

PREA AUDIT REPORT INTERIM FINAL

JUVENILE FACILITIES

Date of report: September 2, 2015

Auditor Information			
Auditor name: Shirley L. Turner			
Address: 3199 Kings Bay Circle			
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Telephone number: 678-895-2829			
Date of facility visit: August 4-5, 2015			
Facility Information			
Facility name: Cuyahoga Hills Juvenile Correctional Facility			
Facility physical address: 4321 Green Road, Highland Hills, OH 44646			
Facility mailing address: <i>(if different from above)</i> Click here to enter text.			
Facility telephone number: (216) 464-8200			
The facility is:	<input type="checkbox"/> Federal	<input checked="" type="checkbox"/> State	<input type="checkbox"/> County
	<input type="checkbox"/> Military	<input type="checkbox"/> Municipal	<input type="checkbox"/> Private for profit
	<input type="checkbox"/> Private not for profit		
Facility type:	<input checked="" type="checkbox"/> Correctional	<input type="checkbox"/> Detention	<input type="checkbox"/> Other
Name of facility's Chief Executive Officer: Chris Freeman			
Number of staff assigned to the facility in the last 12 months: 270			
Designed facility capacity: 256			
Current population of facility: 128			
Facility security levels/inmate custody levels: Minimum, Medium			
Age range of the population: 12-21			
Name of PREA Compliance Manager: Annette Freeney		Title: Program Administrator 2	
Email address: annette.freeney@dys.ohio.gov		Telephone number: (216) 464-8200	
Agency Information			
Name of agency: Ohio Department of Youth Services			
Governing authority or parent agency: <i>(if applicable)</i>			
Physical address: 30 West Spring Street, Columbus, OH 43215			
Mailing address: <i>(if different from above)</i> Click here to enter text.			
Telephone number: (614) 466-4314			
Agency Chief Executive Officer			
Name: Harvey J. Reed		Title: Director	
Email address: harvey.reed@dys.ohio.gov		Telephone number: (614) 466-4314	
Agency-Wide PREA Coordinator			
Name: Marlean Ames		Title: PREA Coordinator	
Email address: marlean.ames@dys.ohio.gov		Telephone number: (614) 644-6179	

AUDIT FINDINGS

NARRATIVE

The Cuyahoga Hills Juvenile Correctional Facility is a minimum to medium security level facility located in Highland Hills, Ohio and is a part of the Ohio Department of Youth Services (ODYS). The design capacity of the facility is 256 and it houses male juvenile offenders. The average length of stay for residents is nine months. Program and services available to the residents are education; vocational; medical; dental; recreation; behavioral health services; religious services; and re-entry services. Residents are provided off-grounds experience through community service and work opportunities. Volunteer services are provided within the facility by members of the community.

The medical unit consists of the Health Services Administrator, seven Registered Nurses and two contract Registered Nurses. The contract physician visits the facility twice a week. The mental health unit includes three Psychologists, two Psychologist Assistants and Licensed Social Workers. The contract psychiatrist visits the facility two days per week. Education services are provided on-site under the management of the Principal, providing high school and middle school classes. The school includes a horticulture program and other vocational classes. Eligible residents have access to on-line college courses through Ashland College. A large library is located within the school building and residents are allowed to check out books. The library is stocked with a large amount of books and also contains various type references and other resources. Youth Specialists provide direct supervision to the residents on the living units and throughout the facility's programs and services. There have been 270 staff members employed at the facility during the past year who may have contact with residents.

Treatment services include substance abuse programming; victim awareness; sex offender programming; and gang interventions. Residents are regularly involved in therapy sessions, individual and group counseling and they participate in treatment team meetings. Some of the issues targeted by treatment services are: conduct disorders; anger; aggression; violence; depression; anxiety; self-injury; and others. There are also supportive programs that aid in the overall development of the residents and consist of a fatherhood training program called Baby Elmo; career speakers; adopt a highway community service; graduate book club; graduate garden club; youth choir; grief recovery; and additional programming services and activities. The facility encourages visitation and approved visitors are allowed to visit the facility seven days per week.

Cuyahoga Juvenile Correctional Facility is accredited by the American Correctional Association (ACA) and is preparing for an upcoming re-accreditation audit. It also participates in the Performance-based Standards (PbS) project, a data-driven improvement model. The facility was awarded the PbS Barbara Allen-Hagen Award for the category of correction facilities for 2015, making this the second time the Award has been earned by the facility. The Award is presented to the facility/program that best exemplifies PbS' commitment to developing and implementing strategic plans that result in positive outcomes for youth, staff and families.

DESCRIPTION OF FACILITY CHARACTERISTICS

The Cuyahoga Hills Juvenile Correctional Facility was built in 1968. It is located on 38 acres of land in a Cleveland, Ohio suburb. The facility is one primary building that was built in 1968 and has been expanded over the years. The main entrance consists of the reception area where visitors sign-in and personal items are checked, main control room, and the lobby. Beyond the main entrance is the administrative area; the business office is adjacent to administration. Additional offices and a conference room are also located in this area. The building also contains; 24 classrooms; school library; staff training room; kitchen with an office; dining room; centralized laundry room; medical unit; large gymnasium; smaller recreation area; storage rooms and additional offices. The facility contains eight living units and each unit contains a dayroom and bathroom. The living units have the PREA reporting information posted and the ODYS Youth Safety Guide is posted which also contains reporting information and guidelines for residents to follow that will help keep them safe. The offices of Unit Managers, Social Workers and mental health staff are located in the living units. Appropriate space exists in the facility for counseling sessions and visitation.

Signs are posted throughout the facility indicating areas where residents are not allowed or areas where residents may enter only when accompanied by staff. A fence surrounds the facility and cameras are strategically placed inside and on the outside of the building. The outside grounds contain an attractive gazebo and a very spacious recreation area that can accommodate various sports and other recreation activities. The green house for the horticulture program is located on a hill and within walking distance from the horticulture classroom. Vegetable gardens are located on the grounds and planted and maintained by the residents, under the guidance of the horticulture instructor.

During the past year additional cameras have been added within the facility and there is a plan to increase the current number of cameras. Information regarding reporting sexual assault and sexual harassment, including third-party reporting is posted in the lobby and throughout the facility. The third-party reporting information is available and accessible to visitors, residents and employees. Administrative investigations that facility staff consider to be PREA related are referred to the ODYS Office of the Chief Inspector. When it is determined that the allegation is of a criminal nature, the case is referred to the Ohio State Highway Patrol and the child welfare agency. The facility provides an office in the facility that is utilized by a State Trooper from the Ohio State Highway Patrol.

SUMMARY OF AUDIT FINDINGS

The notifications of the on-site audit were posted in various parts of the facility prior to the site visit. Photographs were taken of the the posted notices and forwarded to this Auditor; the Pre-Audit Questionnaire and the supporting documentation were uploaded to a flash drive and mailed. After a review of the information, notes were sent to the ODYS statewide PREA Coordinator and a conference call was scheduled and later held with the facility Superintendent, Program Administrator 2 who also serves as the PREA Compliance Manager, and the ODYS statewide PREA Coordinator to discuss the audit process, clarify information, and to discuss additional information needed.

The on-site audit was conducted August 4-5, 2015 and Flora Boyd, Certified PREA Auditor, assisted during this audit. An entrance meeting was held in the afternoon of the first day with the facility's management staff, statewide PREA Coordinator and other ODYS staff. The meeting included a helpful program overview by the Superintendent with the aid of a powerpoint presentation. After the entrance meeting a comprehensive tour of the facility was conducted by the Superintendent and the PREA Compliance Manager accompanied by members of the facility's management team and other ODYS staff. The tour included primary and secondary areas of the facility including living units; classrooms; medical clinic; gym; small recreation area; outside grounds; offices; storage areas; library; control room; kitchen; dining room; intake area; and loading dock. During the tour, staff members were observed supervising residents and monitoring residents while they were in school and on the living units. The facility utilizes a camera system to enhance and support the direct supervision provided by Youth Specialists and other staff.

Ten residents and 21 staff members were interviewed. The staff consisted of a sample of specialized and random staff that were randomly selected. Additional interviews included one contractor; a volunteer and two staff members from the ODYS central office. Staff and residents revealed through their interviews that they received initial PREA training and refresher training. Staff members were knowledgeable of their duties and responsibilities as they relate to PREA. Direct care staff members were interviewed from all three shifts. The residents interviewed spoke easily and willingly about the PREA education sessions that they had been involved in and indicated familiarity with the meaning and purpose of PREA. Refresher training has been conducted with the residents so that they are clear on how to contact victim advocacy services and that they are more aware of the services that may be provided by the agency, if they ever need them.

The supporting documentation for each standard was provided in organized folders during the on-site audit and additional documentation was provided as requested. A close-out meeting was held at the conclusion of the second day of the on-site audit with the facility Superintendent; PREA Compliance Manager; key facility staff; ODYS PREA Coordinator; and other ODYS staff. Additional ODYS central office staff participated in the close-out meeting by telephone. A summary of the audit findings was provided during the close-out meeting.

Number of standards exceeded: 0

Number of standards met: 40

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.

Agency Policy 304.04, Sexual Abuse, Sexual Assault and Sexual Harassment, outlines the strategies for a zero-tolerance approach to sexual assault and sexual harassment, including how to prevent, detect and respond to sexual assault and sexual harassment. Additional policies and standard operating procedures provide additional details and support for Policy 304.04. Prohibited behaviors, sanctions for those who participate in such behaviors and related definitions are included in the Policies. The Program Administrator 2 serves in the role of PREA Compliance Manager as verified by staff interviews and the documented facility organization chart. The Policy provides that the designated PREA Compliance Manager would have sufficient time and authority to coordinate the facility’s efforts to comply with the PREA standards; the interview with the PREA Compliance Manager was aligned with Policy 304.04.

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)

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The agency, Ohio Department of Youth Services (ODYS), has entered into or renewed five contracts for the confinement of residents since August 20, 2012. The contracts for the confinement of residents are with private and other government agencies and contain language that requires the contractors to comply with all PREA standards. However, the agency reports that two of the five contractors are not required to comply with the PREA standards because the population in each of the two facilities is not comprised of 51% of ODYS youth. Interviews with ODYS central office staff, facility staff and a review of PREA audit reports confirmed that three of the five contractors are monitored for PREA compliance.

The agency’s interpretation of this standard is that a contractor has to comply with the PREA standards if the facility houses 51% of ODYS residents within their total population. Based on that premise, the agency has lifted the requirement of PREA compliance for two of the five contractors. The three facilities that have been identified by the agency as requiring PREA audits have received those audits and are monitored by the ODYS PREA Coordinator. Written communication from the ODYS central office documents that the current standard language in all contracts requiring PREA audits will be modified to specify whether or not each contractor providing residential treatment will need to comply with the PREA standards. Because PREA auditing is still in the three-year cycle, the final determination should be made by August 2016.

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.

Policy 103.02 requires a facility staffing plan and compliance with it; the staffing requirements are addressed in the Policy and other supporting documents. Staff interviews addressed mandated overtime and how it is used to maintain the required staffing ratios. The facility is obligated through a federal lawsuit to maintain a staffing ratio of 1:5 on all three shifts. The annual review of the facility’s staffing plan is documented in the ODYS Annual Workforce Plan and through the facility document, Staffing Analysis Project. The facility reports that there have not been any deviations from the staffing plan during the past year. Policy 304.04 provides that a Vulnerability Assessment is conducted annually by a team assembled by the PREA Coordinator. A review of the completed form documents the practice of completing Vulnerability Assessments.

Unannounced rounds are conducted by intermediate or higher level staff on all shifts and are documented on the Vulnerable Area Assessment form. The facility prohibits staff from alerting other staff when the unannounced rounds are occurring. Staff interviews and a review of documentation verified that the unannounced rounds are being conducted.

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.

Standard Operating Procedure 301.08.03 and Policy 304.04 address this standard, including how searches are to be conducted, documentation of searches, and staff training. The facility reports that during the past year there have been no cross-gender visual body cavity searches or cross-gender pat-down searches of residents and this was confirmed through staff and resident interviews. Corrective actions were implemented that document practices and enhance policies to ensure reasonable privacy and limited viewing especially during use of the bathroom and searches after visitation. The facility has made upgrades to one bathroom in a unit that will be used as a model to upgrade the others. Until the additional upgrades occur, mobile curtain screens are being used to add privacy for residents when they use the toilet. The related Post Orders have been updated to include the shower procedures and use and storage of the mobile screens.

Staff members of the opposite gender are directed by Policy 304.04 to announce their presence when entering the housing units and areas where residents may be showering, changing clothes or performing bodily functions. A key is used to activate a buzzer that lets the residents know that a female has entered the living unit. Resident and staff interviews revealed that the buzzer is activated each time a female staff member enters the living unit. Staff members are prohibited by Policy from searching transgender or intersex residents to determine the resident’s genital status. The Policy also states, and was supported by interviews and training documentation, that staffs are trained regarding cross-gender pat-down searches and the searching of transgender and intersex residents.

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

- Exceeds Standard (substantially exceeds requirement of standard)

- Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- Does Not Meet Standard (requires corrective action)

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

Policy 404.06 requires support services for residents with disabilities and who are limited English proficient and provides that the services will be provided as needed. The Operating Standards for Ohio Educational Agencies Serving Children with Disabilities ensure access to support services. Qualified facility staff may also provide identified support services to residents. Interpreter and translation services will be provided so that each resident has an equal opportunity to participate in or benefit from all aspects of the facility’s efforts to prevent, detect and respond to sexual abuse and sexual harassment. The facility does not rely on resident interpreters or resident readers, which was confirmed by interviews with staff. The facility has PREA information posted in a dominant language other than English and the Youth Orientation Handbook informs the resident that support services will be provided..

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.

Standard Operating Procedures 103.03.02, 103.03.03, 103.03.04 provide guidance and details regarding the hiring process and the grounds for termination, in accordance with the standard. Background checks are conducted on new employees and at least every 5 years on current employees and contractors who may have contact with residents. Interviews and a review of personnel documents confirmed that the practices meet the requirements of the standard.

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.

Direct staff supervision is supplemented with electronic monitoring and the facility’s camera system has been updated since August 20, 2012. Another server was added which gives access to additional high definition cameras. The facility has continued to assess the electronic monitoring system in order to continually increase and enhance visibility and has made a formal request for additional cameras.

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.

Policies 304.04, 101.5 and Ohio State Highway Patrol Policy address this standard. The facility staff make referrals to the Office of the Chief Inspector regarding allegations of sexual assault and sexual harassment and an investigator is assigned to conduct an administrative investigation. The Ohio State Highway Patrol is responsible for conducting investigations of allegations that may be criminal in nature and the children’s welfare agency is also contacted. Investigators receive training to conduct the appropriate investigation.

The Letter of Agreement with the Cleveland Clinic Health System/South Pointe Hospital document that forensic examinations will be conducted by Sexual Assault Forensic Examiners (SAFE) or Sexual Assault Nurse Examiners (SANE). If a SAFE or SANE practitioner is not available at South Pointe, the Letter of Agreement states that the youth will be transferred to another Cleveland Clinic facility that can provide a SANE or SAFE practitioner. The Letter of Agreement also ensures that forensic exams will be provided at no cost to the victim. No forensic exams have been conducted during this audit period.

Victim advocacy services have been arranged and are documented in a Memorandum of Understanding with the Cleveland Rape Crisis Center. The services that will be provided to residents, as verified by the Vice President of Programs, include accompaniment to the hospital for the forensic examination; accompaniment during the interviews with law enforcement or child welfare agency; written information to help the resident cope; referral for counseling services while the resident is in the facility or when he returns home; and agency staff will talk with the resident about his rights, including legal actions he can take. Information regarding advocacy services is provided to the residents during the intake process. A refresher session was recently conducted with the residents to ensure their knowledge of the services that will be provided by the Cleveland Rape Crisis Center, if they are needed.

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.

Policies 101.5, 304.04; ODYS Standard Operating Procedure 101.14.01; Ohio State Highway Patrol Policy; and ODYS staff interviews provide that allegations of sexual assault and sexual harassment will be referred for administrative or criminal investigations. The facility reports that during the past 12 months, seven allegations were received; four resulted in administrative investigations and none were referred for a criminal investigation. The facility provides an office for the Ohio State Highway Patrol.

A review of documentation, including completed investigations, demonstrate that allegations are documented as required and that administrative investigations are completed by the Office of the Chief Inspector. Agency policy and other information regarding reporting allegations of sexual assault and sexual harassment are available on the ODYS website and within the facility, accessible to the public.

Standard 115.331 Employee training

- Exceeds Standard (substantially exceeds requirement of standard)
- Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- Does Not Meet Standard (requires corrective action)

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Policy 304.04 provides that staff receive PREA training and details what is required. The training officer ensures that staff training occurs and that records are maintained. A review of documentation such as the PREA training curriculum; Training Session Report/Sign-In Sheet records; and PREA training post-tests, PREA Written Assessment; as well as staff interviews confirmed the required training. Staff also receive refresher training to remain knowledgeable and aware of current issues. Refresher training may occur through roll call or town hall meetings; formal training must be completed annually.

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.

Policy 304.04 requires that volunteers and contractors who have contact with residents be trained on PREA and their responsibilities regarding sexual assault prevention, detection, and response to any allegations. Sample documentation revealed that volunteers sign the form, Declaration of Understanding, acknowledging their receipt of information that includes definitions of sexual assault and sexual harassment and reporting responsibilities. The training was evidenced through an interview with a contractor and volunteer who were present during the site visit.

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.

Policy 304.04 provides that all residents receive information about the facility’s zero-tolerance policy, including how to report allegations of sexual assault or sexual harassment and the right to be free from retaliation. Residents receive PREA education verbally and in writing; a review of sample documents, Youth Orientation Notice of Understanding, supported the practice. PREA information, including the ODYS Youth Safety Guide, is posted in each living unit and additional information is posted in various areas of the facility. The agency provides for interpreters, assistance from qualified staff, and other support services. Staff interviews support that residents are not used as interpreters or readers for other residents.

Standard 115.334 Specialized training: Investigations

- Exceeds Standard (substantially exceeds requirement of standard)
- Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- Does Not Meet Standard (requires corrective action)

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Policy 101.15 addresses the required training of investigators in the Office of the Chief Inspector who are responsible for conducting administrative investigations. The agency maintains documentation of training and an interview with the Chief Inspector confirmed the training of agency investigators. Additional training by the State Trooper/investigator assigned to the facility from the Ohio State Highway Patrol includes completion of the online training course, PREA: Investigating Sexual Abuse in a Confinement Setting, through the National Institute of Corrections.

Standard 115.335 Specialized training: Medical and mental health care

- Exceeds Standard (substantially exceeds requirement of standard)
- Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- Does Not Meet Standard (requires corrective action)

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Standard Operating Procedure 304.04.01 addresses this standard. Documentation indicates that the medical and mental health staff members have received specialized training. Healthcare staff received initial and refresher training and receive updates as needed along with other staff. The specialized training includes completion of online modules through the National Institute of Corrections.

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)

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Policy 304.04 address this standard and requires that the screening for risk of sexual abuse victimization or sexual abusiveness toward other residents be conducted at the reception facility. When the resident arrives at Cuyahoga Hills Juvenile Correctional Facility, the screening instrument is reviewed by staff. The screening instrument, Sexual Abuse and Sexual Assault Victim/Aggressor Profile Checklist, may be administered at the receiving facility if a need is identified by mental health staff. Staff and resident interviews and a review of documentation confirmed that the risk screenings are being conducted.

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.

Policy 304.04 provides information on how the information obtained from the screening instrument is used. Information gleaned from the screening instrument assists in determining housing and designated risk related to PREA. Interviews with staff and residents and a review of documentation confirmed that risk screening does occur. Interviews with staff confirmed that the information is used as intended by the standard with the goal of keeping all residents safe and free from sexual abuse and sexual assault. The facility practice is that isolation is very rarely used and if used, it is for a short duration as a cooling-off period. Less restrictive measures will be used in keeping residents safe rather than isolation. However, Standard Operating Procedure 304.02.01 which also addresses this standard, provides that when isolation is used, residents shall be provided large muscle exercise; legally required and other programming and services; daily visits from mental health and medical staffs; and access to work opportunities to the extent possible. During this audit period, it was reported that no residents were placed in isolation because they were at risk of sexual victimization.

Standard Operating Procedure 304.02.01 prohibits placing gay, bisexual, transgender, or intersex residents in separate housing based solely on such identification or status. Additionally, the Policy prohibits considering gay, bisexual, transgender or intersex identification or status as an indicator of likelihood of being sexually abusive. If a resident is held in isolation for his protection, the Standard Operating Procedure provides for a review to be conducted every 30 days to determine whether there is a continuing need for separation from the general population. Staff interviews and a review of training documentation demonstrated staffs' familiarity with the Policy and Standard Operating Procedures and the required visits if residents are held in isolation.

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)

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Policy 304.04 provides for multiple internal ways for a resident to report allegations of sexual abuse; sexual harassment; retaliation for reporting; and staff neglect or other violation that may lead to abuse. Residents may talk to any staff member; complete a Request for Conference form to speak with a specific staff member; and use the designated phone, located on each unit to call the ODYS Tip Line and/or the Public Defender’s Office. A written request to speak to an attorney from the Public Defender’s Office may be placed in the grievance box where it will be forwarded to the Office by the grievance officer. Residents have access to writing utensils, paper, and the forms for written requests on a daily basis. Staff members are required to document verbal reports received from residents prior to the end of their shift. The Policy states that staff will also accept reports from third-parties, which was confirmed through staff and resident interviews.

Information regarding resident reporting is posted in each living unit and in other locations. Resident interviews revealed that they are aware of the different ways they can report and are aware of third-party reporting of sexual abuse and sexual harassment. Staff interviews revealed that they are aware of the resident reporting methods and how staff can anonymously report allegations of sexual abuse and sexual harassment. Staff members are informed of resident reporting methods through Policy, training and posted information.

A corrective action was implemented that provides residents with direct accessibility through the telephone on each living unit to the Cleveland Rape Crisis Center. Refresher training was conducted on each unit to ensure that residents understood how to use the modified phone service to contact the Center to report allegations and/or request supportive services. The documented training with residents also ensured the residents’ awareness and understanding of the services provided by the Rape Crisis Center if they should ever need them.

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.

Policy 304.03 addresses the grievance process and provides that an administrative process is used in dealing with grievances, facilitated by the Grievance Coordinator. There is no time limit for filing a grievance; residents have access to grievance forms, writing materials and the locked grievance box. Grievances completed after regular business hours, weekends and holidays are placed in a Health Call box which is checked by medical staff. Information is provided to the resident in the Youth Orientation Handbook . Residents are not required to use an informal grievance process or otherwise attempt to resolve a PREA related issue with staff. The facility reports that residents are not disciplined for filing a grievance. No grievances have been completed during this audit period alleging substantial risk of imminent sexual abuse.

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.

The facility provides residents 24-hour access to outside victim advocacy services through the Cleveland Rape Crisis Center for emotional support services related to sexual abuse. The identified agency and telephone number is provided in the pamphlet, ODYS Safety Guide, which is posted in each living unit along with other agencies that provide supportive services. Residents are also provided written and verbal information indicating that the victim services can be obtained, if needed. A designated phone is provided in each living unit to report allegations of sexual assault and/or to request advocacy services from the Cleveland Rape Crisis Center.

During the on-site audit and a test of the telephone, there was some difficulty in contacting the Rape Crisis Center. The agency implemented a corrective action through the telephone service and now the residents are able to have direct access to the Cleveland Rape Crisis Center through the telephone located in each living unit. The facility provides the written address to the advocacy agency in each living area. Residents are also provided the contact information for the State of Ohio Public Defender’s Office which is another outside agency where they can report allegations. Residents may also complete a form, requesting to talk to the Public Defender’s Office and place it in the grievance box. The Grievance Coordinator will ensure that the request is forwarded to the Public Defender’s Office. Policies 304.04 and 304.02 and resident and staff interviews document that residents are provided confidential access to their attorney or other legal representative and reasonable access to their parents or legal guardian.

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.

Policy 304.04 provides for third-party reporting of sexual assault and sexual harassment. Third-party reporting information is posted on the ODYS website. Information on how to report allegations of sexual assault and sexual harassment is posted throughout the facility, including the lobby. Staff and resident interviews confirmed their knowledge of the meaning of third-party reporting and how it may occur. Third-party reporting forms are maintained in the lobby available to employees, contractors, volunteers, and the public.

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.

Policies 304.04 and 304.05 require all staff members to report any allegation of sexual misconduct. The facility staff members are also required by Policy to immediately report information to the Superintendent or his designee and to document reported allegations prior to the end of their current shift. Written policy provide direction to staff regarding reporting duties and prohibits staff from revealing any information related to a sexual abuse report to anyone, other than those persons required to make treatment, investigation, security or administrative decisions.

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.

The facility practice is that a Safety Plan is developed to provide additional protection of residents when staff learn that the resident is at risk of imminent sexual abuse. The Safety Plan ensures that the resident will always remain in close proximity to the identified staff throughout the facility programs and service. The Plan details the protective actions that are to be taken by staff and the resident. Interviews with staff revealed when a Safety Plan could be developed and how it could be implemented. During the past 12 months, no residents were identified as subject to 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.

According to Policy 304.04, upon receiving an allegation that a resident was sexually abused while confined in another facility, the Superintendent or designee will notify the appointing authority or designee of the facility where the alleged abuse occurred. Policy provides that the notification is made as soon as possible but no later than 72 hours of receipt of the allegation. The Policy states that contact will also be made to the Ohio State Highway Patrol.

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)

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.

Policy 304.04 contains the first responder duties and outlines the requirements; reference is also made to the ODYS form, Institutional Plan for Coordinated Response to Sexual Abuse and Sexual Assault. Staff interviews with staff members who would serve as first responders and non-security staff revealed that they are aware of their duties. During this audit period there has not been an incident where a first responder had to separate an alleged victim and abuser.

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.

The facility has a written institutional plan that coordinates action that is to be taken in response to an incident of sexual abuse. Policy 304.04 and the Institutional Plan for Coordinated Response to Sexual Abuse or Assault provide guidance and also identify the staff positions required for an effective facility response. Staff interviews revealed that they are aware of their duties in response to an incident of 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.

This standard is Not Applicable. As of the writing of this report, no new agreements have been entered into or renewed since August 20, 2012.

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.

Policy 304.04 provides direction regarding protection against retaliation for residents and staff who report sexual abuse or sexual harassment or cooperate with investigations. The Policy also includes areas to monitor and the actions to take if retaliation is identified. The Policy designates the PREA Compliance Manager as the staff to monitor for retaliation against residents and staff. The PREA Compliance Manager will monitor for at least 90 days following a report of sexual abuse or sexual assault; the monitoring will be conducted for at least 90 days and beyond if necessary as provided by Policy and as stated in the staff interview. The facility reports that there have been no incidents of retaliation during this audit period.

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 facility practice is that a resident who alleges to have suffered sexual abuse will not be placed in isolation. A review of documentation and staff interviews revealed that other safety measures will be implemented, as needed. These measures include re-assignment of a bed to place resident closer to the staff station in the living unit, re-assign living unit, and/or develop a Safety Plan for the resident. The facility reports that during this audit period, there have been no residents placed in isolation as a result of allegations of sexual abuse or who were placed in isolation to protect them from sexual victimization. Isolation is used infrequently and only for a short duration for a cooling-off period if necessary; however, there is awareness by clinical staff for the required visits as needed which have been conducted in the past but were not related to PREA.

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.

Policies 304.04 and 101.15 provide guidance to staff regarding this standard. Administrative investigations are conducted by the Office of the Chief Inspector and the Ohio State Highway Patrol conducts the investigations for reports that indicate they are criminal in nature. The Policies and interviews with facility and other ODYS staff provide information for administrative and criminal investigations in accordance with the standard. A review of investigation packets demonstrate that allegations are thoroughly investigated.

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.

According to Policy 101.15, the investigations are conducted using the standard of a preponderance of the evidence in determining whether allegations of sexual abuse or sexual harassment are substantiated. Staff interviews and a review of the completed investigations support the Investigations Policy.

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.

Policy 101.15 provides for the alleged victim to be informed that the investigation has been concluded and the outcome. Following the completion of an investigation, the resident is notified of the findings in writing through the Youth Notification Letter. The Letter shows that residents are notified and the notification is acknowledged by the resident’s and the Labor Relations Officer’s signatures. In a situation where an investigation is conducted by the Ohio State Highway Patrol Office, the Superintendent remains abreast of the investigation through contact with the investigator who utilizes an office within the facility. The facility reports no allegations of sexual abuse. The facility uses the ODYS Alleged Sexual Abuse and Assault Response Checklist which assists in ensuring that the required steps are implemented beginning with the reported allegation until the conclusion of the case. The Checklist provides a synopsis of the steps that may be taken by staff regarding allegations of sexual abuse, sexual assault, sexual harassment, and a subsequent investigation.

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.

According to Policy 103.17, staff members are subject to disciplinary sanctions up to and including termination for policy violations. The Policy provides that all terminations for violations of sexual abuse or sexual harassment policies or resignations by staff who would have been terminated if not for their resignation, are reported as required. During this audit period, no staff member has been terminated or disciplined due to substantiated findings of an investigation regarding allegations of sexual assault or sexual harassment.

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.

Policy 304.04 addresses this standard regarding PREA policy violations by contractors and volunteers. The Policy requires that contact with residents would be prohibited when there are violations. Notifications will be made to the Ohio State Highway Patrol, unless the actions were clearly not criminal, and to relevant licensing bodies. During the past 12 months, there have been no contractors or volunteers who have been reported for a violation of PREA policies. The interviews with the Superintendent supported the requirements of Policy 304.04 and the standard.

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.

Policy 303.01 and Standard Operating Procedure 303.01.03 address this standard. Residents found in violation of facility rules are subject to sanctions pursuant to a formal administrative process. When there are violations of PREA policies, residents may be subject to disciplinary sanctions. During this audit period, there have been no administrative or criminal findings for resident-on-resident sexual abuse. According to staff interviews, following administrative or criminal findings of resident-on-resident sexual abuse, a resident may receive extra time or be referred to another facility. It is a practice that when isolation is used, it is of short duration and serves as a cooling-off period.

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.

Policy 304.04 and Standard Operating Procedure 304.04.01 address this standard. All residents are screened utilizing the screening instrument, Sexual Abuse and Sexual Assault Victim/Aggressor Profile Checklist within 24 hours of arrival at the reception facility and it is reviewed and administered again, if indicated, when the resident arrives at the receiving facility. Interviews with mental health staff revealed that residents who disclose prior victimization or previously perpetrating sexual abuse are seen during the intake process by medical and mental health staffs. Clinical records are maintained by mental health and medical staffs that document the services provided. The informed consent form may be utilized at the reception and receiving facilities.

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.

Policy 304.04.01 provides that treatment services regarding sexual assault will be provided at no cost to the victim. The Policy, interviews with clinical staff and the Letter of Agreement with the hospital support that victims of sexual assault will receive timely, unimpeded access to emergency medical treatment and crisis intervention services and that these services will be based on the professional judgment of medical and mental health staffs. Interviews with medical and mental health staffs and a review of documentation also indicate that the related services are consistent with the community level of care.

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.

Standard Operating Procedure 304.04.01 ensures ongoing medical and mental health care for sexual abuse victims and abusers. Interviews with clinical staff support the Policy and stated that follow-up treatment and care would be provided and they verbalized what ongoing care would entail. Policy and staff interviews revealed that resident victims of sexual abuse will be offered tests for sexually transmitted infections that are medically appropriate. Known resident-on-resident abusers, as well as the other residents receive mental health evaluations within the first 10 days of admission to the facility.

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.

According to Policy 304.04, the incident review team has been established and the Policy provides details regarding the role of the team and identifies the team members. The incident reviews occur within 30 days of the conclusion of the investigation. Staff interviews and a review of the investigation packets and the Sexual Abuse and Sexual Assault Incident Review Checklists demonstrate that incident reviews were conducted after the investigations were completed alleging sexual harassment. Interviews with staff revealed that they understand the role of the incident review team.

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.

Policy 101.14 and Standard Operating Procedure 101.14.01 address this standard and provide direction to staff regarding incident reports and the Policy contains the related definitions. The agency collects data for allegations of sexual assault, sexual harassment and sexual misconduct through the Activity Management System (AMS). The agency aggregates incident-based data at least annually as evident by ODYS staff interviews and a review of the 2014 Annual Report on Sexual Abuse, Sexual Assault and Sexual Harassment Data report. The AMS includes the data necessary to answer all questions from the Survey of Sexual Violence conducted by the Department of Justice.

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.

Policy 101.07 provides for internal monitoring, including data review, mock audits, and the application of corrective measures to improve the effectiveness of the implementation of the PREA standards. An annual report is documented and the Policy provides that the Office of Quality Assurance and Improvement is responsible for all policies, reports and data being available to the public as required. ODYS staff interviews and a review of documentation support the Policy and confirms the practices.

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.

The incident-based and aggregate data and other related documents are securely stored. Policy 101.07 addresses data storage, publication and destruction and provides for the required data to be maintained for 10 years unless a state, federal or local law requires otherwise. A review of the 2014 Annual Report on Sexual Abuse, Sexual Assault and Sexual Harassment Data shows that 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.

Shirley L. Turner

September 2, 2015

Auditor Signature

Date