

PREA AUDIT REPORT INTERIM FINAL
JUVENILE FACILITIES

Date of report: September 14, 2016

Auditor Information			
Auditor name: Shirley L. Turner			
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Telephone number: 678-895-2829			
Date of facility visit: August 16-17, 2016			
Facility Information			
Facility name: Circleville Juvenile Correctional Facility			
Facility physical address: 640 Island Road, Circleville, OH 43113			
Facility mailing address: <i>(if different from above)</i> Click here to enter text.			
Facility telephone number: 740-477-2500			
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: Phillip Elms			
Number of staff assigned to the facility in the last 12 months: 262			
Designed facility capacity: 144			
Current population of facility: 133			
Facility security levels/inmate custody levels: Minimum, Medium, Close			
Age range of the population: 12-21			
Name of PREA Compliance Manager: Denise Conrad		Title: Client Advocate Administrator/PREA Compliance Manager	
Email address: Denise.Conrad@dys.ohio.gov		Telephone number: 740-751-2500	
Agency Information			
Name of agency: Ohio Department of Youth Services (ODYS)			
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: ODYS PREA Administrator	
Email address: Marlean.Ames@dys.ohio.gov		Telephone number: 614-644-6179	

AUDIT FINDINGS

NARRATIVE

The Circleville Juvenile Correctional Facility (CJCF) is located in Circleville, Ohio and serves males who have been adjudicated by the courts. The residents of CJCF range from 12 to 21 years of age and the average length of stay is 18 months. The design capacity of the facility is 144 and the population during the time of the audit was 133. The facility is accredited by the American Correctional Association (ACA). The programs and services provided include education and vocational services; behavioral health services; unit management; medical services; dental care; recreation; religious services; community service opportunities; and re-entry services. Additional opportunities for residents include but are not limited to: substance abuse programming; victim awareness services; sex offender programming; and gang interventions. Treatment services targets a variety of issues such as conduct disorders; anger; aggression; violence; depression; anxiety; self-injury; and more. There are also a variety of distinct programs offered at the facility that include but are not limited to: basketball fellowship with Circleville Christian University; Celebrate Recovery; job readiness services; Horticulture and Urban Agriculture Program; musical opportunities; and the Woodwork Construction Program.

Medical services are provided by onsite medical staff that consist of the Health Services Administrator, 10 Registered Nurses, and two Psychiatric Nurses. The contract physician visits the facility twice a week; contract dentist visits the facility twice a week, and the dental hygienist is onsite once per week. The facility has medical staff on all three shifts. Forensic medical examinations are not conducted at the facility and will be conducted at the Berger Hospital, located in Circleville. Mental health services are provided by the Psychology Supervisor, two Social Worker Supervisors, nine Social Workers and two Psychology Assistants. The contract psychiatrist provides services onsite four days a week and the contract psychologist position is currently vacant. Education staff includes the Principal, Assistant Principal, 19 teachers and two Guidance Counselors. A contract speech/hearing specialist provides services onsite. Youth Specialists, Operations Managers and Unit Managers ensure the proper management and supervision of the residents during the programming activities and provision of services. During the comprehensive tour of the facility, positive staff and resident interactions were observed while staff provided direct supervision to the residents on the living units, in the school and throughout the facility's program operations. Additional contract staff positions that provide services to the facility include a dental technician; barber; and Occupational Therapist.

There is an array of specialized programs at CJCF that enhance the services provided in preparation of the resident's return to the community such as the apprenticeship program; Toastmasters; Youth Work Program; Roots of Success; Baby Elmo; O.N.E.-Stop; and others. The facility is an approved apprenticeship site through the Ohio Apprenticeship Council. The apprentice opportunities for residents are for the positions of culinary/cook; landscape management; maintenance repairs; recovery operator; and janitor. The Toastmasters is a national program available to residents aimed at coaching them in public speaking and leadership development. The Youth Work Program is available to residents who have graduated from high school. These graduates have the opportunity to work and save funds for their future. Roots of Success provides residents the opportunity to be trained in environmental literacy and green job skills. Baby Elmo teaches and coaches young fathers at the facility in developing healthy and meaningful relationships with their children. The O.N.E.-Stop program, in partnership with the Ohio Department of Job and Family Services, provides high school graduates with access to focused employment, training, and support services.

The Ohio Department of Youth Services provides transportation for families through the C.L.O.S.E. Program (Connecting Loved Ones Sooner than Expected) by providing transportation assistance. This program encourages and support parental and family involvement with the resident and in his treatment services. Parents or legal guardians are also afforded a Parent Handbook which provides, as well as seeks, specific information related to the resident's stay in the facility. The Parent Handbook includes the following:

- Informative letters from the Superintendent and Health Services Administrator;
- Summary of services offered;
- Medical History Request;
- Permission slip allowing residents to participate in religious programs;
- Directions to the facility;
- Visitation times;
- Resident grievance process;
- Contact information at the facility;
- Billing plan for collect calls; and,
- Example of the resident's daily schedule.

In August the facility held its 2nd Annual Youth Summit which is a conference style day for the residents. It is a day of inspiration and education consisting of workshops, displays by local businesses and agencies, and other activities. There were 12 businesses and agencies that had displays at the Youth Summit this year and included the Ohio Public Defender's Office; Greater Miami Jacobs Career College; Bureau of Motor Vehicles; Lithko Contracting; Columbus Zoo; Ohio Attorney General's Office; and Urban Minority Alcoholism and Drug Abuse Outreach Program. The residents are provided with a list of the workshops that will be presented and they are able to choose and rank the ones they would like to attend. All the workshops provide life skills and supportive information. A sample listing of the workshops available during the Youth Summit activities appears below:

Real Talk 2 – Open and honest youth conversation regarding challenges and successes with young adult panel members who have been released from ODYS.

Lessons in Fatherhood – Discussion about fatherhood and how to become better parents as well as the importance of building and maintaining healthy relationships.

Stepping Up: The College Life – Young college students discuss the benefits and challenges of attending college and share information about the life of a college student.

Giant Eagle – Business professionals help residents become better prepared for job interviews. Residents learn and practice interviewing skills and techniques that can help them obtain employment in the future.

The Annual Youth Summit is a campus-wide activity and is coordinated by the Deputy Superintendent-Programs. This activity is a popular event at the facility with both staff and residents anticipating the event. The theme or slogan is "Believe the HYPE." The acronym, HYPE, stands for Helping Youth Pursue Excellence. The conference type environment is also supported by the provision of T-Shirts displaying the acronym/slogan; colorful wrist bands that display the slogan and other positive messages; and flyers that advertise and support the event.

DESCRIPTION OF FACILITY CHARACTERISTICS

The CJCF was opened on October 18, 1993 and is located on 42 acres, 18 of those acres are within the fenced area of the facility structures. The fenced area includes a total of seven buildings: three housing units; education building; food service/kitchen and dining hall; gymnasium; storehouse/maintenance building. The housing units maintain six dormitories with four pods each. There are six rooms, a dayroom and two bathrooms in each pod. Each dormitory contains an area used as the library, providing reading materials for residents. There are areas of the housing buildings between each dorm where group activities can be conducted and where offices are located. Each of the housing buildings contain a single cell near the front entrance that may be used for special housing as determined by the management staff. The housing buildings also contain staff offices and a laundry room.

The administration building is located in the front, just outside of the fenced area and contains offices, medical clinic and a room for visitation. The entrance to the administration building contains a lobby and a station where visitors, as well as staff, are checked in and out of the facility. Each visitor is required to submit their identification and obtain a visitor's badge and sign-in upon entrance and sign-out upon leaving the facility. All persons entering the building walk through a metal detector and a wand is used for searches where indicated. All belongings that a visitor may enter the building with are searched by staff. The spacious campus was observed to be clean and maintained. Additionally, a greenhouse is located within the fenced area just outside of the school. With the assistance of a dedicated staff member, the residents grow and maintain various vegetables and fruit. They also maintain a fish tank stocked with fish in the greenhouse.

The number of staff currently employed at the facility who may have contact with residents is 262 and the facility identifies 80 volunteers and contractors who are currently authorized to enter the facility and who may have contact with residents. Mirrors and 24-hour burning lights have been placed in identified areas to increase visibility and keep residents and staff safe. Signs are posted in various areas of the facility indicating where residents are not allowed or areas where residents may enter only when accompanied by staff. The facility has continually installed additional mirrors and signs that limit the entrance of the areas by residents. Recommendations were made by the Auditor for additional signs which were mounted during the onsite audit and pictures have been submitted showing the installation of additional mirrors and signs. The housing units, lobby and the visitation room in the administration building contain PREA reporting information. There are also third-party reporting forms in the front entrance lobby and in the visitation room. Cameras are strategically placed outside as well as inside of the facility and may be monitored from main control located in the administration building. There are no cameras located in the administration building where the administrative offices are located. A sign that restrict residents' entry without staff supervision has been posted and the policies and procedures provide guidelines for staff to follow while residents are in the offices.

Through a virtual tour online provided by ODYS, a resident may see a glimpse of different areas of the facility prior to arrival. Parents and legal guardians and the general public with computer access may also view the glimpse of the areas such as the outside of a resident's room; visitation room; dining hall; outside grounds; community service opportunities; front lobby, greenhouse; classroom; and more. The programs and services provided at the facility are aligned with the agency's mission which is, "improve Ohio's future by rehabilitating youth and empowering families and communities." The vision statement of the agency reads as follows: A safer Ohio: one youth, one family, and one community at a time. The facility provides residents with opportunities to participate in community service projects. The community service projects include: Pickaway County Dog Shelter; Friends of the Homeless; Adopt-A-Highway; Urban Gardening; Vineyard Nursing Home; Mid-Ohio Foodbank; and South Side Roots Café & Market.

SUMMARY OF AUDIT FINDINGS

Posted notifications of the site visit were observed to be posted in various parts of the facility and pictures of the postings were sent to this Auditor prior to the site visit. The Pre-Audit Questionnaire and the supporting documentation were uploaded to a flash drive and it was mailed to the Auditor. After a review of the information, notes were sent to the ODYS statewide PREA Coordinator requesting additional information and clarification on some of the information provided. The PREA Administrator and the facility's PREA Compliance Manager responded to the requests. The Client Advocate Program Administrator serves as the PREA Compliance Manager and the ODYS statewide PREA Administrator provides guidance regarding the PREA audit process.

The site visit was conducted August 16-17, 2016 and Flora Boyd, Certified PREA Auditor, assisted during the visit. The Client Advocate Program Administrator, Superintendent and both Deputy Superintendents met the auditors and the ODYS PREA Administrator upon arrival to the facility. An entrance meeting with the aforementioned staff and other key staff was conducted by this Auditor and introductions and a review of the audit process and itinerary were completed. After the entrance meeting, a comprehensive tour of the facility was conducted by the management team and other key staff. The tour covered all areas of the facility including all housing units; education building; medical clinic; gymnasium; offices; storage areas; visitation room; and intake area. During the tour, staff members were observed directly supervising and interacting with residents while they were in school and on the housing units. The facility utilizes a camera system; mounted mirrors; and 24-hour burning lights in certain areas to enhance and support the direct supervision provided by staff.

A total of 133 residents were in the facility on the day of the site visit; 10 were interviewed that covered all housing units. Ten direct care staff members were interviewed that covered all three shifts. There were 13 specialized staff interviews conducted and included a contractor and a volunteer. The interviews with staff members and residents revealed that they are aware of the zero-tolerance concept and understand how to report allegations of sexual abuse and sexual harassment. Staff members were knowledgeable of their duties and responsibilities as they relate to PREA.

The supporting documentation for each standard was provided in organized and neat folders during the site visit and additional documentation was provided as requested. An exit meeting was held at the conclusion of the the site visit and a summary of the audit findings was provided. The facility staff included in the exit meeting were the Superintendent; Client Advocate Program Administrator/PREA Compliance Manager; Deputy Superintendent-Direct; Deputy Superintendent-Programs; Unit Management Administrator; Security Threat Group Coordinator; Re-entry Coordinator; a Unit Manager; and other key facility staff. There were also ODYS central office staff members that attended the exit. The four central office staff members in attendance were the Deputy Director; PREA Administrator; Bureau Chief of Quality Assurance & Improvement; and Bureau Chief of Unit Management.

Number of standards exceeded: 0

Number of standards met: 40

Number of standards not met:

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.

Policy 304.04 provides the Ohio Department of Youth Services (ODYS) and the facility's overview of zero-tolerance for all forms of sexual abuse and sexual harassment and outlines the approach to preventing, detecting, and responding to such allegations. There are other agency policies that support the primary PREA policy and the zero-tolerance approach to sexual assault and sexual harassment. The primary and supportive policies outline the strategies for addressing the components of the PREA standards: prevention and responsive planning; training and education; risk screening; reporting; official response following a resident report; investigations; discipline; medical and mental care; and data collection and review. Prohibited behaviors, sanctions for those who participate in such behaviors and related definitions are included in the policies.

The Client Advocate Program Administrator serves as the PREA Compliance Manager and reports to the Superintendent, as verified by the interviews with the Superintendent and the Client Advocate Administrator and the documented facility's administration organization chart. The PREA Compliance Manager expressed in her interview that she has sufficient time and authority to manage and coordinate the facility's efforts in complying with the PREA standards. She discussed her processes in coordinating and implementing the facility's efforts in complying with the PREA standards.

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.

The agency has five contracts for the confinement of residents with private agencies. The contracts contain language that requires the contractors to comply with the PREA standards. The agency reports that two of the five contractors are not subject to a PREA audit, which through discussions, is supported by the PREA Resource Center. The documentation provided indicate that the two identified facilities do not maintain the population requirements that would mandate a PREA audit. Interviews with ODYS central office staff and a review of the PREA audit reports conducted during this audit cycle confirm that the three contractors that require audits are evaluated for PREA compliance.

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 provides for the development of a staffing plan and for compliance with the staffing plan. The staffing requirements are outlined in the Policy. During the tour the staffing ratio was observed to be aligned with the standard. The Policy also requires that if a deviation from the staffing ratios occurs, the deviation must be documented. The facility has been able to maintain the required staffing levels through methods that include the implementation of a hold-over system. During the interview, the Superintendent explained how he and other management and supervisory staffs ensure adequate coverage at all times and that the schedule is reviewed on a regular basis to maintain the appropriate staff coverage. The interviews with the Superintendent and the PREA Compliance Manager and a review of the staffing plan and the ODYS Annual Workforce Plan support that the staffing plan is reviewed and assessed annually. Staffing levels are based on factors such as the number and make-up of the population; any licensing requirements; general practices for juvenile correctional facilities; number of supervisory staff; and program activities. The facility reports that during the last 12 months, there have been no deviations from the staffing plan. The average daily number of residents since August 20, 2012 is 130 and the average daily number of residents on which the staffing plan was predicated since August 20, 2012 is 130.

Policy 301.13 provides for unannounced rounds to be conducted. The Policy requires that intermediate or higher level supervisors who serve as Administrative Duty Officers conduct unannounced rounds in order to identify and deter sexual abuse and sexual harassment. A review of documentation and an interview with a Unit Manager who conducts unannounced rounds confirmed that they occur. The practice is that staff does not alert other staff when the rounds occur, in accordance with the Policy, unless the need for others to know is legitimate to the facility operations. The Unit Manager described an unpredictable pattern in conducting unannounced rounds. There is a detailed form used for documenting unannounced rounds and it identifies the numerous areas and activities within the facility. The form and Policy 301.13 requires that staff document observations and communication of issues or concerns; results of conversations with residents and staff; and observations of conditions and activities.

A Vulnerability Assessment is conducted annually by the ODYS PREA Administrator which reviews the physical plant regarding practices and physical barriers that may impact the protection of residents from sexual abuse and sexual harassment. A written report is provided to the facility by the PREA Administrator after the completion of each assessment. The report provides supportive information regarding observations and opportunities for improvement. The facility has used recommendations in the report to enhance the monitoring of residents.

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.

Policies 304.04 and Standard Operating Procedures 301.08.03 and 304.02.01 address this standard and provide guidance and definitions regarding all types of searches. The facility does not conduct cross-gender strip searches; cross-gender visual body cavity searches; or cross-gender pat down searches, which was verified by staff and resident interviews. The facility reports that none of the aforementioned type searches have been conducted during the past 12 months. A review of completed searches on the Search Form revealed that searches are conducted and are documented. It was determined through staff interviews, a review of the powerpoint training, and a review of the training

roster that staff receive training in conducting cross-gender pat-down searches and pat-down searches of transgender and intersex residents. 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 any resident. The policies and procedures ensure that residents are able to shower, change clothes and perform bodily functions without being viewed by the opposite gender. The staff and resident interviews, a review of the policies and procedures, and the information provided during the tour regarding staff duties and practices for using the bathroom and shower procedures confirmed the practices. The procedures and practices and configuration of the bathrooms provide residents with the reasonable expectation of privacy for each resident.

Staff members of the opposite gender are directed by policy to announce their presence when entering the housing units where residents may be showering, changing clothes or performing bodily functions. The female staff verbally announce their presence and use a key that activates a bell. The practice was observed and verified through interviews with staff and residents. Staff members are prohibited by policy from searching transgender or intersex residents to determine the resident's genital status. The staff interviews confirmed their knowledge regarding the policy of not searching residents solely for the purpose of determining the genital status of a resident. Where the genital status of a resident is unknown, learning this information would be part of a broader medical examination conducted by the medical staff in private.

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.

Policies 304.02, 304.04 and 404.06 require support services for residents with disabilities and who are limited English proficient and provides that the services will be provided as needed. The Ohio Department of Administrative Services has a contract with Vocalink, Incorporated for the provision of the required translation and interpretation services to the facility as requested. Qualified facility and contract staff may also provide identified support services to residents. The Operating Standards for Ohio Educational Agencies Serving Children with Disabilities ensure the facility's access to support services. The policies and the education guide and a review of the documentation confirm that 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 resident handbook contains information regarding reporting allegations of sexual abuse and sexual harassment. The facility has the PREA information posted in Spanish and English. The facility reports and the interviews of direct care staff support that residents have not been used as interpreters, readers or in any way to provide interpretive services during this audit period.

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.

Policy 103.03 and Standard Operating Procedures 103.03.02; 103.03.03 and 103.04 provide the details regarding the hiring process, completion of background checks, and the grounds for termination, in accordance with each section of the standard. State and federal criminal background checks are conducted on all employees and contractors. A check is also conducted through the Abuser Registry. Background checks were conducted on long-term employees a few years ago in preparation for the background checks that will be conducted every five years. During the interview, the Human Capital Management Senior Analyst explained the hiring process and the procedures for securing background checks.

The interview process for new hires includes the inquiry about whether the potential hire may have engaged in sexual abuse in a prison, jail, lockup, community confinement facility, institution or juvenile facility; convictions of engaging in or attempting to engage in sexual assault; civilly or administratively adjudications regarding the aforementioned. A review of a sample of personnel records, review of the policy and procedures, and the interview with the Human Capital Management Senior Analyst confirmed that the facility considers any incidents of sexual abuse or sexual harassment in determining whether to hire an employee or contractor or to promote an employee. In the past 12 months, there have been 78 new hires who may have contact with residents that had criminal background checks conducted. Policy provides that staff has a continuing duty to report related misconduct and that omissions of such conduct or providing false information will be grounds for termination, which was also supported by the interview with the Human Capital Management Senior Analyst.

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)

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Direct staff supervision is provided to residents and is supplemented by the facility's camera system. There have been no expansions made to the facility; however, the camera system has been improved. The enhancements include, recently in July 2016, old cameras being removed from the education building and replaced with new ones. Additional areas of the facility have been identified where new cameras will be installed. The facility is currently involved in a project to continually add mirrors in identified areas to increase the supervision and monitoring of residents.

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)

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Policy 101.15 and Standard Operating Procedures 101.14.01 and 304.04.01 and Ohio State Highway Patrol Policy address this standard. The ODYS Office of the Chief Inspector investigates administrative investigations and criminal investigations are conducted by the Ohio State

Highway Patrol. A review of documentation shows that the investigators from the Office of the Chief Inspector has received training on conducting PREA related investigations and the child welfare agency is also contacted. The Standard Operating Procedure provide the guidelines for the protocols of PREA related investigations and the required contacts to be made. The Ohio State Highway Patrol Policy indicates that the Highway Patrol will provide response services regarding allegations that are criminal in nature. A review of correspondence and other documentation reveals that the Highway Patrol is notified of all allegations and they respond as to whether an investigation will be conducted by their office.

A letter exists that has been sent to Hospital Administrators by the ODYS Medical Director. The letter details the requirement of the PREA standards, including the forensic examination of victims of allegations of sexual assault. The letter informs that the examination be conducted by a Sexual Assault Nurse Examiner (SANE) or a Sexual Assault Forensic Examiner (SAFE) and by other qualified medical practitioner when a SANE or SAFE is not available. The facility policy states that forensic examinations and related treatment will be conducted at no cost to the victim. The Ohio State Highway Patrol and the agency have policy and practices that maximizes the potential for obtaining usable physical evidence for administrative proceedings and criminal prosecutions. Medical forensic examinations will be conducted at Berger Hospital as detailed in a Letter of Agreement for hospital services between ODYS and the Berger Health System. The hospital has agreed that alleged victims from the facility will be medically examined by a SANE or SAFE practitioner and when one is not available, the resident will be transferred to another hospital such as Children's Hospital which can provide a SANE or SAFE practitioner for the examination, data and evidence collection; and treatment. There have been no forensic examinations conducted during this audit period.

A letter from the Executive Director of Haven House of Pickaway County Incorporated states that the agency will provide telephone victim advocacy services which include reporting allegations of sexual abuse received by residents from the facility and that the agency will provide emotional support to a resident. Haven House is committed to providing 24-hour telephone services seven days a week for any resident to contact an advocate. The letter states that advocates will not advise residents on what they should do; they will only provide emotional support for any past or current sexual abuse reports and provide notification of any allegations of sexual abuse occurring in the facility. Victim advocacy training is provided for identified ODYS staff so that they may serve as victim advocates for residents as requested. The trained ODYS advocates will accompany and support the resident during the forensic investigations and the investigative process; provide options for resources; and coordinate follow-up services, as needed. Information regarding advocacy services is posted in each housing unit by the telephone used by residents to report allegations of sexual abuse or sexual harassment.

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.

Policy 101.5; Standard Operating Procedure 101.14.01; Ohio State Highway Patrol Policy; and interviews that have been conducted with ODYS staff provide that allegations of sexual abuse and sexual harassment will be referred for administrative or criminal investigations. During the past 12 months the facility reports there were 31 allegations of sexual abuse and sexual harassment received, resulting in six administrative investigations conducted. There have been no criminal investigations conducted at the facility. The Policy directs staff to report verbal or written allegations immediately to their supervisor and to document the receipt of verbal allegations by the end of their shift. An incident report form exists to document significant incidents and completed incident reports and related documentation were reviewed. The staff interviews confirmed the requirement of documentation of verbal allegations of sexual abuse or sexual harassment. Additional internal forms including the PREA Criminal Investigation Checklist have been created to track the reporting process, referrals for investigations to be conducted, and notifications and contacts. Agency policy and other information regarding reporting allegations of sexual abuse and sexual harassment are available on the facility's website and within the facility, accessible to the public.

One portion of an incident was determined by the facility to meet the criteria for being a PREA related incident and internally substantiated the incident at the facility level regarding the actions of the residents involved. Only a portion of the incident regarding staff supervision of

residents was referred for an investigation to be conducted by the Office of the Chief Inspector. The Auditor informed facility management staff that per the standard and the agency policy, all allegations or incidents must be referred for an investigation and that facility staff must not determine its own findings regarding PREA allegations or related incidents. A corrective action was implemented which involved formally referring the entire incident for a complete investigation and not just a portion of it. The initial administrative investigation was re-opened by the Office of the Chief Inspector for all portions of the incident to be investigated. The investigation has been completed and a review of the updated report revealed that the formal findings by the investigator were that there were substantiated findings for a PREA incident. Documentation was also reviewed indicating that the victim was notified regarding the outcome of the investigation and an incident review was conducted.

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.

Policy 304.04 provides that all employees receive PREA related training and provides information on the type of training required. The training is tailored for the population served. A review of the training materials, including training rosters and powerpoint presentation, and staff interviews confirmed that the required training occurs. Refresher training is also provided for staff as needed and formal training is conducted annually. PREA post-tests are completed by each participant after completion of the presentation. Each test is scored by the Instructor and indicates whether the participant passed or failed the test. The Training Session Report/Sign-In Sheet includes a description of the training session, signature of the participants and the signature of the training instructor. All random staff interviewed reported receiving the required PREA training.

Interviews with staff and a review of training documentation verify that the PREA training includes the following:

The facility/afency zero-tolerance policies;

Staff responsibilities regarding allegations or incidents of sexual abuse or sexual harassment;

Resident's right to be free from sexual abuse and sexual harassment;

The right for staff and residents to be free from retaliation for reporting allegations or cooperating in an investigation;

The dynamics of sexual abuse and sexual harassment in juvenile facilities;

Residents and employees rights to be free from retaliation for reporting sexual abuse and sexual harassment;

How to avoid inappropriate relationships with residents;

The common reactions of sexual abuse and sexual harassment juvenile victims;

How to communicate effectively and professionally with residents, including gay, bisexual, transgender, intersex, or gender non-conforming residents;

Mandatory reporting; and

Relevant laws regarding the applicable age of consent.

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 107.03 addresses the training for volunteers and contractors and require that volunteers and contractors who have contact with residents receive PREA training. The training includes the responsibilities of volunteers and contractors regarding sexual assault prevention, detection, and response to a PREA allegation. A review of training rosters; training curriculum; training logs, and signed acknowledgement statements revealed that volunteers and contractors receive the required training. The number of volunteers and contractors who have contact with residents and who have received the PREA training is 80.

A Declaration of Understanding is signed, acknowledging the receipt and understanding of the PREA information and it informs the volunteer or contractor of consequences when the policies are not adhered to. The form contains definitions of sexual assault and sexual harassment and describes reporting responsibilities. The training for volunteers and contractors was validated through interviews with a contractor and a volunteer and a review of the training documentation. The interviews revealed that the volunteer and contract staffs understand the zero-tolerance policy regarding sexual abuse and sexual harassment and how to report such allegations or incidents.

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 admitted to the facility receive information about the facility's zero-tolerance policies, including how to report allegations of sexual assault or sexual harassment and the right to be free from retaliation for reporting. Residents receive PREA education verbally and in writing upon admission to the facility and are provided with related materials, including a Youth Safety Guide. The residents also view a video that provides additional PREA education. All of the information provided is age appropriate. The Youth Safety Guide contains information on how to report allegations and how to obtain a victim advocate. The PREA related information is also contained in the Youth Orientation Handbook. Residents sign a form, Youth Orientation Notice of Understanding Education Acknowledgement, indicating receipt of PREA information. A review of the education materials, training rosters, staff interview, and the resident interviews indicate that the PREA education sessions had occurred. The facility reports that the number of residents admitted in the past 12 months who received age-appropriate PREA education is 204.

While the residents were aware of how they could report allegations through the hotline services of Haven House Incorporated, they were not familiar with the specific advocacy services that would be available to them by Haven House and the ODYS staff who have been trained as victim advocates. A corrective action has been implemented and the Client Advocate Program Administrator coordinated the PREA refresher education sessions that were conducted in each housing unit by the Unit Manager. The training specifically covered and emphasized the services that would be available to a victim of sexual abuse that would be provided by the Haven House and the ODYS staff who serve as victim advocates. The training also covered the importance of the hotline services and consequences that may be imposed when there are prank calls or allegations not made in good faith by residents. Haven House staff has reported and it has been determined that the agency has received numerous prank calls from residents at the facility. A training packet was received and reviewed by this Auditor that contained training rosters with the date and signed name of each resident; training agenda; and meeting notes regarding the refresher education sessions for each housing unit. The packet and communication with the Client Advocate Program Administrator/PREA Compliance Manager document that the corrective action of the refresher training had been completed.

The facility has the capability of providing the PREA education in formats accessible to all residents, including those who may be limited English proficient; deaf; visually impaired, or otherwise disabled, and to residents who have limited reading skills. The facility has the PREA information posted in all housing units in English and Spanish. Through a State contract, the facility has access to translation and interpretation services and interviews confirmed that residents are not used as translators or readers for other residents. Facility education and other qualified staff and facility contractors also provide support services to residents as needed and to ensure access to services that will provide disabled residents the opportunity to participate in PREA education sessions. PREA information is posted in various areas of the facility. The facility reports that 204 residents, admitted in the last 12 months, received comprehensive age-appropriate education on their rights to be free from sexual abuse and sexual harassment; from retaliation for reporting such incidents; and on agency policies and procedures for responding to such incidents within 10 days of arrival to the facility.

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.

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 a previous interview with the Chief Inspector confirmed the training of agency investigators. Documentation for investigators include training certificates for "Investigating Sexual Abuse in Confinement Settings: Training for Correctional Investigators" presented by the Moss Group through the PREA Resource Center, and "PREA: Investigating Incidents of Sexual Abuse and Sexual Harassment," presented by the Ohio Department of Rehabilitation and Correction." The ODYS Administrative Investigations Training Manual is also used as a resource for investigators. Investigations that are criminal in nature are investigated by the Ohio State Highway Patrol.

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.

Standard Operating Procedure 304.04.01 require medical and mental health staff members to receive the initial PREA training and the specialized training. The specialized training is obtained through completion of online training through the National Institute of Corrections, ODYS training, and refresher training to receive updates as needed along with other staff. Training certificates and a training roster were reviewed for the specialized training for medical and mental health staffs. The training certificates are for completion of the modules in "PREA: Medical Health Care for Sexual Assault Victims in a Confinement Setting" and "Behavior Healthcare for Sexual Assault Victims in

a Confinement Setting.” A signed ODYS roster documents training for medical and mental health staff members in “Medical Policies-PREA-Sexual Abuse/Assault/Harassment.” Interviews with the Registered Nurse and the Social Worker Supervisor supported that they had received the required PREA training. One hundred percent of the medical and mental health practitioners who work regularly in the facility have received the specialized PREA training. Forensic medical examinations are not conducted at the facility; they will be conducted at the Berger Hospital or Children’s Hospital.

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.

Standard Operating Procedure 304.04.01 requires that the screening for risk of sexual abuse victimization or sexual abusiveness toward other residents be conducted on each resident admitted to the facility within 24 hours of their arrival and that an objective screening instrument be used. The screening instrument, Sexual Abuse and Sexual Assault Victim/Aggressor Profile Checklist, is used by the Psychologist Assistant II who was interviewed and confirmed that the instrument is used to assess and obtain information that will assist staff in reducing the risk of sexual abuse by or upon a resident. The instrument also provides for the reassessment of a resident’s risk level due to an incident of sexual abuse; a referral or request that is made; or when there is new information that bears on the resident’s risk of sexual victimization or abusiveness. Completed risk screening instruments were reviewed that also included completion of updates or reassessments.

The risk screening instrument obtains personal information that includes but is not limited to:
Prior sexual victimization or abusiveness;
Resident’s identification as gay, straight, bisexual, transgender, or intersex;
Intellectual or developmental disabilities;
Physical disability or disfigurement;
History of sexual activity in a correctional facility;
Resident’s concern for his own safety;
Age; and,
Gender non-confirming appearance or manner.

The Psychologist Assistant II obtains the required information to complete the risk screening instrument through a review of the related court paperwork packet and parent interviews. The Psychologist Assistant II revealed that her method in completing the instrument with the resident is to ask direct questions and probe when it is needed. The interviews with the staff member and the residents and a review of documentation verified that initial risk screenings and reassessments are being conducted as required and the initial assessment is conducted within 24 hours of the resident’s arrival to the facility. The number of residents admitted to the facility within the past 12 months who were screened for risk of sexual victimization or risk of sexually abusing other residents within 72 hours of admission is 204.

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.

Policies 304.04, 502.01 and Standard Operating Procedures 304.04.01 and 304.02.01 provide guidance to staff on how the information obtained from the risk screening instrument is used. Information gleaned from the screening instrument is intended to assist staff in determining housing and program assignments with the goal of keeping all residents safe and free from sexual abuse and sexual harassment. During the interview, the Psychologist Assistant II shared how the information is used in determining housing and program activities. The facility reports that isolation is not used as a practice in this facility. During the tour it was observed that some of the rooms that were used for isolation have been converted into rooms to be used to house residents on an as needed basis such as medical and other conditions. It was observed during the tour that at least two of the rooms housed residents with medical concerns and that the cameras had been removed from the rooms. During this audit period, there were no residents placed in isolation because they had been determined to be 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; housing assignments will be made on a case-by-case basis. Additionally, the Standard Operating Procedure prohibits considering gay, bisexual, transgender or intersex identification or status as an indicator of likelihood of being sexually abusive. The Standard Operating Procedure and the risk screening instrument provide for consideration of all resident's concern for their own safety while in the facility. The staff is familiar with the requirements of the standard and that a transgender or intersex resident must be reassessed at least twice a year and must be given the opportunity to shower separately.

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.

Policies 304.02 and 304.04 provide 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 or submit a grievance form with their name and date on it. The facility provides a designated resident telephone in each housing unit for access to residents for directly reporting, through the Haven House hotline, allegations of sexual abuse or sexual harassment. There is also posted information to call the ODYS Tip Line and/or the Public Defender's Office. The ODYS Tip Line was established with the intent to make facilities as safe as possible for residents and staff and may be used to report any safety issues, including those related to sexual misconduct.

Residents have access to writing utensils, paper, and the grievance forms for completing written requests and submitting allegations of sexual abuse and sexual harassment. The grievance forms are posted in each housing unit, accessible to residents. Staff members are required to document verbal reports received from residents prior to end of their shift. The Policy states that staff will accept reports from third-parties, which was confirmed through staff and resident interviews. Third-party reporting forms are located in the front lobby and the visitation room, accessible to staff and visitors.

Information regarding residents reporting allegations of sexual abuse and sexual harassment is posted in each housing unit and in other locations of the facility. Resident interviews revealed that they are aware of the different ways they can report and are aware that reports will be received by staff from anonymous or 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 and privately report allegations of sexual abuse and sexual harassment. Staff members are informed of resident reporting methods through policy, training and posted information. The ODYS does not detain youth for civil immigration purposes.

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 and provides details regarding any third-party assistance to the resident and how to appeal the initial decision in response to the grievance. The Policy provides that there is no time limit for filing a grievance related to an allegation of sexual abuse and residents are not required to use an informal process or give the grievance to any staff member regarding such allegations. The residents have access to grievance forms, writing materials and locked grievance boxes. The Policy contains the timelines regarding the grievance procedure including that an initial response to an emergency grievance is provided within 48 hours of receipt of the grievance and that a final decision is provided within five days of receipt of the grievance. All grievances are entered into an electronic system and are reviewed by the Chief Inspector or designee to ensure consistency and compliance with all ODYS policies and procedures. The Inspector General or designee document their review of grievances in the electronic system.

Information regarding the grievance process is provided to the residents verbally, in the Youth Orientation Handbook, and in the Youth Grievance Handbook. Interviews with residents revealed that they are aware that they are not required to use an informal grievance process or otherwise attempt to resolve a PREA related issue with staff. The emergency grievance process requires that the resident place his name and date on the grievance form and checks the box indicating his having been sexually abused or a concern about being sexually abused and the grievance is to be placed in a locked grievance box which were observed to be on each housing unit and other areas. The residents are familiar with how to submit regular and emergency grievances as was evident through their interviews. The instructions are included on the grievance form.

Grievances completed after regular business hours, weekends or holidays are placed in the medical box so that medical staff may have access to them, when a grievance officer is not present, so that the required response timelines may continue to be met. A review of a completed grievance form and electronic grievance system database print-outs show that grievances are received and responded to. Three PREA related grievances were reviewed; one was handled through the initiation of an administrative investigation and the other two were determined to have no merit. The resident interviews revealed that they are aware that the grievance system can be used for reporting an allegation of 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.

Policy 702.01 address this standard. The facility provides residents 24-hour, seven days a week access to outside victim advocacy services by telephone and advocacy services are provided by identified ODYS staff who have received victim advocacy training. The Haven House receives allegations and reports them. Emotional support is provided to residents who have been victimized in the past or currently being victimized. The contact information is provided to the residents during intake in the PREA education information and is posted in each housing unit on the wall by the dedicated resident phone used for reporting allegations of sexual abuse. The ODYS Tip Line information and phone number is also posted, along with the contact information for the Ohio Public Defender's Office for reporting allegations of sexual abuse or sexual harassment. Staff members from the Public Defender's Office make periodic visits to the facility for informational purposes and two attorneys were visiting the facility the first day of the PREA audit. Residents are also provided written and verbal information regarding things a victim advocate can do and what a victim advocate does not do. Refresher training was provided to residents after the PREA site visit to ensure that they fully understand the role and duties of a victim advocate. The posted information and the refresher training for residents inform them of things advocates will do; such as they will accompany the victim to the hospital to be examined after a sexual assault. The resident is informed that, among other things, the advocate will not provide legal advice or investigate the allegations. The information provided to the residents also include the limitations of confidentiality and the reporting process.

The representative from the Haven House validated the support services that will be provided and ODYS staff confirmed the advocacy training and the role of ODYS staff advocates for residents. The signed roster for the advocacy staff was reviewed which documented the training. The Haven House representative reported that the agency has received numerous prank calls from the residents at the facility. The report of the prank calls have also been made to the facility staff. The ODYS PREA Administrator is coordinating a meeting to further address and resolve the concerns. The plan is to provide further education to the Haven House staff regarding the residents served and review with the residents the importance of and the seriousness of the hotline services.

Policy 304.02, interviews with the Superintendent and all residents; and observations document that residents are provided confidential access to their attorney or other legal representative and reasonable access to their parents or legal guardian. A review of documentation support that residents are able to visit with attorneys or other legal representatives and with their parents or guardians. Information regarding visitation is also provided in the Youth Orientation Handbook and the visitation hours are posted on the facility's website. Visitation is allowed on a daily basis and residents may also communicate with parents and legal guardians by telephone.

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 that third-party reporting of sexual abuse and sexual harassment will be received by facility staff and reported as required. Third-party reporting information is posted on the agency's website and the information and third-party reporting forms are posted in the front lobby of the facility and in the visitation room, accessible to staff, residents, contractors, and visitors. Third-party reports can also be made directly to ODYS central office through the ODYS Tip Line which is another method of reporting safety concerns. Staff and resident interviews confirmed their knowledge of the meaning of third-party reporting and staff members are aware of the documentation and how to report allegations made through third-parties. All residents interviewed could identify someone that did not work at the facility that they could report to about sexual abuse or sexual harassment.

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 and State statute require all staff members to immediately report all allegations of sexual abuse to the Superintendent or designee and to document reported allegations prior to the end of their shift. The facility staff members are also required by Policy to report allegations that were made anonymously or by a third-party. According to interviews with the mental health and medical staffs interviewed, they initially inform residents of their duty to report. 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.

Administrative investigations are investigated by the Office of the Inspector General and allegations that are criminal in nature are investigated by the Ohio State Highway Patrol. A review of policy and dedicated forms and staff interviews reveal that notifications will be made immediately, including ODYS central office staff; the appropriate child welfare agency; parents/legal guardians or child welfare agency case worker where indicated.

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.

Interviews with the Superintendent and direct care staffs revealed that immediate measures to protect a resident would be taken and include but not be limited to close monitoring; moving resident to another housing unit; and/or contacting a supervisor or management staff for assistance. According to Policy 304.03, when information is received in a grievance that a resident is subject to a substantial risk of imminent sexual abuse the person acting as the grievance officer must notify the site manager to ensure the protection of the resident. Staff interviews and the Policy revealed that residents may be placed on a Safety Plan which would identify the protective actions that should be taken by staff and the resident. During the past 12 months, no residents were identified as being 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.

Policy 304.04 provides that upon the facility receiving an allegation that a resident was sexually abused while confined in another facility, the Superintendent/designee will notify the appointing authority or designee of the facility where the alleged abuse occurred and will also notify the Ohio State Highway Patrol. The Policy provides that the notification is made as soon as possible but no later than 72 hours of receipt of the allegation. During the past 12 months, there were no allegations of a resident being sexually abused while confined in another facility.

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.

Policy 304.04 contains the first responder duties and outlines the requirements of the first responder including: separate the victim from the abuser; preserve and protect the scene; and request that the alleged victim does not take any action that would destroy physical evidence. Staff interviews with staff members who would serve as first responders and non-security staff revealed that they are aware of their duties. The non-security staff who may act as a first responder knew to request that physical evidence be preserved and to contact direct care staff for assistance. 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.

Policy 304.04 and the written institutional plan provides guidance to staff regarding the actions to take in responding to an incident of sexual abuse. The facility has a written guide, Institutional Plan for Coordinated Response to Sexual Abuse or Assault that supports the Policy. The Plan outlines, in a charted format, steps to be taken in response to an incident of sexual abuse. The Policy and the Plan identify the staff positions required for an effective facility response, such as the Superintendent; other management staff; direct care staff; medical and mental health practitioners; and investigators. Staff interviews revealed that they are aware of their duties in response to an incident of sexual abuse or 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.

Policy 103.22 addresses this standard and contains the following statement: Nothing in this standard restricts the renewal of agreements that govern the conduct of the disciplinary process as long as the agreement is not inconsistent with the provisions of PREA standards 115.372 and 115.376; or whether a no-contact assignment that is imposed pending the outcome of an investigation shall be expunged from or retained in the staff member's personnel file following a determination that the allegation of sexual abuse is not substantiated.

There is documentation of a contract between the State of Ohio and the Ohio Civil Service Employees Association for July 1, 2015 through February 28, 2018. The contract states that agency work rules or institutional rules and directives must not be in violation of the Agreement. The Agreement also states that the work rules must be reasonable and the Union must be notified prior to the implementation of any new work rules and must have the opportunity to discuss them.

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 guidance to staff regarding protection against retaliation from others for residents and staff who report sexual abuse or sexual harassment or who may cooperate with investigations. The Policy includes the areas to monitor such as housing or program changes; disciplinary reports; and negative job performance reviews. A review of Retaliation Monitoring Checklist forms and the interview with the PREA Compliance Manager who also serves as the retaliation monitor revealed that the monitoring occurs. She further added that in addition to the areas to monitor according to the Policy, she would also monitor privilege suspensions to assist in determining if retaliation is occurring. The Retaliation Monitoring Checklist is designed to track retaliation activities according to the standard and to document the monitoring activities.

The Policy provides that the retaliation monitor acts immediately to remedy the situation when retaliation activities are discovered. The retaliation is to be reported to Operations and the Superintendent and an incident report must be completed. According to Policy and the staff interview, retaliation monitoring will be conducted for at least 90 days, longer if needed, following a report of sexual abuse or sexual harassment. The retaliation monitor expressed various measures that would be taken to protect residents and staff from retaliation such as close monitoring; place resident on Safety Plan; and change housing units. The facility reports that there have been no incidents of retaliation during 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.

This standard is not applicable. Segregation is not used in this facility.

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 the requirements for conducting administrative investigations and the responsibility of the agency regarding investigations that are criminal in nature. Administrative investigations are investigated by the ODYS Office of Chief Inspector and the Ohio State Highway Patrol investigate allegations that are criminal in nature. The Ohio State Highway Patrol has policy regarding conducting investigations regarding juveniles. There have been no investigations conducted in the facility by the Ohio State Highway Patrol during the past year. There have been no sustained allegations of conduct that appeared to be criminal that were referred for prosecution since the time period identified by the standard of August 20, 2012. Agency policies provide guidance to staff on referral for prosecution; retention of reports; staff cooperation with investigations, and those reports made by third-parties and anonymously. The Superintendent maintains contact with the Office of the Chief Inspector who is in contact with the Ohio State Highway Patrol on all investigations.

The investigators within the Office of the Chief Inspector have received documented training from the Ohio Department of Rehabilitation and through the PREA Resource Center. The administrative investigations are documented in written reports that contain the requirements of the standard such as descriptions of the physical and testimonial evidence; copies of documentary evidence; and investigative facts and findings. The agency investigators are provided training and policy regarding gathering and preserving physical evidence. The Ohio State Highway Patrol has a comprehensive policy which provide details regarding gathering, preserving and storing evidence. A review of reports demonstrates that the agencies do not terminate an investigation solely because the source of the allegation recants the allegation; once an investigation is initiated, it is completed.

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.

Policy 101.15 provides that 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. A review of a sample of investigation reports support that the Policy is followed.

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 101.5 provides that the resident be informed that the investigation has been concluded and the outcome of whether it was determined to be substantiated, unsubstantiated or unfounded. The notification process provides that the resident be notified of the outcome of an investigation in writing. The Labor Relations Officer delivers the Notification Letter to residents within five days of the case being closed in the electronic records system for investigations. A review of the Notification Letters demonstrates that the residents are notified and receipt of the information is acknowledged by the resident’s and the Labor Relations Officer’s signatures. Six administrative investigations were conducted in the facility during the past 12 months by the ODYS Office of the Chief Inspector.

In a situation where an investigation is conducted by the Ohio State Highway Patrol, the Superintendent remains abreast of the investigation through contact primarily with the Office of the Chief Inspector who communicates with the State Highway Patrol Office regarding each allegation of sexual abuse. The facility uses the ODYS Alleged Sexual Abuse and Sexual Assault Response Checklist to assist staff in taking the required actions for processing the alleged incident and to document steps taken in that process. The Checklist also serves as a guide to staff of the steps that are to be taken when allegations of sexual abuse are made.

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.

Policy 103.17 states that staff members are subject to disciplinary sanctions up to and including termination for violations of sexual abuse or sexual harassment policies. According to the Policy, 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, will be reported as required to law enforcement, unless the activity was clearly not criminal, and to relevant licensing bodies. The disciplinary sanctions for violations relating to sexual abuse or sexual harassment, other than engaging in sexual abuse, will be commensurate with the act committed; the staff member’s disciplinary history; and the similar history of other staff. During this audit period, a staff member was terminated due to substantiated findings of an administrative investigation regarding allegations of sexual abuse. There is documentation that the relevant licensing body, regarding the staff member’s credentials, was notified by ODYS central office staff.

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 when a contractor or volunteer engages in sexual abuse with a resident, contact with the resident would be prohibited and contact will be made with law enforcement, unless the activity was clearly not criminal, and relevant licensing bodies. Appropriate remedial measures will be taken and further contact prohibited if there are violations of other PREA related policies. The acknowledgement statement for contractors and volunteers reminds them of the consequences for violations of the zero-tolerance policy. During the past 12 months, there have been no contractors or volunteers who have been reported for a violation of PREA policies. The interview with the Superintendent was aligned with the contents of the Policy.

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 and provide that residents may be subject to disciplinary sanctions only after formal proceedings, an Intervention Hearing, regarding resident-on-resident sexual abuse. Residents found in violation of facility rules are subject to sanctions pursuant to the formal administrative process or following a criminal finding of guilt. The disciplinary sanctions have been developed to be commensurate with the nature and circumstances of the abuse committed; the resident's disciplinary history; similar histories of other residents; and consideration of mental disabilities or mental illness contributing to the behavior. An electronic database is maintained of the Intervention Hearings that are conducted in the agency's facilities.

The policies and interviews with the mental health and medical staffs revealed that a resident's participation in treatment services are not required for him to access programming or education. The facility may discipline a resident for sexual contact with staff only upon a finding that the staff member did not consent to such contact. According to the Standard Operating Procedure, a resident who reports an allegation of sexual abuse will not be disciplined or considered to have made a false report if the allegation was made in good faith. It also provides that the facility may discipline a resident for sexual contact with staff only upon a finding that the staff member did not consent to such contact.

There was one incident during the past 12 months involving a staff member and a resident and the resident received a disciplinary hearing. Due to information that was received beyond the hearing date, it was determined that the record of the Intervention Hearing, including the findings, warranted removal from the resident's record. There is documentation confirming that the record of the Intervention Hearing has been deleted from the system.

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 and require that when a resident discloses prior victimization or abusiveness during the intake screening process, a follow-up meeting would be provided with a mental health or medical practitioner within 14 days of the intake screening as prescribed by Policy and according to staff. All residents are screened utilizing the screening instrument, Sexual Abuse and Sexual Assault Victim/Aggressor Profile Checklist within 24 hours of arrival to the facility. The reassessment of the resident may also be completed using the same form by completing the update section. This section of the instrument is completed when new information is received or there is a significant occurrence. The Policy states that any information related to sexual victimization or abusiveness occurring in an institutional setting is limited to medical and mental health providers and other staff as required to inform treatment plans and security management decisions.

Clinical records are maintained by mental health and medical staffs that document the services provided to residents. The facility has an informed consent form, “Consent for Youth Age 18 and Over to Report Allegations of Abuse,” which is utilized prior to disclosing allegations reported by residents who are age 18 and over, of prior sexual victimization that did not occur in an institutional setting. The facility reports that during the past 12 months, no residents disclosed prior victimization or previously perpetrated sexual abuse during the screening process. If this information is learned through the admission packet prior to the resident’s arrival, a follow-up meeting is scheduled and generally occurs within one to two days after the residents arrival to the facility, according to staff. Interviews with mental health staff revealed that when a resident may disclose prior victimization or previously perpetrating sexual abuse they will be 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 to residents.

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.

Standard Operating Procedure 304.04.01 and the Letter of Agreement with the Berger Health System/Berger Hospital ensure that timely and unimpeded emergency medical and mental health services regarding sexual assault will be provided at no cost to the victim and whether or not the victim names the accuser or cooperates with the investigation. The interviews with the medical and mental health staffs were aligned with the Standard Operating Procedure and the standard and they stated that emergency services will be provided based on the practitioner’s professional judgment. The interviewers confirmed and the Policy provides that timely information would be provided regarding sexually

transmitted infection prophylaxis. Medical and mental health staffs will provide immediate treatment and crisis intervention services and the staffs interviewed revealed that timely and unimpeded access to emergency medical treatment and crisis intervention services will be provided regarding an allegation or incident of sexual assault.

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 provides for ongoing medical and mental health evaluations and treatment, where appropriate, for sexual abuse victims and abusers. According to the staff interviews, the ongoing medical and mental health care may include follow-up services; referrals; and mental health appraisals accompanied by treatment plans for appropriate services. The mental health and medical services are consistent with the community level of care based on observations, a review of a sample of records, and interviews with the Registered Nurse and Social Worker Supervisor.

The Policy, staff interviews and the Letter of Agreement document that resident victims will be offered tests for sexually transmitted infections as medically appropriate. The Policy also states that all treatment services will be provided at no cost to the victim. Standard Operating Procedure 304.04.01 provide that the facility will conduct a mental health evaluation of all known resident-on-resident abusers within 60 days of learning of such abuse history and offer treatment when deemed appropriate. However, the staff interview stated that the practice is and sample records revealed that mental health appraisals are completed on all residents within an approximate week of intake.

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.

Policy 304.04 provides details regarding the role of the incident review team and identifies the team members that would conduct the review of the incident where the allegation was either substantiated or unsubstantiated. The incident reviews are to occur within 30 days of the conclusion of the investigation, per Policy. The incident review team members have been identified as the Superintendent; Deputy Superintendent- Direct; PREA Compliance Manager; Operations Administrator; Unit Management Administrator; Gang Intervention Specialist; Health Services Administrator; and the Psychology Supervisor. A review of a sample of forms that track and document the incident review process reveal that the incident review occurs within the time limit. The form requires documentation of the considerations by the team such as the need to change policy or practice; motivation factors that may have contributed to the incident; physical barriers; adequacy of staffing levels; adequacy of monitoring technology; and input from line supervisors.

An interview with an incident review team member stated that the team meets monthly and she was familiar with the items that are considered during the review process. Interviews with the Superintendent and the PREA Compliance Manager and a review of the documentation also support that the guidelines for the incident review process outlined in the Policy are followed and further confirmed the monthly meetings of the team. The forms provide the documentation of the review of the incident; recommendations for improvement; and indication whether the recommendations were implemented. The forms were lacking in documented recommendations; however, staffs were able to articulate and confirm corrective actions taken regarding allegations and incidents that had been investigated. It was recommended that the recommendations and corrective measures be documented on the dedicated form.

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 101.07 and Standard Operating Procedure 101.14.01 provide directions regarding incident reports and for collecting accurate uniform data for every allegation of sexual abuse and the Policy 101.07 provide the requirements of the annual report for aggregated data and the Policy contains related definitions. A review of the samples from the ODYS Activity Management System (AMS) shows the collected data of significant incidents. The agency has the capacity to collect data for allegations of sexual assault, sexual harassment and sexual misconduct create the required reports through the AMS and aggregates incident-based data at least annually. The AMS includes the data necessary to answer all questions from the Survey of Sexual Violence conducted by the Department of Justice. The agency provides the related data from the previous calendar year to the United States Department of Justice as required. A review of the documentation and interviews with the Superintendent, Client Advocate Administrator and PREA Administrator confirmed the data collection activities.

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. The mock PREA audits led by the PREA Administrator along with other support assists facilities in assessing their compliance status and identifying the opportunities for improvement regarding sexual abuse prevention, detection, and response policies, practices, and training. 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. Identifying information is not included in the

posted reports.

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.

Policies 101.7 and 106.5 address this standard, including that 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 documentation shows that all personal identifiers are removed from annual reports. The reports are available to the public through the agency’s website.

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 14, 2016

Auditor Signature

Date