PREA AUDIT REPORT ☐ INTERIM ☒ FINAL

JUVENILE FACILITIES

Date of report: 04/30/16

Auditor Information			
Auditor name: Dorothy Xanos			
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Telephone number: (813) 918-1088			
Date of facility visit: March 29–30, 2016			
Facility Information			
Facility name: Hillcrest Youth Correctional Facility			
Facility physical address: 2450 Strong Rd. SE, Salem, OR 97302			
Facility mailing address: *(if different from above)* Click here to enter text.			
Facility telephone number: (503) 986-0400			
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: Troy Gregg			
Number of staff assigned to the facility in the last 12 months: 161			
Designed facility capacity: 147			
Current population of facility: 140			
Facility security levels/inmate custody levels: No Security Level Classification			
Age range of the population: 12-24			
Name of PREA Compliance Manager: Loren Calkins		**Title:** Treatment Services Manager	
Email address: Loren.Calkins@oya.state.or.us		**Telephone number:** (503) 986-0320	
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

Hillcrest Youth Correctional Facility (HYCF) is a 180 bed male secure residential facility currently budgeted for 147 beds and governed by the Oregon Youth Authority (OYA). HYCF has a rich history of serving at-risk residents. The campus was built in 1914 as the first reform school for girls in Oregon. Currently, residents are sent the to facility through both the adult and juvenile court systems. Residents who have committed a crime (Measure 11) and have been charged as an adult are placed at the facility under the Oregon Department of Corrections. Many of these residents will eventually be moved to an adult correctional facility to finish their sentence. Residents involved in the juvenile system work with a probation officer from their home county while at the facility and eventually transition to a less restrictive OYA facility, back to their home, or a community placement. HYCF offers two (2) distinct programs for incarcerated residents, Intake and Long Term. The Intake Program serves residents new to the system or parole violators. Intake residents participate in behavioral, psychological, medical assessments and an educational assessment through the school. The average length of stay in the Intake Program can range from 1-2 days up to 90 days. Currently the average length of stay for a resident in Intake is 32 days. Upon completion of the intake process residents are then assigned to a Long Term Program in one (1) of eight (8) different facilities located throughout the state, one of which is at HYCF. The Long Term Program at the facility involves treatment programs provided by OYA as part of their Individual Treatment Plans. The average length of stay for Long Term residents could range from a few months to 2-3 years. In some cases residents have been housed for five (5) or more years. There were one hundred forty (140) residents at the facility at the time of the review.

HYCF is staffed with one-hundred and sixty one (161) full-time and part-time employees. The staff consisted of: Superintendent; Treatment Services Manager; ten (10) Principal Exec/Manager A; two (2) Program Analyst 2, eight (8) Psychiatric Social Worker; one hundred & five (105) Group Life Coordinator 2 (Direct care staff); (9) Youth Corrections Unit Coordinator; and twenty-five (25) other staff (food service, maintenance, temporary assignment and administrative office). Additionally, four (4) psychologists and one (1) psychiatrist provide mental health services at the facility.

The medical and dental staff providing services at the facility consisted of: one (1) registered nurse supervisor, six (6) full-time and part-time licensed registered nurses, licensed practical nurses providing nursing services on-site twenty-four (24) hours a day, seven (7) days a week and an on-call physician. All residents are seen by a physician upon arrival to the facility. Additionally, all nurses are supervised by an on-site registered nurse supervisor who is responsible for coordination of the medical services. The medical staff provides medical care to include: completing the initial intake assessment, routine and additional lab work as ordered, STD testing and treatment as indicated, updating immunization records, seasonal flu vaccinations, routine eye exams (optical lab), dietary services and referrals, administration of medications/treatments as prescribed, assessments of resident injuries and treatment as required, medical assessments and monitoring with any restraint or seclusion, assessments of somatic health complaints with treatment as indicated, develop treatment plans and provide medical discharge plans. The dental staff consisted of a dentist and a dental assistant providing dental services Monday through Friday consisting of dental care, cleaning, education, and treatment fillings to extractions. All residents are seen by the dentist at least annually for a wellness check. Emergency services and forensic examinations are conducted at the Salem Hospital and Center for Hope & Safety, Salem, Oregon.

The Robert Farrell School is centrally located on the Hillcrest campus and was named after Robert S. Farrell, Jr. who was the Oregon Speaker of the House of Representatives in 1941 and Oregon Secretary of State from 1943 until his death in 1947. The building was constructed in 1950 and is representative of school building constructed during this era. The primary goal of the school is to work with residents who have not completed their high school graduation requirements. Residents need to earn 24 credits under the state's minimum graduation requirements and successfully meet the Essential Skills requirements in order to earn a diploma. Robert Farrell is a year round school and operates on a 220 day calendar. All instruction is provided by teachers licensed through the Oregon Teachers Standards and Practices Commission and who are properly endorsed in each content area. The school employs nine (9) Core Content Area teachers, (1.5) Special Education Teachers, (.4) School Psychologist, (.2) SLP, Autism Specialist as needed, one (1) Transition Specialist, two (2) Instructional Assistants, two (2) Registrars, one (1) Clerical Support Staff and an (.6) Administrator.

Achievements include:

1. A major hurdle for many residents has been to pass the Essential Skills requirments. PLC Team's focus has been to develop plans and implement strategies to help residents be successful with SBAC assessment and Essential Skills Work Samples.
2. Teachers from Robert Farrell and William Lord High School at MacLaren Youth Correctional Facility have been working on a curriculum project to develop instructional units specifically designed for all three (3) settings. Content areas include Math, Lanuage Arts, Science and Social Science.
3. As part of the School Improvement Plan, residents participated in a school wide writing program these past years. Once a month every resident completed a practice work sample using a nonfiction writing prompt. Teachers scored each student's work and provided individual feedback. The PLC Teams used the results to develop instructional strategies.
4. HYCF and school staff maintain a strong collaborative partnership. Since HYCF staff work in the school building, much of the communication is face-to-face. Email is extensively used to communicate with one another. Each classroom is equipped with a telephone where by teachers and unit staff exchange information.
5. The school calendar includes five (5) professional development days (full days) scattered through the calendar and one half-day each month. Durng 2014-2015 school year trainings included curriculum development and lesson planning, writing and reading

strategies, school safety and behavior management, and using techonoloy in the instructional process. HYCF provided one (1) full day of update trainings each year which focus on topics such as gang behaviors and interventions, sexual offender behaviors, safety and security protocols, PHD and other topics that are important to working in a correctional facility.

6. Starting in the 2015-2016 school year, Robert Farrell High School offered a Inside/Out SOC 206 class for residents who are close to graduating so they can become familiar with college courses.
7. For the past seven (7) years, the school has offered a Community 101 class via a grant and partnership with the Oregon Community Foundation. Residents learn leadership skills though their work with community nonprofit agencies by awarding small grants used to support special projects.
8. The Cascade Aids Project partnered with Robert Farrell during the 2014 – 2015 school year to offer classes on HIV Prevention. Residents attended classes and participated in activities designed to build content knowledge and gain an understanding of the social implications of this health issue.
9. During the 2012-2013 school year a Bicycle Repair program was also started; in this program, residents learn bicycle mechanic skills while repairing bicycles distributed by a community nonprofit agency.

DESCRIPTION OF FACILITY CHARACTERISTICS

Hillcrest Youth Correctional Facility (HYCF) became an all male residential facility in 2008 and is located in Salem, Marion County, Oregon. The facility is located approximately 6 miles from the Central Agency Offices in Willamette Valley. HYCF has seventeen (17) buildings, most of the buildings are within a fenced, secure area that composes the primary community for the residents and two (2) buildings outside of the fenced area that serve as maintenance and administration buildings. Additionally, there are two (2) homes located outside of the fenced area that currently serve as office buildings for the Central agency physical plant and other office functions. Administrative office, conference rooms and the maintenance shop are located outside of the fenced area. HYCF has two areas that serve as the visitation area: one in the intake building and one in the cafeteria of the long-term dorm. The fenced area has two main entrances: a double door walk-through door and a double door vehicle entrance controlled by security. The main courtyard is an outside front area with sidewalks and grass that is used as an additional recreational area. There are two sports field areas: a baseball field, soccer field and volley ball court. Residents utilize a specific area for multicultural events such as Native-American Sweat Lodge ceremonies. There are two (2) modular buildings on campus inside the fence: the Human Unity Building (HUB) and the recreation building. Both of these structures are used for treatment groups and cultural activities, recreation, programming, treatment groups, cultural activities and unit celebrations with families. Vocational programming is offered for training in grounds maintenance, electrical, plumbing, painting, janitorial, culinary arts, food preparation, barbering and bicycle repair.

The grounds inside of the fenced area have two (2) dormitory buildings consisting of: The Scott building houses newly-committed residents (2 units) and parole violators (one unit) for the purposes of intake, assessment and evaluation. The building has four (4) living units (with dorms) on the 2nd and 3rd floors. At this time, 3 of the 4 living units are occupied. HYCF transport staff/equipment are housed on the second floor of the building. The medical clinic, canteen and office space account for use of the bottom floor. The Scott building four (4) living unit/dormitories are identical in layout. Recently, two (2) living units were remodeled, reducing the maximum population from twenty-one (21) to fourteen (14) residents. The parole violator unit located on the 2nd floor of the building, houses twenty-one (21) residents. All four (4) units contain areas to conduct strip searches in private and have isolation cells with cameras for constant observation. A large conference room with video conference capability is located on the bottom floor and is used to facilitate meetings with outside parties such as special family visits, multidisciplinary team meetings and court appearances. The Norblad building houses long-term residents for the purposes of treatment. There are four (4) living units (with dorms) located on the 2nd and 3rd floors of the building. At this time, one (1) living unit is used for vocational programming and treatment groups. The bottom floor of the building consists of the kitchen/dining area providing three (3) meals a day and the supply warehouse. The Norblad building dormitories are identical in layout and consists of one (1) large room with twenty-five (25) beds, one (1) bathroom that contains toilets, sinks, and showers, one (1) individual room used as a “privilege area”, and a laundry room. The dormitories have video cameras.

Additionally, there is another housing unit called the Zeta building for special-needs residents, younger in age and presenting mental health or other developmental needs and the Iota (isolation unit) located against the south side of the Scott building. The building provides secure, single cell, short-term holding for residents deemed to be a danger to self, other residents, staff or safety-security of the facility.

The Robert Farrell High School building contains classrooms, activity rooms and a gymnasium for educational services. The Robert Farrell education staff provides education that allows residents to attain their state certified high school diploma. Once the graduation requirements are met, residents can then enter into college course via on-line programming, Inside/Out college courses that occur on the facility campus or through free course offered through the Education Portal that is accessible on each of the long term living units. The gymnasium is a large area with a full basketball court and includes a weight and equipment room with a camera to monitor both areas.

Robert Farrell High School is operated by the Willamette Education Service District and the day to day operations are reliant on a strong and collaborative partnership with the HYCF. The majority of residents come to school with credit deficient and compared to their typical peers they are significantly behind academically. The majority of residents report that they were not successful in community schools and many of them dropped out prior to being incarcerated. A large percentage of the residents have a history of drug use and many are gang involved. On average approximately fifty percent of the residents are eligible for special education services. At the time of enrollment, residents are assessed to identify their academic strengths and weaknesses. They receive individualized and small group instruction that enables them to earn the credits they need to graduate. Despite many academic challenges the majority of residents make excellent progress while enrolled at Robert Farrell. In addition, for many residents this is their first positive school experience and as a result they achieve greater success while enrolled. The school is staffed with caring and compassionate teachers, instructional assistants and clerical staff who have empathy for the residents. With such a large special needs population teachers meet bi-weekly with HYCF staff to address resident needs and ensure the appropriate differentiation/accommodations are in place. Residents on IEP’s receive services through push-in and pull-out services as well as having access to individualized support through the use of an Online Academic Program (Acellus). For residents on a Modified Diploma track the content and delivery methods are adjusted to meet their educational needs. For English Language Learners the sheltered instruction and pull out services are provided. Currently, three (3) teachers who have their ESOL endorsement work with residents and staff to ensure that the students are receiving the appropriate materials/instruction. In addition to sheltered Instruction, the pull out services are for those residents who need more individualized support. In the area of Mathematics residents are placed in the appropriately leveled Algebra class or math foundations class. The Algebra classes are designed to allow residents to move at their own pace and demonstrate proficiency through tests and quizzes. In addition, Geometry courses are offered that are designed to assist residents in a more intensive manner. These courses have a maximum of five (5) residents per class so residents can receive the individualized support they need.

In the area of English Language Arts the primary focus is to improve each residents writing skills through the use of Build Your Own curriculum lessons and Step Up to Writing lessons. Residents are taught the foundations of the writing process and are placed in Writing Composition courses according to their current skill level. ELA teachers use a scoring rubric that is aligned to the SBAC assessment so residents can accurately monitor their progress as it relates to the current state test. For reading, the primary focus is to teach residents how to identify and pull out the key concepts from a variety of different texts and then use this information to demonstrate mastery in each particular state standard strand. In order to support ELA across all content areas teacher's in Social Studies, Science, P.E. and Health, require residents to demonstrate understanding through use of formalized writing assessments using the same rubric that is used by the ELA teachers. Part of the School Improvement Plan is to offer students monthly opportunities to demonstrate progress through the use of a school wide writing prompt/essay. All students are expected to participate. Upon completion the school staff scores each paper using the same rubric and then the ELA teacher reviews the scores with each student.

The school's purpose is to welcome middle and high school residents who are highly at risk into a positive learning environment that includes targeted instruction for each individual with a common goal of a high school diploma. Robert Farrell High School Mission Statement - Provide opportunities for individual resident to improve academic and interpersonal skills enabling them to contribute to their communities. The mission of the school is supported by programs, activities, and the culture of the school. The Site Council at Robert Farrell High School has focused on school improvement efforts, staff development activities, and school climate. Membership includes residents, teachers, classified staff, HYCF staff, and a community member. Meetings are held monthly and meeting minutes are available on the server. After each quarter an Honor Roll party is held to recognize exceptional student performance. On average, over 115 certificates are handed out to residents to recognize their accomplishments successes during the previous quarter. Residents who make the Honor Roll receive a certificate in addition to being invited to the Honor Roll Pizza Party, which has been very popular for residents.

Graduation is another very important day on campus. Graduation is held one time each year and this ceremony is typical of graduation ceremonies held in public schools. A professional photographer using a mobile studio takes graduation photos which are available for families for free. Graduates wear a cap and gown and invite family members to come and participate. During the ceremony family members are invited to step up to a microphone and say a few words about their graduating son. Their comments are always from the heart and highly emotional with many tears of joy. The entire Long Term student body participates as well which emphasizes the significance and importance of education.

SUMMARY OF AUDIT FINDINGS

The notification of the on-site audit was posted by February 16, 2016, 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 received by March 1, 2016. The documents, which were uploaded to a UBS flash drive, were organized and easy to navigate. The initial review revealed the need for additional information in regard to the Pre-Audit Questionnaire and supporting documentation which did not sufficiently address some of the standards. After a discussion with the OYA PREA Coordinator and providing a list of noted concerns, the OYA PREA Coordinator sent the documentation prior to arrival to the facility. Also several documents were provided during the on-site visit. Specific corrective actions during the on-site visit taken to address some of the deficiencies are summarized in this report under the related standards.

The on-site audit was conducted on March 29-30, 2016. An entrance briefing was conducted with the OYA PREA Coordinator, OYA Rules/Policy Coordinator, OYA Chief Audit Executive, OYA Chief Investigator, Superintendent, and Treatment Services Manager/PREA Compliance Manager. 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, two (2) dormitory buildings, 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.

During the two (2) day on-site visit, there were a total of one hundred & forty (140) residents in the facility. There are seven (7) living unit/dorms and two (2) residents were randomly selected from each dorm for the interview process. Also this auditor spoke with three (3) residents asking various questions during the facility tour. A total of seventeen (17) residents were interviewed on both days 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 the Center for Hope & Safety to provide confidential emotional support to residents who are victims of sexual abuse and forensic exams.

Twenty-three (23) staff including those from all three (3) shifts, administrative and supervisory staff, medical and mental health/substance abuse staff, youth corrections unit coordinator, psychiatric social work staff, group life coordinators, contracted staff (teachers), the Superintendent and Treatment Services Manager/PREA Compliance 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 the on-site visit. 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 with the OYA Chief Audit Executive, OYA PREA Coordinator, Superintendent, and Treatment Services Manager/PREA Compliance Manager. At the exit debriefing, it was discussed additional documentation was required for five (5) standards and it was determined this information would be sent to this auditor within the next two (2) weeks to be in compliance with all the PREA standards. The requested information was sent to this auditor by the OYA PREA Coordinator. This auditor reviewed all requested information and this facility is in full compliance with the PREA Standards.

Number of standards exceeded: 1

Number of standards met: 39

Number of standards not met: 0

Number of standards not applicable: 1

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 Harrassment)] 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 excutive 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 nine (9) residential facilities. The Treatment Services Manager is designated as their 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. During the initial documentation review, the facility staff to resident ratios varied due to the fluxuation of the resident population. During the two (2) day site-visit, the staff to resident ratios were varied during the awake hours in the dorm areas (1:4, 1:6, 1:8 & 1:12) and varied during the sleeping hours (1:19, 1:21 & 1:25). The OYA executive administration will be revisiting the staffing of this facility to ensure compliance with this standard by October 1, 2017. 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. However, all staff were able to describe what an exigent circumstance would be but in most instances were not knowledgeable of the procedures for securing authorization to conduct such a search as well as the requirements for justifying and documenting those searches. After the on-site visit, all staff were trained on 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. The OYA PREA Coordinator sent the documentation to this auditor. The information was reviewed by this auditor and the facility is in full compliance with this standard.

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 Harrassment)] and 1-D-2.1 (Use of Language Servies; 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. Robert Farell High School staff will provide residents with disabilities and residents who are limited English proficient with various interpreter services on an as needed basis. 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 assistants and there were no instances of resident interpreters or readers being used in the past 12 months. Since the initial review and on-site visit, the documentation was received prior to the submission of this report.

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 Harrassment)] 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.

HYCF has not been newly designed or had a substantial expansion or modification since August 20, 2012. The initial documentation review did not contain any information, however prior to the on-site visit a list of installation dates for all residential facilities was provided. The facility upgraded their cameras and video surveillance system in 2015 to address any blind spots in the facility. This will enhance their capabilities to assist in monitoring blind spots and the review of incidents. Additionally, this enables the staff to monitor residents more efficiently throughout the physical plant of the facility.

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 HYCF 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 Center for Hope & Safety to provide confidential emotional support to residents who are victims of sexual abuse. Documentation was provided that the medical examiners at Salem 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 fifteen (15) allegations of sexual abuse and sexual harassment resulting in administrative investigations and eight (8) referred for criminal investigations. 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 notified 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)

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 Harrassment)] 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 an "Facilities Access Level 2" form 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 Harrassment)] 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. Interviews with two (2) contracted teachers 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)

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 Harrassment)] 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)

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 Harrassment)] 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 four (4) investigators statewide who conduct investigations for OYA and all four (4) 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)

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 Harrassment)] 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 two (2) 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 Harrassment)] 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 practioner 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 reassed at a minimum of every thirty (30) days 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 Harrassment)], 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 seven (7) 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 Harrassment)], 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 HYCF 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, coorespondence 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 (dining area, living areas) 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 Harrassment)], 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 the Center for Hope & Safety 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 two 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 Harrassment)], 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 Harrassment)] 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 Harrassment)] 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 received two (2) 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 Harrassment)] 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. There has been nine (9) allegations of sexual abuse during the past 12 months. Three (3) of which first security staff responded to the report separating the alleged victim and abuser. The other six (6) allegations had non-security staff identified as the first responders. 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, without hesitation, 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.

HYCF Local Operating Protocal 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 Salem Hospital and Center for Hope and Safety . Interviews with the Superintendent and other staff validated their technical 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 Harrassment)] 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 Services 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. 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 Harrassment)] 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. There has been eight (8) reported investigations of alleged staff's or residents inappropriate sexual behavior that occurred in this facility in the past 12 months. It was evident the staff reported 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 Harrassment)] 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. There has been eight (8) reported investigations of alleged staff or resident's inappropriate sexual behavior that occurred in this facility in the past 12 months. Two (2) of which were investigated and completed by an outside agency. 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 Harrassment)] 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 Harrassment)] 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 Harrassment)], 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. HYCF 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. There were three (3) administrative findings of guilt for resident-on-resident sexual abuse that have occurred at the facility in the past 12 months. 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 Harrassment)] 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 Harrassment)], 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. Salem Hospital provides the emergency services and Center for Hope & Safety 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 Harrassment)], 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 to the Center for Hope & Safety 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 Harrassment)] 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 within seven (7) days. HYCF Sexual Abuse Incident Review Team consists of the Superintendent, Treatment Services Manager/PREA Compliance Manager, Medical, Mental Health, and Education staff. There has been three (3) investigations of alleged staff or resident's inappropriate sexual behavior that occurred in this facility in the past 12 months. Two (2) of which were unfounded incidents. 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 Harrassment)] 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 Harrassment)] 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 2013 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 2013 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 Harrassment)] 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.

Dorothy Xanos _____ April 30, 2016

Auditor Signature Date