA policy can be found at the state's website www.oregon.gov/oya/pages/pso/prea.aspx. The facility has reported no allegations of sexual abuse and sexual harassment in the last year. All staff interviews reflected and confirmed their knowledge on the reporting and referral process and policy's requirements. Additionally, the staff knew the agency to notify in response to an allegation of sexual abuse, sexual harassment and sexual misconduct.

Standard 115.331 Employee training

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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An initial review of the OYA Policy 1-A-10.0 [General Administration (Preventing, Detecting and Responding to Offender Sexual Abuse and Sexual Harassment)] requires PREA Training upon initially becoming an employee (entry level training) as well as refresher training annually. All eleven (11) topics covered during PREA training are consistent with this standard's requirements and is tailored to the facility's male resident population. The staff training documentation and staff interviews confirmed staff receives PREA training during initial training and during refresher training. All employees are trained as new hires regardless of their previous experience. All staff are required to sign their name on the web-based training, and complete a question and answer exam upon completion of the initial PREA training. A review of sampled electronically maintained training rosters as well as staff interviews confirmed that staff are receiving their required PREA Training. Staff interviews confirmed their comprehension of the PREA training and their obligation to report any allegation of the sexual abuse and or sexual harassment.

Standard 115.332 Volunteer and contractor training

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

An initial review of the OYA Policy 1-A-10.0 [General Administration (Preventing, Detecting and Responding to Offender Sexual Abuse and Sexual Harassment)] requires volunteers, interns and contractors who have contact with residents to receive PREA training. All volunteers, interns and contractors receive the "Volunteer Training Overview" and the training is documented. All volunteers, interns and contractors are required to sign and date a "Facility Access - VET" or "Facility Access – 1" or "Facility Access – 2" and complete a question and answer exam upon completion of the initial PREA training acknowledging they understand the training they received. Documentation confirmed they are aware of the facility's requirement for confidentiality and their duty to report any incidents of sexual abuse and or sexual harassment. An interview with a volunteer, via phone, confirmed their knowledge of the PREA training.

Standard 115.333 Resident education

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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An initial review of the OYA Policy 1-A-10.0 [General Administration (Preventing, Detecting and Responding to Offender Sexual Abuse and Sexual Harassment)] requires residents to receive comprehensive age appropriate education information regarding safety, their rights to be free from sexual abuse, sexual harassment, retaliation, reporting and the agency's response to allegations within 10 days upon arrival. However, the youth corrections unit coordinator and psychiatric social work staff provides the residents with this information immediately upon arrival during their initial intake and orientation process. This information is reviewed verbally with the resident and a handbook is provided to them for future reference. After the review with the resident he is asked to sign various forms which include: Intake/Close Custody Youth Safety Orientation and Youth Sexual Safety Education, to name a few verifying receipt for all information regarding orientation to the facility. All residents are provided an OYA Youth Safety Guide which includes information on prevention/intervention, self-protection, reporting and treatment/counseling and is available in Spanish. Documentation of resident's signatures were reviewed and confirmed during resident interviews. All residents interviewed stated they received this information the same day they arrived at the facility and identified the receipt of the handbook. Additionally, they indicated their youth corrections unit coordinator staff have continued to provide this education on an ongoing basis.

Standard 115.334 Specialized training: Investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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An initial review of the OYA Policy 1-A-10.0 [General Administration (Preventing, Detecting and Responding to Offender Sexual Abuse and Sexual Harassment)] requires an administrative and/or criminal investigation for all allegations of sexual abuse or sexual harassment and requires staff to refer all alleged incidents of sexual abuse, harassment or misconduct to the Professional Standard Office (PSO) for investigation. There are investigators statewide who conduct investigations for OYA and all have completed the NIC "Specialized Training – Investigating Sexual Abuse in Confinement Settings" course; Moss Group Legal Issues; OYA Investigator & Interview Training, and Prison Rape and Sexual Assault Investigations. All investigators statewide were required to attend these trainings. A review of the documentation and OYA Chief Investigator interview confirmed he attended the required training.

Standard 115.335 Specialized training: Medical and mental health care

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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An initial review of the OYA Policy 1-A-10.0 [General Administration (Preventing, Detecting and Responding to Offender Sexual Abuse and Sexual Harassment)] requires PREA training and specialized training for medical and mental health staff. Initial review of training documentation revealed medical and mental health/substance abuse staff received the basic PREA training provided to all staff. All medical and mental health staff received specialized training through NIC Medical Health Care for Sexual Assault Victims and SARRC & PCM Training. Interviews with medical and mental health staff confirmed their understanding of the requirement to complete the specialized training and verified completing the course. None of the medical staff conduct forensic examinations.

Standard 115.341 Screening for risk of victimization and abusiveness

☒ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

An initial review of the OYA Policy 1-A-10.0 [General Administration (Preventing, Detecting and Responding to Offender Sexual Abuse and Sexual Harassment)] requires prior to placement as part of the screening process each resident is screened upon admission with an objective screening instrument for risk of victimization and sexual abusiveness with the Sexual Violence Assessment Tool and within 72 hours a mental health staff will conduct a YCF Initial Mental Status Assessment and YCF Brief Mental Status Assessment. All residents are screened within twenty-four hours upon arrival at the facility to determine placement and their special needs. Those residents who score vulnerable to victim or sexually aggressive are included into the alert system, as well as receiving further assessments, as identified. This intake screening is used in combination with information about personal history, medical and mental health screenings, conversations, classification assessments as well as reviewed court records and case files. Residents are reassessed annually or as needed, and throughout their stay at the facility. The facility's policies limits staff access to this information on a "need to know basis". Resident interviews and the documentation revealed that risk screenings are being conducted on the same day as the admission. Staff interviews confirmed a screening is completed on each resident upon admission to the program. Residents reporting prior victimization, according to staff, are referred immediately for a follow-up with medical or mental health. Although there have been no transgender or intersex residents admitted to the facility within the past year, staff were aware of giving consideration for the resident's on views of their safety in placement and programming assignments.

Standard 115.342 Use of screening information

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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.

An initial review of the OYA Policy 1-A-10.0 [General Administration (Preventing, Detecting and Responding to Offender Sexual Abuse and Sexual Harassment)], Policy II-F-1.0 (Offender Rights) and Policy II-B-1.2 (Use of Time-out, Isolation, and Special Program Placements in OYA Facilities) precludes gay, bi-sexual, transgender and intersex residents being placed in a particular housing unit, beds or other assignments based solely on their identification or status. In addition, the policy describes the screening and assessment process (Sexual Violence Assessment Tool) and how that information, along with information derived from medical and mental health screening and assessments, records reviews, database checks, conversations and observations, is used to determine a resident's appropriate placement, housing and bed assignments, as well as work, education, and program assignments with the goal of keeping all residents safe and free from sexual abuse. The youth corrections unit coordinator staff utilize various forms and any other pertinent information during the resident's admission process. Staff interviews described how information is derived from the forms as indicated above and the initial health assessment and mental health/substance abuse screening forms to determine placement and risk level. There are two (2) living unit/dorms with both single rooms and open bay areas.

Standard 115.351 Resident reporting

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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.

An initial review of the OYA Policy 1-A-10.0 [General Administration (Preventing, Detecting and Responding to Offender Sexual Abuse and Sexual Harassment)], Policy 0-2.3 (Mandatory Reporting of Offender Abuse and Child Abuse), Policy II–F-1.1 (Offender Grievance Process), Policy II-F-3.4 (Use of Telephone), Policy II-F-3.6 (Youth Legal Assistance) and CRYTF provides multiple internal ways for residents to report sexual abuse and harassment retaliation, staff neglect or violation of responsibilities that may have contributed to such incidents. Residents are informed verbally and in writing on how to report sexual abuse and sexual harassment. These various ways of reporting include advising an administrator, a staff member, telephoning the hotline, correspondence to the Governor's Office Constituency Services Office, placing a written complaint in the grievance box, and third party. While touring the entire facility, it was observed in the living areas postings of the PREA information (posters). The victim advocate information postings were limited. Reporting procedures are provided to residents through the OYA Safety Guide. All staff and resident interviews along with the safety guide and supporting documentation verified compliance with this standard. Prior to completing the on-site audit, victim advocate information was clearly posted in various areas posted throughout the facility.

Standard 115.352 Exhaustion of administrative remedies

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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.

OYA Policy II–F-1.1 (Offender Grievance Process) describes the orientation residents receive explaining how to use the grievance process to report allegations of abuse and has administrative procedures/appeal process for dealing with resident's grievances regarding sexual abuse or harassment. Residents may place a written complaint in the grievance box located in various locations throughout the facility. The facility has a multi-layered grievance process enabling timely response and layers of review. The policies and procedures describe an unimpeded process and allow for other individuals to assist a resident in filing a grievance or to file grievances themselves on behalf of residents. Residents are not required to utilize an informal process for reporting allegations of sexual abuse or sexual harassment nor are they required to submit it to the staff member involved in the allegation. Grievances are to be resolved with a written response no later than seven (7) working days. Also, the facility has an emergency grievance procedure requiring an initial response within 24 hours. Resident interviews and documentation confirmed the grievance process relating to sexual abuse or sexual harassment.

Standard 115.353 Resident access to outside confidential support services

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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.

An initial review of the OYA Policy 1-A-10.0 [General Administration (Preventing, Detecting and Responding to Offender Sexual Abuse and Sexual Harassment)], Policy II–F-3.0 (Offender Mail in OYA Facilities), Policy II-F-3.4 (Use of Telephone), Policy II-F-3.6 (Youth Legal Assistance) and Policy II-E-2.5 (Visits with Youth) ensures that residents are provided access to outside confidential support services, legal counsel and parent/guardian. There is documentation of the OYA PREA Coordinator's obtaining the MOU with Shelter from the Storm for victim advocate services. There have been no calls from residents to outside services in the past 12 months. Resident interviews confirmed they have reasonable and confidential access to their attorneys and reasonable access to their parent/guardian either through visitation, correspondence or by telephone. The facility provides calls to parents/legal guardians weekly, provides for the toll free hotline to report sexual abuse, permits parental/legal guardians visitation and letter writing to parents/legal guardians. The Youth Safety Guide contained information of outside services and information was provided on the Governor's Constituent Services Office. Resident interviews revealed limited knowledge of how to access outside services. However, additional education has been provided to the residents on victim advocate services and the telephone number is clearly posted for residents viewing.

Standard 115.354 Third-party reporting

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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.

OYA Issue Brief (Keeping Youth Safe while in OYA's Care & Custody) dated March 2014 and June 2015 identifies third party reporting process and instruct staff to accept third party reports. OYA website provides the public with information regarding third-party reporting of sexual abuse or sexual harassment on behalf of a resident and a OYA Complaint form. Additionally, OYA has created a "Keeping Youth Safe" brochure, Family Guides for DOC & OYA Youth (English and Spanish) and Final Safety Survey/Final Service Survey for both Family and Residents regarding third–party reporting of sexual abuse or sexual harassment. All resident interviews confirmed their awareness of reporting sexual abuse or harassment to others outside of the facility including access to their parent(s)/legal guardian(s) and attorney. Additionally, they are instructed to report allegations of sexual abuse and sexual harassment to a trusted adult, parent/legal guardian, and/or attorney. All staff interviews were able to describe how reports may be made by third parties.

Standard 115.361 Staff and agency reporting duties

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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.

An initial review of the OYA Policy 1-A-10.0 [General Administration (Preventing, Detecting and Responding to Offender Sexual Abuse and Sexual Harassment)], Policy 0-2.1 (Professional Standards) and Policy 0-2.3 (Mandatory Reporting of Offender Abuse and Child Abuse) identified the reporting process for all facility staff to immediately report any knowledge, suspicion or information they receive regarding sexual abuse and harassment, retaliation against residents or staff who report any incidents or any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation. All facility staff are mandated reporters and random staff interviews confirmed the program's compliance with this standard. Interviews with medical and mental health staff confirmed their responsibility to inform residents under 18 years old of their duty to report and limitations of confidentiality. All facility staff receive information on clear steps on how to report sexual misconduct and to maintain confidentiality through facility protocol and or on line training (iLearnOregon).

Standard 115.362 Agency protection duties

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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.

An initial review of the OYA Policy 1-A-10.0 [General Administration (Preventing, Detecting and Responding to Offender Sexual Abuse and Sexual Harassment)] require that immediate action to be taken upon learning that a resident is subject to a substantial risk of imminent sexual abuse. There were no residents determined to be subject to substantial risk of imminent sexual abuse in the past 12 months.

Documentation and interviews with the Superintendent and other random selected staff were able to articulate, without hesitation, the expectations and requirements of OYA Policies and PREA Standards, upon becoming aware that a resident may be subject to a substantial risk of imminent sexual abuse. Staff indicated if a resident was in danger of sexual abuse or at substantial risk of imminent sexual abuse, they would act immediately to ensure the safety of the resident, separate from the alleged perpetrator and contact their immediate supervisor. Additionally, the resident would be referred for mental health services. All resident interviews reported they feel safe at this facility and none had ever reported to staff that they were at substantial risk of imminent sexual abuse.

Standard 115.363 Reporting to other confinement facilities

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

An initial review of the OYA Policy 1-A-10.0 [General Administration (Preventing, Detecting and Responding to Offender Sexual Abuse and Sexual Harassment)] and Policy 1-D-4.0 (Professional Standards Office Administrative Investigations) requires the Superintendent, upon receiving an allegation that a resident was sexually abused while confined at another facility, to notify the Superintendent where the alleged abuse occurred and to report it in accordance with OYA policy and procedures. Also according to policy and procedure the Superintendent is to immediately report the incident to the Professional Standards Office (PSO) for investigation and complete an incident report. The Superintendent had not received any allegations that a resident was abused while confined at another facility during the past 12 months.

Standard 115.364 Staff first responder duties

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

OYA Policy 1-A-10.0 [General Administration (Preventing, Detecting and Responding to Offender Sexual Abuse and Sexual Harassment)] and Facility First Responders to Sexual Abuse Checklist form requires staff to take specific steps to respond to a report of sexual abuse including; separating the alleged victim from the abuser; preserving any crime scene within a period that still allows for the collection of physical evidence; request that the alleged victim not take any action that could destroy physical evidence; and ensure that the alleged abuser does not take any action to destroy physical evidence, if the abuse took place within a time period that still allows for the collection of physical evidence. Random staff and first responder interviews validated their technical knowledge of actions to be taken upon learning that a resident was sexually abused. Also, every interviewed staff described actions they would take immediately and these steps were all consistent with OYA policies and procedures. It was evident that staff have been trained in their responsibilities as first responders.

Standard 115.365 Coordinated response

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

CRYTF Local Operating Protocol I-A-10.0 (Sexual Abuse Response Plan) provides a written facility plan to coordinate actions taken in response to an incident of sexual assault among staff first responders, medical, mental health, facility leadership and executive staff. Coordinated Response clearly enumerate the actions to be taken by each discipline or involved staff person. Additionally, the plan identified a Sexual Assault Response Resource Team (SAART) and their response to the incident. A number of individuals are involved identified as: First Responder, Supervisor or Officer of the Day (OD), Medical and Mental Health Staff, Superintendent, PREA Coordinator, PSO and SARRT members (resident's treatment manager, JPPO, facility RN, QMHP and Treatment Services Manager). Plans include instructions for accessing Grande Ronde Hospital and safety from the Storm. Interviews with the Superintendent and other staff validated their knowledgeable of their duties in response to a sexual assault.

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

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Documentation was provided for the 2013-2015 State of Oregon and SEIU Local 503, OPEU Collective Bargaining Agreement Master Agreement Indexing System referencing a number to each Coalition and a letter to each Agency within the Coalition consistent with provisions of PREA standards 115.372 and 115.376.

Standard 115.367 Agency protection against retaliation

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance

determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

OYA Policy 1-A-10.0 [General Administration (Preventing, Detecting and Responding to Offender Sexual Abuse and Sexual Harassment)] requires the protection and monitoring of residents and staff who have reported sexual abuse and sexual harassment or who have cooperated in a sexual abuse or harassment investigation. OYA policy prohibits retaliation against any staff or resident for making a report of sexual abuse as well as retaliation against a victim who has suffered from abuse. The monitoring at a minimum will take place for a period of 90 days or longer, as needed. The Treatment Manager/PREA Compliance Manager is responsible with monitoring 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 determine if changes that may suggest possible retaliation exist. The statewide PREA Coordinator also assists each facility Superintendent in monitoring staff retaliation. This monitoring would include resident disciplinary reports, housing and program changes, negative performance reports as well as reassignments of staff. There were no incidents of retaliation in the past 12 months.

Standard 115.368 Post-allegation protective custody

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The initial review of this policy OYA Policy II-B-1.2 (Use of Time-out, Isolation, and Special Program Placements in OYA Facilities) contained information on post-allegation protective custody or guidelines for moving a resident to another housing area or another facility as a last measure to keep residents who alleged sexual abuse safe and only until an alternative means for keeping the resident safe can be arranged. The facility restricts any isolation placement no longer than five (5) days. No residents who have alleged sexual abuse in the past 12 months were secluded or isolated from the other residents. The residents would be placed in another housing group or staff would be placed on "no contact with resident."

Standard 115.371 Criminal and administrative agency investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

OYA Policy 1-A-10.0 [General Administration (Preventing, Detecting and Responding to Offender Sexual Abuse and Sexual Harassment)] and Policy 1-D-4.0 (Professional Standards Office Administrative Investigations) require all staff to refer all alleged incidents of sexual

abuse, harassment or misconduct to the Professional Standards Office (PSO) for investigation and determination of criminal charges. It is evident the staff know to report incidents as required and reports are maintained for as long as the alleged abuser is incarcerated or employed by the department, plus 20 years unless the abuse was committed by a juvenile and applicable laws require a shorter period of retention.

Standard 115.372 Evidentiary standard for administrative investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

OYA Policy 1-D-4.0 (Professional Standards Office Administrative Investigations) contains all the elements of the standard and the Professional Standards Office (PSO) investigates the allegation and indicates a standard of a preponderance of the evidence or a lower standard of proof for determining if allegations are substantiated. An interview with the OYA Chief Investigator indicated that they conduct fact finding investigations and do not make conclusions following their investigations (which are administrative in nature) therefore the Superintendent in consultation with legal and his supervisory staff and Human Resources would make a determination regarding disciplinary actions to be imposed and the standard they would use is the preponderance of evidence.

Standard 115.373 Reporting to residents

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

OYA Policy 1-A-10.0 [General Administration (Preventing, Detecting and Responding to Offender Sexual Abuse and Sexual Harassment)] requires that any resident who makes an allegation that he or she suffered sexual abuse is informed in writing contains the process for notifying residents whether the allegation proves substantiated, unsubstantiated or unfounded following an investigation. This policy further requires that following a resident's allegation that a staff member has committed sexual abuse against the resident, the facility informs the resident unless the allegations are "unfounded" whenever the staff member is no longer posted within the resident's unit; the staff member is no longer employed at the facility; OYA learns that the staff member has been indicted or convicted on a charge related to sexual abuse within the facility. With regard to investigations involving resident-on-resident allegations of sexual abuse, the facility will inform the resident whenever the facility learns that the alleged abuser has been indicted or convicted on a charge related to sexual abuse within the facility. The Superintendent validated his technical knowledge of the reporting process during his interview.

Standard 115.376 Disciplinary sanctions for staff

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

OYA Policy 1-A-10.0 [General Administration (Preventing, Detecting and Responding to Offender Sexual Abuse and Sexual Harassment)] requires staff disciplinary sanctions up to and including termination for violating facility's sexual abuse or harassment policies. The policy also mandates that the violation be reported to law enforcement. All disciplinary sanctions are maintained in the employees HR file in accordance with OYA policy and procedures. Termination is the presumptive sanction for staff who have engaged in sexual abuse. Additionally staff may not escape sanctions by resigning. Staff who resign because they would have been terminated, are reported to the local law enforcement, unless the activities were not clearly criminal. There has been no employees terminated in the past 12 months for violation of the facility's sexual abuse or harassment policies. The Superintendent interview validated his technical knowledge of the reporting process was consistent with OYA policies and procedures.

Standard 115.377 Corrective action for contractors and volunteers

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

OYA Policy 1-A-10.0 [General Administration (Preventing, Detecting and Responding to Offender Sexual Abuse and Sexual Harassment)] and Policy 1-D-4.0 (Professional Standards Office Administrative Investigations) requires that volunteers and contractors in violation of the facility's policies and procedures regarding sexual abuse and harassment of residents will be reported to local law enforcement unless the activity was clearly not criminal and to relevant licensing bodies. Additionally, the policies requires the facility staff to take remedial measures and prohibit future contact with residents in the case of any violation of the facility's sexual abuse and harassment policies by contractors or volunteers. This was verified during an interview with the Superintendent. There have been no volunteers or contractors reported in the past 12 months.

Standard 115.378 Disciplinary sanctions for residents

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

OYA Policy 1-A-10.0 [General Administration (Preventing, Detecting and Responding to Offender Sexual Abuse and Sexual Harassment)], Policy 2.1 (Offender Accountability in OYA Facilities) and OAR 416-470 Exhibit 1: OYA Behavior Refocus Options Matrix found to have violated any of the agency's sexual abuse or sexual harassment policies will be subject to sanctions pursuant to the behavior management program. CRYTF provides each resident with a Youth Safety Guide that includes their rights and responsibilities, a disciplinary list of violations, disciplinary procedures and transfers. Residents will be offered therapy counseling or other interventions designed to address and correct the underlining reasons for their conduct. The Superintendent indicated that residents may also be referred for prosecution if the allegations were criminal.

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

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

OYA Policy 1-A-10.0 [General Administration (Preventing, Detecting and Responding to Offender Sexual Abuse and Sexual Harassment)] require that medical and mental health evaluation and, as appropriate, treatment, is offered to all residents victimized by sexual abuse. Residents who report prior sexual victimization or who disclose prior incidents of perpetrating sexual abuse, either in an institution or in the community, are required to be offered a follow-up with a medical or mental health practitioner within 14 days of admission/screening. There were no residents who disclosed prior victimization during their initial screening process. During the interviews with the medical and mental health staff confirmed that although there were no disclosures, all residents were offered follow-up meetings with medical and mental health providers.

Standard 115.382 Access to emergency medical and mental health services

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

OYA Policy 1-A-10.0 [General Administration (Preventing, Detecting and Responding to Offender Sexual Abuse and Sexual Harassment)], Policy II-D-1.0 (Facility Health Services) and Procedure HS 1-A-10.0 (Preventing, Responding to and Monitoring Offender Sexual Abuse/Assault) victims of sexual abuse are offered timely information about and timely access to emergency contraception and sexually transmitted disease prophylaxis, in accordance with professionally accepted standards of care, where medically appropriate and crisis intervention services. Documentation provided confirmed treatment services are provided to every victim without financial cost. Grande Ronde Hospital provides the emergency services and Shelter from the Storm provides forensic examinations and victim advocate services for this facility. Interviews with the medical and mental health staff confirmed that residents have immediate access to emergency medical and mental health services.

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

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

OYA Policy 1-A-10.0 [General Administration (Preventing, Detecting and Responding to Offender Sexual Abuse and Sexual Harassment)], Policy II-D-1.0 (Facility Health Services) and Procedure HS 1-A-10.0 (Preventing, Responding to and Monitoring Offender Sexual Abuse/Assault) requires ongoing medical and mental health care for sexual abuse victims and abusers. Additionally, the policy requires the facility to offer medical and mental health evaluations and appropriate follow-up treatment. Victims of sexual abuse will be transported Grande Ronde Hospital where they will receive treatment and where physical evidence can be gathered by a certified SANE medical examiner. There is a process in place to ensure staff track on-going medical and mental health services for victims who may have been sexually abused.

Standard 115.386 Sexual abuse incident reviews

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

OYA Policy 1-A-10.0 [General Administration (Preventing, Detecting and Responding to Offender Sexual Abuse and Sexual Harassment)] and Policy I-E-4.0 (Incident Reviews) requires a Sexual Abuse Incident Review of every sexual abuse allegation at the conclusion of all investigations, except those determined to be unfounded. Incident review to be updated within 30 days of a disposition being reached (for substantiated or unsubstantiated incidents of sexual abuse). CRYTF Sexual Abuse Incident Review Team consists of the Superintendent, Treatment Manager/PREA Compliance Manager, Medical, Mental Health, and Education staff. Staff interviews confirmed they would document their review on their Administrative Incident Review Report form that captures all aspects of an incident.

Standard 115.387 Data collection

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

OYA Policy 1-A-10.0 [General Administration (Preventing, Detecting and Responding to Offender Sexual Abuse and Sexual Harassment)] requires the collection of accurate, uniform data for every allegation of sexual assault. The OYA PREA Coordinator implemented a data collection protocol and collects all data relating to PREA. OYA has a data collection instrument to answer all questions for the U.S. Department of Justice Survey of Sexual Abuse Violence. A review of the annual report revealed it was completed according to this standard.

Standard 115.388 Data review for corrective action

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

OYA Policy 1-A-10.0 [General Administration (Preventing, Detecting and Responding to Offender Sexual Abuse and Sexual Harassment)] requires the review of data for corrective action to improve the effectiveness of its prevention, protection and response policies, practices and training. A review of the 2013 Annual Report indicated compliance with the standard and included all of the required elements. The OYA 2014 Annual Report is posted on the OYA Website for public review. The facility monitors collected data to determine and assess the need for any corrective actions. The 2014 annual report was readily available on the OYA website.

Standard 115.389 Data storage, publication, and destruction

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

OYA Policy 1-A-10.0 [General Administration (Preventing, Detecting and Responding to Offender Sexual Abuse and Sexual Harassment)] requires that data is collected and securely retained for 20 years. The aggregated sexual abuse data was reviewed and all personal identifiers are removed.

AUDITOR CERTIFICATION

I certify that:

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

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

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

G. Peter Zeegers _ 08/28/2016

Auditor Signature Date