# Prison Rape Elimination Act (PREA) Audit Report
## Juvenile Facilities

☐ Interim ☒ Final

**Date of Interim Audit Report:** Click or tap here to enter text. ☒ N/A
*If no Interim Audit Report, select N/A*
**Date of Final Audit Report:** July 27, 2021

## Auditor Information

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|---|---|
| **Name:** Shirley L. Turner | **Email:** shirleyturner3199@comcast.net |
| **Company Name:** Correctional Management and Communications Group, LLC | |
| **Mailing Address:** P. O. Box 370003 | **City, State, Zip:** Decatur, GA 30037 |
| **Telephone:** 678-895-2829 | **Date of Facility Visit:** June 14, 2021 |

## Agency Information

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|---|---|---|---|
| **Name of Agency:** Juvenile Residential Center of Northwest Ohio | | | |
| **Governing Authority or Parent Agency** *(If Applicable)* | | | |
| **Address:** 1012 S. Dunbridge Road | | **City, State, Zip:** Bowling Green, OH 43402 | |
| **Mailing Address:** Same as Above | | **City, State, Zip:** Same as Above | |
| **The Agency Is:** | ☐ Military | ☐ Private for Profit | ☐ Private not for Profit |
| ☐ Municipal | ☒ County | ☐ State | ☐ Federal |
| **Agency Website with PREA Information:** www.jrcnwo.org | | | |

### Agency Chief Executive Officer

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|---|---|
| **Name:** Montana Crawford, Director | |
| **Email:** mcrawford@jrcnwo.org | **Telephone:** 419-353-4406 |

### PREA Coordinator

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|---|---|
| **Name:** Greg Wortman, Quality Assurance Coordinator | |
| **Email:** gwortman@jrcnwo.org | **Telephone:** 419-353-4406 |
| **PREA Coordinator Reports to:** Montana Crawford, Dir. | **Number of Compliance Managers who report to the PREA Coordinator:** 0 |

## Facility Information

| | | | |
|---|---|---|---|
| **Name of Facility: Juvenile Residential Center of Northwest Ohio** | | | |
| **Physical Address: 1012 S. Dunbridge Road** | | **City, State, Zip: Bowling Green, OH 43402** | |
| **Mailing Address:** Same as Above | | **City, State, Zip:** Same as Above | |
| **The Facility Is:** | ☐ Military | ☐ Private for Profit | ☐ Private not for Profit |
| ☐ Municipal | ☒ County | ☐ State | ☐ Federal |
| **Facility Website with PREA Information: www.jrcnwo.org** | | | |
| **Has the facility been accredited within the past 3 years?** ☒ Yes ☐ No | | | |
| **If the facility has completed any internal or external audits other than those that resulted in accreditation, please describe:**<br>Compliance audit which is based on agency/facility policies, procedures, practices, and national standards conducted by certified auditors with the American Correctional Association. | | | |

### Facility Administrator/Superintendent/Director

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|---|---|
| **Name: Montana Crawford** | |
| **Email: mcrawford@jrcnwo.org** | **Telephone: 419-353-4406** |

### Facility PREA Compliance Manager

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|---|---|
| **Name:** NA | |
| **Email:** | **Telephone:** |

### Facility Health Service Administrator ☐ N/A

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|---|---|
| **Name: Lakisha Turner** | |
| **Email: lnturner@wellpath.us** | **Telephone: 419-353-4406** |

### Facility Characteristics

| | |
|---|---|
| **Designated Facility Capacity:** | **42** |
| **Current Population of Facility:** | **25** |
| **Average daily population for the past 12 months:** | **26** |
| **Has the facility been over capacity at any point in the past 12 months?** | ☐ Yes ☒ No |
| **Which population(s) does the facility hold?** | ☐ Females ☒ Males ☐ Both Females and Males |

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| **Age range of population:** | **12-18** |
| **Average length of stay or time under supervision** | **8.1 months** |
| **Facility security levels/resident custody levels** | **Medium** |

| | |
|---|---|
| **Number of residents admitted to facility during the past 12 months** | **40** |
| **Number of residents admitted to facility during the past 12 months whose length of stay in the facility was for *72 hours or more*:** | **40** |
| **Number of residents admitted to facility during the past 12 months whose length of stay in the facility was for *10 days or more*:** | **40** |
| **Does the audited facility hold residents for one or more other agencies (e.g. a State correctional agency, U.S. Marshals Service, Bureau of Prisons, U.S. Immigration and Customs Enforcement)?** | ☐ Yes ☒ No |

| | |
|---|---|
| **Select all other agencies for which the audited facility holds residents: Select all that apply (N/A if the audited facility does not hold residents for any other agency or agencies):** | ☐ Federal Bureau of Prisons<br>☐ U.S. Marshals Service<br>☐ U.S. Immigration and Customs Enforcement<br>☐ Bureau of Indian Affairs<br>☐ U.S. Military branch<br>☐ State or Territorial correctional agency<br>☐ County correctional or detention agency<br>☐ Judicial district correctional or detention facility<br>☐ City or municipal correctional or detention facility (e.g. police lockup or city jail)<br>☐ Private corrections or detention provider<br>☐ Other - please name or describe: Click or tap here to enter text.<br>☒ N/A |

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|---|---|
| **Number of staff currently employed by the facility who may have contact with residents:** | **34** |
| **Number of staff hired by the facility during the past 12 months who may have contact with residents:** | **18** |
| **Number of contracts in the past 12 months for services with contractors who may have contact with residents:** | **2** |
| **Number of individual contractors who have contact with residents, currently authorized to enter the facility:** | **6** |
| **Number of volunteers who have contact with residents, currently authorized to enter the facility:** | **0** |

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|---|---|
| | |
| **Physical Plant** | |
| Number of buildings:<br><br>Auditors should count all buildings that are part of the facility, whether residents are formally allowed to enter them or not. In situations where temporary structures have been erected (e.g., tents) the auditor should use their discretion to determine whether to include the structure in the overall count of buildings. As a general rule, if a temporary structure is regularly or routinely used to hold or house residents, or if the temporary structure is used to house or support operational functions for more than a short period of time (e.g., an emergency situation), it should be included in the overall count of buildings. | 1 |
| Number of resident housing units:<br><br>Enter 0 if the facility does not have discrete housing units. DOJ PREA Working Group FAQ on the definition of a housing unit: How is a "housing unit" defined for the purposes of the PREA Standards? The question has been raised in particular as it relates to facilities that have adjacent or interconnected units. The most common concept of a housing unit is architectural. The generally agreed-upon definition is a space that is enclosed by physical barriers accessed through one or more doors of various types, including commercial-grade swing doors, steel sliding doors, interlocking sally port doors, etc. In addition to the primary entrance and exit, additional doors are often included to meet life safety codes. The unit contains sleeping space, sanitary facilities (including toilets, lavatories, and showers), and a dayroom or leisure space in differing configurations. Many facilities are designed with modules or pods clustered around a control room. This multiple-pod design provides the facility with certain staff efficiencies and economies of scale. At the same time, the design affords the flexibility to separately house residents of differing security levels, or who are grouped by some other operational or service scheme. Generally, the control room is enclosed by security glass, and in some cases, this allows residents to see into neighboring pods. However, observation from one unit to another is usually limited by angled site lines. In some cases, the facility has prevented this entirely by installing one-way glass. Both the architectural design and functional use of these multiple pods indicate that they are managed as distinct housing units. | 4 |
| Number of single resident cells, rooms, or other enclosures: | 42 |
| Number of multiple occupancy cells, rooms, or other enclosures: | 0 |
| Number of open bay/dorm housing units: | 0 |
| Number of segregation or isolation cells or rooms (for example, administrative, disciplinary, protective custody, etc.): | 0 |
| Does the facility have a video monitoring system, electronic surveillance system, or other monitoring technology (e.g., cameras, etc.)? | ☒ Yes ☐ No |
| Has the facility installed or updated a video monitoring system, electronic surveillance system, or other monitoring technology in the past 12 months? | ☐ Yes ☒ No |
| | |

| Medical and Mental Health Services and Forensic Medical Exams | |
|---|---|
| **Are medical services provided on-site?** | ☒ Yes ☐ No |
| **Are mental health services provided on-site?** | ☒ Yes ☐ No |
| **Where are sexual assault forensic medical exams provided? Select all that apply.** | ☐ On-site<br>☒ Local hospital/clinic<br>☐ Rape Crisis Center<br>☐ Other (please name or describe: Suncoast Center, Inc.) |

| Investigations | |
|---|---|
| **Criminal Investigations** | |
| **Number of investigators employed by the agency and/or facility who are responsible for conducting CRIMINAL investigations into allegations of sexual abuse or sexual harassment:** | **0** |
| **When the facility received allegations of sexual abuse or sexual harassment (whether staff-on-resident or resident-on-resident), CRIMINAL INVESTIGATIONS are conducted by: Select all that apply.** | ☐ Facility investigators<br>☐ Agency investigators<br>☒ An external investigative entity |
| **Select all external entities responsible for CRIMINAL INVESTIGATIONS: Select all that apply (N/A if no external entities are responsible for criminal investigations)** | ☒ Local police department<br>☐ Local sheriff's department<br>☐ State police<br>☐ A U.S. Department of Justice component<br>☐ Other (please name or describe: Click or tap here to enter text.)<br>☐ N/A |
| **Administrative Investigations** | |
| **Number of investigators employed by the agency and/or facility who are responsible for conducting ADMINISTRATIVE investigations into allegations of sexual abuse or sexual harassment?** | **6** |
| **When the facility receives allegations of sexual abuse or sexual harassment (whether staff-on-resident or resident-on-resident), ADMINISTRATIVE INVESTIGATIONS are conducted by: *Select all that apply*** | ☒ Facility investigators<br>☐ Agency investigators<br>☐ An external investigative entity |
| **Select all external entities responsible for ADMINISTRATIVE INVESTIGATIONS: Select all that apply (N/A if no external entities are responsible for administrative investigations)** | ☐ Local police department<br>☐ Local sheriff's department<br>☐ State police<br>☐ A U.S. Department of Justice component<br>☐ Other (please name or describe:<br>☒ N/A |

# Audit Findings

## Audit Narrative (including Audit Methodology)

*The auditor's description of the audit methodology should include a detailed description of the following processes during the pre-onsite audit, onsite audit, and post-audit phases: documents and files reviewed, discussions and types of interviews conducted, number of days spent on-site, observations made during the site-review, and a detailed description of any follow-up work conducted during the post-audit phase. The narrative should describe the techniques the auditor used to sample documentation and select interviewees, and the auditor's process for the site review.*

The Juvenile Residential Center of Northwest Ohio (JRCNO), located in Bowling Green, Ohio serves adolescent male juvenile offenders. The Ohio Department of Youth Services (ODYS) is responsible for funding which provides for residential treatment services instead of a youth's placement in an ODYS correctional facility. Program services include but are not limited to mental health and counseling; healthcare; education; recreation; and religious programming. The facility serves a population from 12 to 18 years of age with and has a minimum-security level. The Prison Rape Elimination Act (PREA) Audit was conducted by Shirley Turner, certified US Department of Justice PREA Auditor, assisted by a certified PREA Auditor. The assisting Auditor was Flora Boyd who provided support during the onsite audit activities and during the post audit phase.

The audit was attained and assigned to the Auditor by Flora Boyd, Senior Vice President of Program Reviews, Correctional Management and Communications Group LLC (CMCG) located in Minneola, Florida. There were no known existing conflicts of interest regarding the completion of this audit. There were no barriers in completing any phase of the audit. Scheduling considerations for the virtual staff interviews with supervisors and managers were implemented out of an abundance of caution due to the spread of the global pandemic. Due to safety concerns, all interviews with supervisors and managers were conducted remotely which included video arrangements and in accordance with the written guidance from the PREA Resource Center. The virtual interviews were conducted on May 26, 2021 and the site visit was conducted on June 16, 2021. A PREA audit was previously conducted at the facility in August 2018.

The ODYS and the facility had a vested interest in the audit being completed within the current cycle and ensured that the challenges of COVID-19 concerns would not eliminate the occurrence of the audit; safety measures were implemented. The agency, facility and Auditors supported the use of the alternative method of interviewing as a safety measure to enhance the protection of all parties involved. All randomly selected residents were interviewed onsite. Random staff were also interviewed onsite in accordance with the written guidance from the PREA Resource Center.

Information about programs, services and activities conducted at the facility are also summarized on the parent agency/facility website. Detailed information, specific to the facility, is found on the website and includes how to report allegations, facility reports, and general PREA information. Policy and the third-party reporting form may be accessed by the general public

from the website. The ODYS website also provides related PREA information and the facility's PREA audit reports are posted.

**Pre-Onsite Audit Phase**

**Key Processes and Methodology**

The initial planning for the audit was conducted with the ODYS PREA Administrator, the Auditor and the CMCG Senior Vice President of Program Reviews and Audits. There was initial and follow-up communication by the Auditor with the Quality Assurance Coordinator/PREA Coordinator, Greg Wortman; Director, Montana Crawford; and ODYS PREA Administrator, Alexander Stojsavljevic. The methodology, interview schedules, logistics and site review plans were discussed with the parties involved and the Auditor provided the opportunity for questions and clarification of information as needed.

PREA documents were provided to the Auditor initially and throughout the process as requested. During follow-up conversations, the audit process and logistics were reviewed and adjusted as needed. Communication was maintained with facility staff and the ODYS PREA Administrator throughout the audit process. All parties involved supported the use of the alternative method of virtual interviewing to reduce direct contact out of an abundance of caution in an effort to minimize anyone contracting or spreading the coronavirus. The virtual interviews were conducted with the Auditor controlling the video. The interviews did not reveal any information that warranted further inquiry during the in-person onsite review.

The Auditor maintained communication with the Quality Assurance Coordinator/PREA Coordinator regarding the virtual interviews; site review; access to the various staff members; and goals and expectations of the audit process. The facility staff members and residents were receptive to the alternative method for conducting the interviews. Some staff members were familiar with the PREA audit process, having participated in and/or aware of the previous PREA audit and through the implementation of the PREA Standards.

The PREA audit notice was copied and posted in various areas of the facility prior to the onsite audit phase, at least six weeks prior to the audit. The pictures of the notices were taken in their various locations and emailed to the Auditor by the ODYS PREA Administrator. The audit notices were in a format that was easy to see and read and were posted at varying eye levels and easy to see. The ODYS PREA Administrator provided supporting information to the Quality Assurance Coordinator/PREA Coordinator, ensuring placement of the audit notices in areas where they could be seen by residents, staff, contractors and visitors to the facility.

During the onsite phase of the audit, the posted notices were observed to be strategically posted, accessible to residents, staff, any visitors, volunteers and contractors during this time period. The notices contained the Auditor's contact information and information regarding confidentiality of information. No correspondence was received by the Auditor from staff or residents during any phase of the audit. The facility has a process in place to ensure confidential communication by residents. Verification of the posted notices was made by pictures emailed to the Auditor; observations during the comprehensive site review; and as indicated through the interviews conducted with residents and staff.

The completed PREA Pre-Audit Questionnaire, agency and facility policies and procedures, and supporting documentation were uploaded to a flash drive and mailed to the Auditor. The documentation on the flash drive was organized by each standard. This information was received by the Auditor prior to the site review. An initial assessment was conducted of the information and the Auditor conducted a telephonic review with the Quality Assurance Coordinator/PREA Coordinator who provided the information requested. The Auditor also provided a written review (issue log) regarding the information reviewed, detailing the additional documentation needed.

The Auditor provided a document to the Quality Assurance Coordinator/PREA Coordinator that assisted in the completion of the interview schedule titled, "Information Requested to Determine Staff and Residents to be Interviewed During the On-Site PREA Audit." The document which was completed and returned to the Auditor, requested shift assignments; identification of staff members who served and performed in specific PREA related specialized roles; and volunteers and contractors who have contact with residents.

The Auditor requested, through the interview document, a list of direct care staff and their scheduled shifts, supervisors, managers, and a current resident population roster. The written request included information regarding residents who may be in vulnerable categories such as disabled; limited English proficient; intersex, gay, bisexual and/or transgender residents; and residents housed in isolation. The information regarding the residents and staff was made available to the Auditor prior to the onsite audit phase and contributed to the development of the interview schedules.

Staff and residents were randomly selected by the Auditor based on the interview requirements. The interview schedule was developed by the Auditor with input through the Quality Assurance Coordinator/PREA Coordinator. All interviews were conducted in private. When the supervisors were interviewed, the interviewer ensured that there was no interference from other staff members and that there was the privacy of an office. The staff member being interviewed, confirmed that no other staff member was present during the interviews. The Quality Assurance Coordinator/PREA Coordinator also provided assurance the interviews were conducted in private. The areas where staff interviews occurred were observed during the site review. Some staff were asked during the onsite audit phase, if there was any additional information they wanted to share; no additional information was provided.

The Auditor communicated with the Quality Assurance Coordinator/PREA Coordinator to confirm the interview and site review schedules. Assistance was provided to the Auditor in clarifying specialized PREA roles and there was collaboration in efforts to identify residents in vulnerable categories. A resident roster was provided to the Auditor and as a result of the information received, the interview schedules of specialized and random staffs and residents were constructed. The resident roster provided was organized by housing assignment, laying the foundation for the selection of a diverse group of residents.

The Auditor solicited and received input from the Quality Assurance Coordinator/PREA Coordinator regarding any challenges in the availability of identified residents and staff. There were 25 residents in the facility on the day of the site review. There were five targeted interviews

conducted due to identification in vulnerable categories. The Quality Assurance Coordinator/PREA Coordinator and the Auditor reviewed and discussed the population make-up within the facility to ensure a representative sample of random and targeted interviews.

The Auditor reviewed the documents provided on the flash drive and subsequently by email and conferred with the Quality Assurance Coordinator/PREA Coordinator for clarity of information as needed. A representative sample of residents and staff interviews were conducted to ensure the reliability of the triangulated data gleaned from the interviews; review of policies, procedures and other documents; and observations. Once the interview schedules were developed and provided by the Auditor, all interviews (virtual and onsite) were conducted objectively and none of the interviewees were coerced to participate.

The Quality Assurance Coordinator/PREA Coordinator provided documents that assisted with the following determinations and interview selections:

| Information | Comments |
|---|---|
| Resident Roster | Provided |
| Youthful Inmates/detainees | NA |
| Residents with Physical Disabilities | Identified |
| Residents who are Limited English Proficient | None Identified |
| LGBTI Residents | Identified |
| Residents in segregated housing | NA |
| Residents in Isolation | NA |
| Residents who reported sexual abuse | None Identified |
| Residents who reported sexual victimization during risk screening. | Identified |
| Residents with Cognitive Disabilities | Identified |
| Staff Roster | Provided |
| Specialized Staff | Provided |
| Contractors/Volunteers that have contact with residents. | Provided; No volunteers in facility at this time. |
| All grievances/allegations made in the 12 months preceding the audit. | None |
| All allegations of sexual abuse and sexual harassment reported for investigation in the 12 months preceding the audit. | None |
| Hotline calls made during the 12 months preceding the audit. | None |

The agenda for the site review was reviewed by the Auditor with the Director, Quality Assurance Coordinator/PREA Coordinator, and ODYS PREA Administrator. There were no primary concerns regarding the site review. There was assurance by the Auditor that the process would be as non-intrusive as possible where these actions did not interfere with the completion of the onsite review while also providing consideration due to COVID-19 concerns. The site review included taking the paths that residents take within the facility while pointing out the restricted

areas where residents may go only with staff supervision and areas where residents are not allowed.

**Site Review**

**Key Processes and Methodology**

The onsite review of the facility was conducted by the facility Director and Quality Assurance Coordinator/PREA Coordinator. The ODYS PREA Administrator was also present during the facility onsite review. A sign-in process for visitors entering the facility was completed upon arrival. The site review included observations of the buildings and grounds of the facility. The areas examined included the lobby; administrative area; medical clinic space; multi-purpose area, classrooms; offices; housing units; bathrooms; and outside recreation area. Staff members were observed interacting with residents on the living units and while the residents were eating lunch.

Printed notifications of the PREA site visit were observed posted in the areas previously identified in the pictures sent to the Auditor, visible to residents, staff, contractors and visitors. The notices contained large enough print to make them noticeable and easy to see and read and were observed posted in the and main areas of the building and encountered by staff, residents and visitors. The staff and residents stated that female staff ring the doorbell at the door and many times, will also verbally announce their presence upon entering the housing units.

There are signs posted throughout the facility regarding PREA information and materials are available and accessible that contain contact information of the assisting agencies for reporting allegations of sexual harassment and sexual abuse and for seeking help as a result of sexual abuse and sexual harassment. The posted information includes instructions on accessing assistance; grievance and medical request forms; and safety information regarding sexual abuse and sexual harassment in the resident handbook. A staff member cannot impede a resident's use of the telephone to access services to report allegations or request victim advocacy services.

Forensic medical examinations will be conducted at the Wood County Hospital. The examinations will be conducted by a Sexual Assault Nurse Examiner (SANE). When a SANE is unavailable, other qualified medical practitioner will follow the hospital's Sexual Assault Protocols. Victim advocacy services will be provided by The Cocoon/Wood County Rape Crisis Center. The facility has a Memorandum of Understanding with the victim advocacy agency. There is also a Memorandum of Understanding with the Bowling Green Police Department.

The advocacy services to be provided were confirmed by the Supervisor of The Cocoon/Wood County Rape Crisis Center. In addition to other services, an advocate will accompany the resident during the forensic medical examination and during the investigative interview. Information about reporting allegations and requesting services are posted, provided to the residents and reviewed by staff during PREA education sessions. Victim advocacy services for a resident will be in response to the request of advocacy services by the victim. The advocacy services include but are not limited to the aforementioned accompaniment, emotional support,

crisis intervention, hotline access, and referrals. The community support interview regarding advocacy services was conducted by telephone during the Post Audit Phase.

During the onsite review, facility staff answered questions regarding resident activities and staff duties. The discussions included but were not limited to the intake process; daily activities; treatment services; medical process; staff supervision; alternative methods of communication with parents/guardians during the pandemic; staffing ratios; review of the electronic monitoring system; recreation activities; visitation; and other processes and program services. Residents have access to writing materials as observed and determined from the interviews of residents and staff. PREA information signs are professionally printed in both English and Spanish and posted in common areas accessible to residents, staff, and visitors.

The onsite review revealed that cameras are strategically installed to supplement direct staff supervision. The primary camera monitoring system is located in the central control area which sits among the housing units. Visibility is enhanced with the strategic use of cameras, mirrors and windows in doors. The doors to closets and storage rooms are kept locked. A reasonable amount of privacy is provided to residents when they use the toilet, change clothes and shower; there are no cameras in bathrooms. Sensitive information on computers is password protected. Residents' confinement records were observed to be maintained in a locked, secure manner.

Grievance and medical request forms and locked receptacles for the forms are posted in each housing unit and the multi-purpose room, accessible to all residents. A corrective action was implemented by assigning a designated shift supervisor to routinely check the grievance box on weekends and holidays to ensure they are checked daily in the event an emergency grievance is deposited. Each resident receives a handbook which can be accessed in Spanish and other languages as needed. The posted PREA information is also provided in Spanish.

Investigations

Sexual abuse and sexual harassment allegations that are criminal in nature are investigated by the Bowling Green Police Department. Administrative investigations are conducted by a trained facility-based investigator. All of the reporting information is posted and provided to residents and staff. During the 12 months prior to the audit, there were no allegations of sexual abuse or sexual harassment.

Interviews

The interviews with residents and staff assisted in understanding and confirming the facility's practices. The interviews with residents helped to determine how knowledgeable the residents were about the facility's efforts to keep them safe from sexual abuse and sexual harassment. The responses from the residents and staff during the interviews confirmed that PREA education and training exist in the facility. Thirty-four staff members are currently employed at the facility that may have contact with residents.

A total of 25 residents were in the facility on the day of the site review. Ten residents were interviewed after being randomly selected by the Auditor and after being categorized by the vulnerable categories. Five of the 10 residents provided targeted interviews which considered information regarding the general vulnerabilities and make-up of the population. The

methodology in the PREA Auditor Handbook was utilized for determining and conducting the resident interviews.

A total of 12 random staff members were interviewed covering all shifts. Nine individual specialized staff members were interviewed based on their job duties related to the PREA roles, including three contractors. The number of interview protocols used for specialized staff was 13 due to some staff members being interviewed in more than one specialized role. The Director was interviewed in the roles of Superintendent and Agency Head Designee, in addition to Human Resources, however the interviews in the roles of Superintendent and Agency Head Designee were not counted as specialized staff. The Quality Assurance Coordinator was interviewed in the roles of PREA Coordinator, Intermediate Staff and Retaliation Monitor. The interview in the role of PREA Coordinator was also not counted as specialized staff.

The Director, Quality Assurance Coordinator/PREA Coordinator and other staff ensured all resident and staff interviews were conducted in private and residents were not coerced to participate in the interviews. Management and supervisor virtual interviews were conducted in the privacy of offices which was verified prior to the interviews and during the onsite review. The areas where the virtual interviews were conducted were observed. Some of the staff encountered from the virtual interviews were identified during the onsite review.

Two of the three contractors interviewed provide education services to the residents and the other contractor provides medical services. The Quality Assurance Coordinator/PREA Coordinator and other staff managed the accessibility of staff and residents for the onsite interviews. The Auditor identified the residents and staff for the interviews and collaborated with the Quality Assurance Coordinator/PREA Coordinator to ensure the appropriate samples of interviewees.

All interviews conducted were voluntary by the selected participants and there was no coercion. The interviews with residents and staff assisted significantly in gaining insight regarding processes, duties and responsibilities. None of the interviewees appeared surprised by the interviews with the PREA subject matter and were aware of program operations and zero-tolerance of sexual abuse and sexual harassment.

The following number and types of staff interviews were conducted:

| Category of Staff | Number of Interviews |
|---|---|
| Medical Staff | 1 |
| Mental Health Staff | 1 |
| Administrative (Human Resources) Staff | 1 |
| Intermediate or Higher-level Facility Staff (Unannounced Rounds) | 1 |
| Contractors Who Have Contact with Residents | 3 |
| Staff who Perform Screening for Risk of Victimization and Abusiveness | 1 |
| Staff on the Incident Review Team | 1 |
| Designated Staff Member Charged with Monitoring Retaliation | 1 |

| | |
|---|---|
| Intake Staff | 1 |
| Administrative Investigation Staff | 2 |
| **Category of Staff** | **Total Staff Interviews** |
| Number of Specialized Staff Interviews | 13 |
| Number of Random Staff Interviews | 12 |
| Total Random and Specialized Interviews | 25 |
| Total Interviews: including the Director in the roles of Superintendent and Agency Head Designee; and the Quality Assurance Coordinator in the role of PREA Coordinator. | 28 |

The community support interview was conducted by telephone during the onsite audit phase. The Supervisor with The Cocoon/Wood County Rape Crisis Center confirmed the accessibility of advocacy services to the residents and verified the services outlined in the Memorandum of Understanding. The interviews with the residents revealed their knowledge about The Cocoon/Wood County Rape Crisis Center and services available through the agency. The telephone system was tested and they were in working order and an operator was obtained by following the posted information.

It was learned that The Cocoon/Wood County Rape Crisis Center staff could not report allegations of sexual abuse or sexual harassment without the consent of the resident. A corrective action was implemented by the Quality Assurance/PREA Coordinator and facility Director. The ODYS PREA Administrator assisted in obtaining services from the Ohio Department of Rehabilitation and Correction, an outside resource which is used by ODYS facilities for reporting allegations of sexual abuse and sexual harassment. The Quality Assurance/PREA Coordinator provided training to residents and staff on the identification and purpose of the new reporting agency, updated the resident handbook and facility policy, posted the new information, and facilitated the telephone work for the telephone link to the reporting hotline.

Document Review

The Auditor received documentation for each standard as part of the pre-onsite audit phase data gathering process. Additional documentation was provided as requested until the completion of the audit report. The PREA Pre-Audit Questionnaire, facility policies and procedures and supporting documentation were reviewed by the Auditor and communication was maintained with facility leadership and management staffs and the ODYS PREA Administrator.

The documentation reviewed included but was not limited to policies and procedures; various forms documenting service delivery and activities; vulnerability assessments; PREA education and training materials; training certificates; training and other logs; checklists; evidence of unannounced rounds; coordinated response plan; related written communication; annual staffing plan assessment; written agreements; complaint form; grievance forms; medical request form; staff schedules/staffing plan; personnel records; and organization chart. PREA training/education for staff and residents is cumulatively documented by training logs, sign-in sheets, acknowledgement statements; training materials; certificates; and policies and procedures.

Exit Meeting

An exit meeting was held by the Auditors with the Director, Quality Assurance Coordinator/PREA Coordinator, and ODYS PREA Administrator at the conclusion of the site review. The exit meeting served to review the process and provided the Auditors the opportunity to share notes and observations. The Auditor reviewed additional information required, resulting from the implementation of the corrective action regarding the change in the agency for residents reporting allegations of sexual abuse and sexual harassment. The facility staff was given the opportunity to ask additional questions about the audit process and the implementation of the corrective action. The timelines concerning the delivery of interim and final reports as determined was also discussed by the Auditor.

**Post Site Review Phase**

**Key Processes and Methodology**

A Supervisor of The Cocoon/Rape Crisis Center confirmed advocacy services in a telephone interview. The services were confirmed and include but are not limited to accompaniment during the forensic medical examination and investigative interview, emotional support; and referral services.

The documentation was provided by the Quality Assurance/PREA Coordinator confirming the implementation of the two corrective actions for: 1) Ensuring the checking of the grievance boxes on weekends and holidays. 2) Securing an alternate agency for residents reporting allegations and the related telephone work; training residents and staff on the change; updating the related information in the policy and resident handbook; and posting new information.

The review of documentation, including the information for the corrective actions; observations during the comprehensive site review; and consideration of all interviews verified the standards were met. The final report was concluded and submitted to the ODYS PREA Administrator who will subsequently deliver it to the facility.

## Facility Characteristics

*The auditor's description of the audited facility should include details about the facility type, demographics and size of the inmate, resident or detainee population, numbers and type of staff positions, configuration and layout of the facility, numbers of housing units, description of housing units including any special housing units, a description of programs and services, including food service and recreation. The auditor should describe how these details are relevant to PREA implementation and compliance.*

The Juvenile Residential Center of Northwest Ohio is located in Bowling Green, Ohio and is attached to the Wood County Juvenile Court Center. The building also contains the Wood County Juvenile Detention Center. Access between the residential and detention facilities is through a single secured hallway. The facility serves male juvenile offenders between the ages of 12-18 and has a 42-bed capacity. The following 10 counties make up the facility's catchment area: Defiance; Fulton; Hancock; Henry; Ottawa; Paulding; Putnam; Van Wert; Williams; and

Wood. The facility's Director is accountable to a Judges Governing Board of the which consists of the 10 juvenile court judges from the catchment area.

The facility has been operational since August 1994 and is funded by the Ohio Department of Youth Services. The program is designed to address the risk and needs of juvenile felony offenders in a secure environment near their home communities. Programming has been developed to target risk and needs that have contributed to the actions of the juveniles served. The program provides a variety of Cognitive Behavioral Interventions. These interventions are designed to help residents identify areas in their life that may increase their risk to re-offend and teach solutions to those risky behaviors. Residents are provided the opportunity to learn and practice pro-social skills to use as solutions to avoid risky situations. The facility utilizes a reinforcement system, consequence system, graduated treatment goals, and privilege system to motivate residents to make positive decisions.

Treatment services are provided for residents through a structured program utilizing individual, group and family counseling; reinforcement and consequence system, graduated treatment goals and privileges; learning and practicing pro-social skills; and slowly transitioning back to the community. Residents are assigned to treatment groups. In addition to assigned treatment groups, residents meet weekly on an individual basis with the assigned Counselor. Families are required to participate in on-going family counseling as well as a monthly parent support group geared toward their child's offense.

An individualized treatment plan is developed for each resident. In order to advance through the program, residents are required to meet the objectives of the treatment plan objectives; attend groups related to the assigned treatment track; attend school regularly; and participate in individual and family counseling. At the time of discharge, all residents are reassessed to reflect any decrease in risk factors, as well as to assist the next treatment provider with areas to address.

In addition to specialized treatment, mental health and counseling services, the facility also provides education; library; medical; recreation; and religious programming services. The facility provides opportunities for residents to demonstrate pro-social living through the completion of off grounds and in-house community service work. Twice per week, eligible residents travel with staff to off-site locations and contribute to the community. Once per month, eligible residents, accompanied by staff, help to set up and distribute food for the local food pantry.

The program has a behavior management system which is also used to assist in changing a resident's behavior. The system rewards residents for making good choices. Residents have the opportunity to earn points by demonstrating such behavior and achieving goals. Positive behavior has incentives attached and there are consequences for negative behavior. Progressing up the level system allows the resident to earn increasing privileges and assume increasing levels of responsibility. Residents are also provided the opportunity to learn positive ways of dealing with stressful situations and ultimately transition back to their local communities.

Education services are provided by the Wood County Educational Service Center through an annual agreement with the facility. School is conducted on a year-round basis. The courses

taught include English; Life Skills; Mathematics; Science; Health; US Government; American History; and Social Studies. Residents with Individualized Education Plans (IEPs) are also served; accommodations are provided as indicated by a resident's IEP. The Education Coordinator manages the education program and all teachers are certified through the State of Ohio Board of Education.

Medical services are provided by medical staff onsite through a contract with WellPath Health Care, a correctional medical provider. The medical staff includes three Nurses: a full-time Licensed Practical Nurse; one part-time Licensed Practical Nurse; and a Registered Nurse that is onsite once a week. A physician provides onsite weekly services at the facility and is also on-call. All youth admitted to the facility meet with a Nurse during the intake process and receive an initial health screening. Sick call forms were observed placed on the housing units; there are locked boxes posted for the deposit of the sick call forms. The interviews with the residents indicated they received the initial health screening from a Nurse.

The Director provides oversight to provision of mental health and counseling services; Counselors provide onsite services. Residents are assigned a Counselor that works with them individually, as well as with their parents. Parents are encouraged to attend regular family counseling sessions and the monthly Parent Group. Crisis mental health services are obtained through community providers. The facility also ensures residents maintain ongoing treatment appointments with providers they had prior to being admitted to the facility. Off-site mental health, medical and dental appointments are coordinated by the medical unit.

Direct care staff members are responsible for the daily and direct supervision of residents and manage them during daily activities. The staff to resident ratio was observed to be met in all areas of the facility during the comprehensive site review. The camera monitoring system supports the direct supervision provided by staff and the cameras were observed to be constantly monitored at the staff station. Security mirrors and windows in doors are also used for increased visibility.

The facility is a one-story freestanding structure and contains four housing units; administration area; lobby; medical clinic; three classrooms; multi-purpose room; gymnasium; conference room; and storage areas. The multi-purpose room is used for visitation and group activities. Recreation activities in the gymnasium and on the outside grounds are scheduled in order for the residents in detention and the residential facility to remain separated. Each housing unit has single occupancy rooms and a day room area for group, recreation and leisure activities. Only one resident at a time uses the bathrooms; staff explained the procedures during the onsite review. There is no camera access to the restrooms.

Security on the housing units is assisted with the use of magnetic locking mechanisms on each room door and the access door to the housing unit. These doors are controlled through the use of keys by staff or through an electronic control panel located at the central control area or staff station located in the common area/multi-purpose room. All residents interviewed stated that female staff members announce their presence upon entering the living unit by pressing the

buzzer at the door and may also state their name as they enter. During the onsite review, the buzzer was utilized to inform the youth that females were entering the housing unit.

Residents have the opportunity to communicate with approved family members or others. Telephone calls and visitation are permitted. Residents also have the opportunity to communicate with legal representatives and are allowed to write and receive letters. The interviews and observations during the comprehensive site review and discussions with staff confirmed that residents are afforded access to others through avenues of communication. Third-party reporting information is available and accessible to visitors, residents, contractors, volunteers, and employees through the posting of the hotline numbers and information contained on the facility's website.

There is a host of management, supervisory and support staff who are involved in processes and activities that contribute to the facility operations. Documentation and staff and resident interviews confirmed the provision of the programs and services described. Observations during the site review revealed adequate space for conducting the programs and services described and regular and special visitation. There is also space to accommodate visits and meetings in a private setting, as needed.

## Summary of Audit Findings

*The summary should include the number and list of standards exceeded, number of standards met, and number and list of standards not met.*

***Auditor Note:*** *No standard should be found to be "Not Applicable" or "NA". A compliance determination must be made for each standard.*

## Standards Exceeded

**Number of Standards Exceeded:** 0
**List of Standards Exceeded:** Click or tap here to enter text.

## Standards Met

**Number of Standards Met:** 41

## Standards Not Met

**Number of Standards Not Met:** 0
**List of Standards Not Met:** Click or tap here to enter text.

# PREVENTION PLANNING

## Standard 115.311: Zero Tolerance of Sexual Abuse and Sexual Harassment; PREA Coordinator

**All Yes/No Questions Must Be Answered by the Auditor to Complete the Report**

**115.311 (a)**

- Does the agency have a written policy mandating zero tolerance toward all forms of sexual abuse and sexual harassment? ☒ Yes ☐ No
- Does the written policy outline the agency's approach to preventing, detecting, and responding to sexual abuse and sexual harassment? ☒ Yes ☐ No

**115.311 (b)**

- Has the agency employed or designated an agency-wide PREA Coordinator? ☒ Yes ☐ No
- Is the PREA Coordinator position in the upper-level of the agency hierarchy? ☒ Yes ☐ No
- Does the PREA Coordinator have sufficient time and authority to develop, implement, and oversee agency efforts to comply with the PREA standards in all of its facilities? ☒ Yes ☐ No

**115.311 (c)**

- If this agency operates more than one facility, has each facility designated a PREA compliance manager? (N/A if agency operates only one facility.) ☒ Yes ☐ No ☐ NA
- Does the PREA compliance manager have sufficient time and authority to coordinate the facility's efforts to comply with the PREA standards? (N/A if agency operates only one facility.) ☒ Yes ☐ No ☐ NA

**Auditor Overall Compliance Determination**

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

**Instructions for Overall Compliance Determination Narrative**

*The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.*

**Documents Reviewed:**
Facility Policy 3.10, PREA Rape Elimination (PREA)
Organization Chart
Job Description
Training Certificate

**Interviews:**
Quality Assurance/PREA Coordinator
Director
Random Staff
Residents

**Provision (a):**
An agency shall have a written policy mandating zero tolerance toward all forms of sexual abuse and sexual harassment and outlining the agency's approach to preventing, detecting, and responding to such conduct.

The Policy provides guidance to staff regarding the facility's approach to preventing, detecting, and responding to allegations of sexual abuse and sexual harassment. The Policy mandates appropriate actions that address conduct that violates the zero-tolerance approach regarding all forms of sexual abuse and sexual harassment. Definitions of prohibited behaviors of sexual abuse and sexual harassment are contained in the Policy and includes sanctions for those found to have participated in the prohibited behaviors. The facility also has additional policies which support the PREA standards.

Staff training, resident education, and intake screening assist in detecting sexual abuse and sexual harassment. The identified Policy includes responding to sexual abuse and sexual harassment through prevention; responsive planning; training and education; reporting; investigations; medical and mental care; assessments; disciplinary sanctions for residents and staff; and data collection and review. The interviews confirmed knowledge of the zero-tolerance Policies regarding sexual abuse and sexual harassment.

**Provision (b):**
An agency shall employ or designate an upper-level, agency-wide PREA Coordinator with sufficient time and authority to develop, implement, and oversee agency efforts to comply with the PREA standards in all of its facilities.

The Quality Assurance Coordinator serves as the PREA Coordinator and serves on the facility's management team, answering directly to the facility Director. He has knowledge of the standards and their implementation and the audit processes. The PREA Coordinator collaborates with the ODYS PREA Administrator regarding PREA related issues as needed.

The interviews and observations revealed the Quality Assurance Coordinator's authority to develop, implement and provide oversight of the implementation of the PREA standards and initiatives. The Director and ODYS PREA Administrator lends support in the PREA efforts as determined from interviews, observations, review of documentation and previous interview and continual communication between the Auditor and the Quality Assurance/PREA Coordinator.

**Provision (c):**
Where an agency operates more than one facility, each facility shall designate a PREA Compliance Manager with sufficient time and authority to coordinate the facility's efforts to comply with the PREA standards.

The Quality Assurance Coordinator has been designated as the PREA Coordinator and a PREA Compliance Manager is not required in this situation. The interview indicated he has the time to fulfill the PREA duties and it was determined that he has the authority required to fulfill those duties. Interviews conducted with staff revealed their awareness of the role of the PREA Coordinator. Observations confirmed he has the support of the facility Director, staff, and the ODYS PREA Administrator.

**Conclusion:**
Based upon the review and analysis of the available evidence, interviews, and observations, it was determined there is compliance with this standard.

## Standard 115.312: Contracting with Other Entities for the Confinement of Residents

**All Yes/No Questions Must Be Answered by the Auditor to Complete the Report**

**115.312 (a)**

- If this agency is public and it contracts for the confinement of its residents with private agencies or other entities including other government agencies, has the agency included the entity's obligation to adopt and comply with the PREA standards in any new contract or contract renewal signed on or after August 20, 2012? (N/A if the agency does not contract with private agencies or other entities for the confinement of residents.) ☐ Yes ☐ No ☒ NA

**115.312 (b)**

- Does any new contract or contract renewal signed on or after August 20, 2012 provide for agency contract monitoring to ensure that the contractor is complying with the PREA standards? (N/A if the agency does not contract with private agencies or other entities for the confinement of residents OR the response to 115.312(a)-1 is "NO".) ☐ Yes ☐ No ☒ NA

**Auditor Overall Compliance Determination**

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

**Instructions for Overall Compliance Determination Narrative**

*The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.*

**Document Reviewed:**
Facility Policy 3.10

**Interview:**
Director

**Provision (a) and (b):**
**Provision (a):** A public agency that contracts for the confinement of its residents with private agencies or other entities, including other government agencies, shall include in any new contract or contract renewal the entity's obligation to adopt and comply with the PREA standards.
**Provision (b):** Any new contract or contract renewal shall provide for agency contract monitoring to ensure that the contractor is complying with the PREA standards.

The interview with the Director revealed the facility does not contract with other facilities for the confinement of its residents, as stated in Policy.

**Conclusion:**
Based upon the review and analysis of the available evidence, the Auditor determined compliance with this standard.

## Standard 115.313: Supervision and Monitoring

**All Yes/No Questions Must Be Answered by the Auditor to Complete the Report**

**115.313 (a)**

- Does the agency ensure that each facility has developed a staffing plan that provides for adequate levels of staffing and, where applicable, video monitoring, to protect residents against sexual abuse? ☒ Yes ☐ No

- Does the agency ensure that each facility has implemented a staffing plan that provides for adequate levels of staffing and, where applicable, video monitoring, to protect residents against sexual abuse? ☒ Yes ☐ No

- Does the agency ensure that each facility has documented a staffing plan that provides for adequate levels of staffing and, where applicable, video monitoring, to protect residents against sexual abuse? ☒ Yes ☐ No

- Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: The prevalence of substantiated and unsubstantiated incidents of sexual abuse? ☒ Yes ☐ No

- Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: Generally accepted juvenile detention and correctional/secure residential practices? ☒ Yes ☐ No

- Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: Any judicial findings of inadequacy? ☒ Yes ☐ No

- Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: Any findings of inadequacy from Federal investigative agencies? ☒ Yes ☐ No

- Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: Any findings of inadequacy from internal or external oversight bodies? ☒ Yes ☐ No

- Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: All components of the facility's physical plant (including "blind-spots" or areas where staff or residents may be isolated)? ☒ Yes ☐ No

- Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: The composition of the resident population? ☒ Yes ☐ No

- Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: The number and placement of supervisory staff? ☒ Yes ☐ No

- Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: Institution programs occurring on a particular shift? ☒ Yes ☐ No

- Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: Any applicable State or local laws, regulations, or standards? ☒ Yes ☐ No

- Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: Any other relevant factors? ☒ Yes ☐ No

**115.313 (b)**

- Does the agency comply with the staffing plan except during limited and discrete exigent circumstances? ☒ Yes ☐ No

- In circumstances where the staffing plan is not complied with, does the facility document all deviations from the plan? (N/A if no deviations from staffing plan.) ☐ Yes ☐ No ☒ NA

**115.313 (c)**

- Does the facility maintain staff ratios of a minimum of 1:8 during resident waking hours, except during limited and discrete exigent circumstances? (N/A only until October 1, 2017.) ☒ Yes ☐ No ☐ NA

- Does the facility maintain staff ratios of a minimum of 1:16 during resident sleeping hours, except during limited and discrete exigent circumstances? (N/A only until October 1, 2017.) ☒ Yes ☐ No ☐ NA

- Does the facility fully document any limited and discrete exigent circumstances during which the facility did not maintain staff ratios? (N/A only until October 1, 2017.) ☒ Yes ☐ No ☐ NA

- Does the facility ensure only security staff are included when calculating these ratios? (N/A only until October 1, 2017.) ☒ Yes ☐ No ☐ NA

- Is the facility obligated by law, regulation, or judicial consent decree to maintain the staffing ratios set forth in this paragraph? ☐ Yes ☒ No

**115.313 (d)**

- In the past 12 months, has the facility, in consultation with the agency PREA Compliance Manager, assessed, determined, and documented whether adjustments are needed to: The staffing plan established pursuant to paragraph (a) of this section? ☒ Yes ☐ No

- In the past 12 months, has the facility, in consultation with the agency PREA Compliance Manager, assessed, determined, and documented whether adjustments are needed to: Prevailing staffing patterns? ☒ Yes ☐ No

- In the past 12 months, has the facility, in consultation with the agency PREA Compliance Manager, assessed, determined, and documented whether adjustments are needed to: The facility's deployment of video monitoring systems and other monitoring technologies? ☒ Yes ☐ No

- In the past 12 months, has the facility, in consultation with the agency PREA Compliance Manager, assessed, determined, and documented whether adjustments are needed to: The resources the facility has available to commit to ensure adherence to the staffing plan? ☒ Yes ☐ No

**115.313 (e)**

- Has the facility implemented a policy and practice of having intermediate-level or higher-level supervisors conduct and document unannounced rounds to identify and deter staff sexual abuse and sexual harassment? (N/A for non-secure facilities) ☒ Yes ☐ No ☐ NA

- Is this policy and practice implemented for night shifts as well as day shifts? (N/A for non-secure facilities) ☒ Yes ☐ No ☐ NA

- Does the facility have a policy prohibiting staff from alerting other staff members that these supervisory rounds are occurring, unless such announcement is related to the legitimate operational functions of the facility? (N/A for non-secure facilities) ☒ Yes ☐ No ☐ NA

**Auditor Overall Compliance Determination**

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

**Instructions for Overall Compliance Determination Narrative**

*The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.*

**Documents Reviewed:**
Facility Policy 2.03, Staff to Youth Ratio
Facility Policy 8.09, Juvenile Management and Official Counts
Facility Policy 10.12, Facility Design and Technology
Staffing Plan Assessment
Work Schedules
PREA Unannounced Rounds
Administrative On-Call Schedule
Facility Schematics-Camera Locations
Facility Schematics-Mirror Locations

**Interviews:**
Director
PREA Coordinator

**Provision (a):**
The agency shall ensure that each facility it operates shall develop, implement, and document a staffing plan that provides for adequate levels of staffing, and, where applicable, video monitoring, to protect residents against sexual abuse. In calculating adequate staffing levels and determining the need for video monitoring, facilities shall take into consideration:
(1) Generally accepted juvenile detention and correctional/secure residential practices;
(2) Any judicial findings of inadequacy;
(3) Any findings of inadequacy from Federal investigative agencies;
(4) Any findings of inadequacy from internal or external oversight bodies;
(5) All components of the facility's physical plant (including "blind spots" or areas where staff or residents may be isolated);
(6) The composition of the resident population;
(7) The number and placement of supervisory staff;
(8) Institution programs occurring on a particular shift;
(9) Any applicable State or local laws, regulations, or standards;
(10) The prevalence of substantiated and unsubstantiated incidents of sexual abuse; and
(11) Any other relevant factors.

The Policy and staffing plan incorporate the details for maintaining the staffing ratios and the Policy contains the staffing requirements. The facility's staffing plan, internal controls and management ensure the PREA staffing ratios are maintained during the waking hours and during the sleeping hours. Direct supervision is provided to residents during the daily activities and program services. The number of staff may be adjusted as needed due to program activities, dynamics of population or other relevant factors. Observations during the site review and interviews indicated the PREA staffing ratios are maintained. Any staffing plan adjustments are reviewed by the Director.

The schematics outline the location of all the cameras and mirrors located throughout and outside of the facility. Provisions of the standard are taken into consideration regarding adequate staffing levels as confirmed through the interviews which outline staffing requirements. The work schedules are based on the facility's staffing plan. The interviews revealed collaboration and review of the work schedules on a regular basis. In addition to program activities and special needs of residents, the shift schedules are made regarding the considerations that ensure adequate shift coverage including standard security practices; composition of the resident population; inclement weather; and emergencies.

**Provision (b):**
The agency shall comply with the staffing plan except during limited and discrete exigent circumstances, and shall fully document deviations from the plan during such circumstances.

The facility reports no deviations from the staffing ratios in the past 12 months. The facility is prepared to document any deviations from the staffing plan. A coordinated effort was described in maintaining the required staffing ratios. The operations of the facility provide for appropriate staff coverage to ensure the PREA staffing ratios are maintained. The management staff understands and are prepared to document any deviations from the staffing requirements. The Director and PREA Coordinator monitor the effectiveness of the work schedules based on the staffing plan requirements. The staffing plan, incorporated in Policy, shows the required staffing ratios. The staffing plan provides for the staffing ratios to be met and staffing practices provide for additional staff for days and times when increased staffing is required.

**Provision (c):**
Each secure juvenile facility shall maintain staff ratios of a minimum of 1:8 during resident waking hours and 1:16 during resident sleeping hours, except during limited and discrete exigent circumstances, which shall be fully documented. Only security staff shall be included in these ratios. Any facility that, as of the date of publication of this final rule, is not already obligated by law, regulation, or judicial consent decree to maintain the staffing ratios set forth in this paragraph shall have until October 1, 2017, to achieve compliance.

Staffing ratios for the facility are provided by the direct care staff. The security practices and policies ensure the PREA ratios of 1:8 during the waking hours and 1:16 during the sleeping hours. The Staffing plan contained in the Policy provides for routine and minimum staffing. The minimum staffing ensures that the PREA ratios are met. The ratios were discussed and observed for and met during the site review and review of documentation. Direct care staff members provide direct observation of residents. The average daily population for the last 12 months has been 29. Since the last PREA audit, the average daily number of residents on which the staffing plan was predicated is 42. The facility is not involved in any lawsuits or consent decrees.

**Provision (d):**

Whenever necessary, but no less frequently than once each year, for each facility the agency operates, in consultation with the PREA Compliance Manager required by §115.311, the agency shall assess, determine, and document whether adjustments are needed to:
(1) The staffing plan established pursuant to paragraph (a) of this section;
(2) Prevailing staffing patterns;
(3) The facility's deployment of video monitoring systems and other monitoring technologies; and
(4) The resources the facility has available to commit to ensure adherence to the staffing plan.

The documented assessment was completed by the Director in collaboration with the PREA Coordinator and Assistant Director/Fiscal. The document reviews but is not limited to the following areas: prevailing staffing patterns and review of staffing plan; electronic monitoring system; and review of other areas related to adequate supervision. The review considers any adjustments that need to be made through input from the assisting staff members. The annual assessment documents the summarization of the review including the staffing, physical plant and the electronic monitoring system; no corrective actions were recommended. The assessment was completed on 3/4/2021.

**Provision (e):**
Each secure facility shall implement a policy and practice of having intermediate-level or higher-level supervisors conduct and document unannounced rounds to identify and deter staff sexual abuse and sexual harassment. Such policy and practice shall be implemented for night shifts as well as day shifts. Each secure facility shall have a policy to prohibit staff from alerting other staff members that these supervisory rounds are occurring, unless such announcement is related to the legitimate operational functions of the facility.

Policy provides for the occurrence of unannounced rounds that are conducted by management staff members and supervisors. The documents show the rounds are made at various times. A form is used which records the areas visited and considerations and observations may be included. The interviews and review of documentation and Policy confirmed the unannounced rounds occur.

The staff is not informed of when the rounds will occur and the visits are not conducted at scheduled times in accordance with Policy. The unannounced rounds are conducted throughout the facility to identify and deter sexual abuse and sexual harassment. Staff members are prohibited from alerting other staff when the rounds are occurring. The unannounced rounds are recorded on the dedicated forms. The areas assessed during the unannounced rounds include but are not limited to all housing units; common area; loading dock; gymnasium; classrooms; and outside recreation area; proper routines being followed; proper facility staffing requirements; and appropriate staff positioning. location The facility reports there were no deviations from the staffing plan.

**Conclusion:**
Based upon the review and analysis of the available evidence and the staff interview, the Auditor determined the facility is adhering to this standard.

## Standard 115.315: Limits to Cross-Gender Viewing and Searches

**All Yes/No Questions Must Be Answered by the Auditor to Complete the Report**

**115.315 (a)**

- Does the facility always refrain from conducting any cross-gender strip or cross-gender visual body cavity searches, except in exigent circumstances or by medical practitioners? ☒ Yes ☐ No

**115.315 (b)**

- Does the facility always refrain from conducting cross-gender pat-down searches in non-exigent circumstances? ☒ Yes ☐ No ☐ NA

**115.315 (c)**

- Does the facility document and justify all cross-gender strip searches and cross-gender visual body cavity searches? ☒ Yes ☐ No

- Does the facility document all cross-gender pat-down searches? ☒ Yes ☐ No

**115.315 (d)**

- Does the facility implement policies and procedures that enable residents to shower, perform bodily functions, and change clothing without nonmedical staff of the opposite gender viewing their breasts, buttocks, or genitalia, except in exigent circumstances or when such viewing is incidental to routine cell checks? ☒ Yes ☐ No

- Does the facility require staff of the opposite gender to announce their presence when entering a resident housing unit? ☒ Yes ☐ No

- In facilities (such as group homes) that do not contain discrete housing units, does the facility require staff of the opposite gender to announce their presence when entering an area where residents are likely to be showering, performing bodily functions, or changing clothing? (N/A for facilities with discrete housing units) ☒ Yes ☐ No ☐ NA

**115.315 (e)**

- Does the facility always refrain from searching or physically examining transgender or intersex residents for the sole purpose of determining the resident's genital status? ☒ Yes ☐ No

- If a resident's genital status is unknown, does the facility determine genital status during conversations with the resident, by reviewing medical records, or, if necessary, by learning that information as part of a broader medical examination conducted in private by a medical practitioner? ☒ Yes ☐ No

**115.315 (f)**

- Does the facility/agency train security staff in how to conduct cross-gender pat down searches in a professional and respectful manner, and in the least intrusive manner possible, consistent with security needs? ☒ Yes ☐ No

- Does the facility/agency train security staff in how to conduct searches of transgender and intersex residents in a professional and respectful manner, and in the least intrusive manner possible, consistent with security needs? ☒ Yes ☐ No

**Auditor Overall Compliance Determination**

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

**Instructions for Overall Compliance Determination Narrative**

*The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.*

**Documents Reviewed:**
Facility Policy 7.02, Residential Housing, Showers and Hygiene
Facility Policy 8.14, Resident Searches
Training Curriculum
Acknowledgement Statements
Training Sign-In Sheet
Search Log

**Interviews:**
Random Staff
Residents
PREA Coordinator

**Provision (a):**
The facility shall not conduct cross-gender strip searches or cross-gender visual body cavity searches (meaning a search of the anal or genital opening) except in exigent circumstances or when performed by medical practitioners.

Policy 8.14 prohibits cross-gender strip and visual body cavity searches are prohibited. Cross-gender pat-down searches are not permitted, except in exigent circumstances, with the Director's approval, and they must be documented. Policy and training provide guidance to staff on how the searches are to be conducted. The practice is that cross-gender pat searches are not conducted and supported by the interviews. There is no evidence of cross-gender searches of any type occurring at the facility in the last 12 months. Based on the review of information and according to the interviews, cross-gender searches have not been conducted at the facility during the past 12 months.

**Provision (b):**
The agency shall not conduct cross-gender pat-down searches except in exigent circumstances.

Policy does not support staff conducting cross-gender pat-down searches. All searches must be documented. Responses from staff included that only male staff conduct searches. The training materials show staff receives training on how to conduct searches, including cross gender searches. Staff participation in the training is documented. Staff interviews confirmed awareness of how to conduct searches. No residents or staff interviewed reported the occurrence of any cross-gender searches. The evidence shows cross-gender pat-down searches have not occurred at the facility during the last 12 months.

**Provision (c):**
The facility shall document and justify all cross-gender strip searches, cross-gender visual body cavity searches, and cross-gender pat-down searches.

Cross-gender strip and cross-gender visual body cavity searches are prohibited. Policy provides for documenting the occurrence of searches which are documented on the dedicated log. All interviews confirmed that no cross-gender searches have occurred at the facility during this audit period. Staff members are aware of the requirement to document all searches. There was no evidence of documenting any cross-gender searches.

**Provision (d):**
The facility shall implement policies and procedures that enable residents to shower, perform bodily functions, and change clothing without nonmedical staff of the opposite gender viewing their breasts, buttocks, or genitalia, except in exigent circumstances or when such viewing is incidental to routine cell checks. Such policies and procedures shall require staff of the opposite gender to announce their presence when entering a resident housing unit. In facilities (such as group homes) that do not contain discrete housing units, staff of the opposite gender shall be required to announce their presence when entering an area where residents are likely to be showering, performing bodily functions, or changing clothing.

The shower and use of bathroom protocols are followed and were explained by staff during the onsite review and confirmed during interviews. Residents are able to shower, perform bodily functions, and change clothes without staff of the opposite gender viewing them, supported by Policy and interviews. No residents interviewed reported ever having been naked in full view of the opposite gender staff while showering, changing clothes, or performing bodily functions. It was observed that residents have a reasonable amount of privacy during use of the bathroom. Residents use the bathroom one at a time; a covering is used for the window.

There are signs outside the housing area reminding female staff to ring the doorbell prior to entering. The Auditor observed this practice during the onsite review. The residents stated that female staff ring the doorbell prior to entering the units and some also verbally announce their presence upon entering the housing units. The practice of opposite gender use of the doorbell and announcement was also confirmed by the random staff interviews. The evidence shows residents shower, perform bodily functions, and change clothing without nonmedical staff of the opposite gender viewing their buttocks or genitalia. The staff interviews and observations supported that viewing of the camera monitors does not show residents when they are showering, using the toilet or changing clothes. The bathroom protocols do not allow staff to view of the resident's body. Hygiene practices are performed with the expectations of reasonable privacy for each resident.

**Provision (e):**
The facility shall not search or physically examine a transgender or intersex resident for the sole purpose of determining the resident's genital status. If the resident's genital status is unknown, it may be determined during conversations with the resident, by reviewing medical records, or, if necessary, by

learning that information as part of a broader medical examination conducted in private by a medical practitioner.

Policy 8.14 and staff training prohibit the search of transgender or intersex residents solely for the purpose of determining the resident's genital status. Staff interviews verified no such searches have occurred or would occur at the facility. Staff received the training on conducting searches, including searches of transgender and intersex youth. Staff interviews confirmed they are aware that Policy prohibits staff from conducting a physical examination of transgender or intersex youth solely for the purpose of determining the resident's genital status. When the genital status of a resident is unknown, learning this information would be part of a broader medical examination conducted by a medical practitioner in private which is aligned with Policy. The training and staff interviews support that a transgender or intersex resident may indicate the gender of the staff preferred to conduct the search.

**Provision (f):**
The agency shall train security staff in how to conduct cross-gender pat-down searches, and searches of transgender and intersex residents, in a professional and respectful manner, and in the least intrusive manner possible, consistent with security needs.

The training curriculum for staff provides information on conducting cross-gender pat-down searches and searches of transgender and intersex youth and supported by the staff interviews. Training records, interviews and training materials indicate the provision of search techniques consistent with security needs. The training materials and interviews indicate staff receive the training. No such searches have been conducted during the past 12 months.

**Conclusion:**
Based on the reviewed documentation and interviews, the Auditor determined compliance with this standard.

## Standard 115.316: Residents with Disabilities and Residents Who Are Limited English Proficient

**All Yes/No Questions Must Be Answered by the Auditor to Complete the Report**

**115.316 (a)**

- Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Residents who are deaf or hard of hearing? ☒ Yes ☐ No

- Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Residents who are blind or have low vision? ☒ Yes ☐ No

- Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Residents who have intellectual disabilities? ☒ Yes ☐ No

- Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Residents who have psychiatric disabilities? ☒ Yes ☐ No

- Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Residents who have speech disabilities? ☒ Yes ☐ No

- Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Other? (if "other," please explain in overall determination notes.) ☒ Yes ☐ No

- Do such steps include, when necessary, ensuring effective communication with residents who are deaf or hard of hearing? ☒ Yes ☐ No

- Do such steps include, when necessary, providing access to interpreters who can interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary? ☒ Yes ☐ No

- Does the agency ensure that written materials are provided in formats or through methods that ensure effective communication with residents with disabilities including residents who: Have intellectual disabilities? ☒ Yes ☐ No

- Does the agency ensure that written materials are provided in formats or through methods that ensure effective communication with residents with disabilities including residents who: Have limited reading skills? ☒ Yes ☐ No

- Does the agency ensure that written materials are provided in formats or through methods that ensure effective communication with residents with disabilities including residents who: Are blind or have low vision? ☒ Yes ☐ No

**115.316 (b)**

- Does the agency take reasonable steps to ensure meaningful access to all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment to residents who are limited English proficient? ☒ Yes ☐ No

- Do these steps include providing interpreters who can interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary? ☒ Yes ☐ No

**115.316 (c)**

- Does the agency always refrain from relying on resident interpreters, resident readers, or other types of resident assistants except in limited circumstances where an extended delay in obtaining an effective interpreter could compromise the resident's safety, the performance of

first-response duties under §115.364, or the investigation of the resident's allegations?
☒ Yes ☐ No

**Auditor Overall Compliance Determination**

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

**Instructions for Overall Compliance Determination Narrative**

*The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.*

**Documents Reviewed:**
Facility Policy 7.20, Prohibited Discrimination and Access to Qualified Personnel
Letter Confirming Services
Interpreting and Translation Agreement
Request for Services Form
Resident Handbook, English and Spanish
Posted PREA Information, English and Spanish

**Interviews:**
Residents
Random Staff
PREA Coordinator

**Provision (a):**
The agency shall take appropriate steps to ensure that residents with disabilities (including, for example, residents who are deaf or hard of hearing, those who are blind or have low vision, or those who have intellectual, psychiatric, or speech disabilities), have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment. Such steps shall include, when necessary to ensure effective communication with residents who are deaf or hard of hearing, providing access to interpreters who can interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary. In addition, the agency shall ensure that written materials are provided in formats or through methods that ensure effective communication with residents with disabilities, including residents who have intellectual disabilities, limited reading skills, or who are blind or have low vision. An agency is not required to take actions that it can demonstrate would result in a fundamental alteration in the nature of a service, program, or activity, or in undue financial and administrative burdens, as those terms are used in regulations promulgated under title II of the Americans with Disabilities Act, 28 CFR 35.164.

The Wood County Educational Center will provide services for residents with disabilities, including those who may be blind, have low vision, limited reading skills, or otherwise disabled. A letter signed by the

Superintendent of the Wood County Educational Center confirms the available services. The education staff also provides support services through qualified staff with the educational background to modify/adapt information for all residents to understand. Policy also addresses the provision of support services for Limited English Proficient and disabled residents by ensuring residents 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. Residents are not used as readers or interpreters, confirmed by staff interviews and Policy. Assistance may also be provided by the treatment staff to ensure all residents' understanding of the PREA information. Reporting information is posted on the housing units and in various areas of the facility.

**Provision (b):**
The agency shall take reasonable steps to ensure meaningful access to all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment to residents who are limited English proficient, including steps to provide interpreters who can interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary.

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. PREA information is accessible to residents in English, Spanish and other languages are obtainable where indicated. The facility is capable of providing access to support services for preventing, detecting, and responding to sexual abuse and sexual harassment to residents who are Limited English Proficient, including taking steps to provide interpreters who can interpret effectively, accurately, and impartially. The facility has identified resources for securing language interpreter services. The interpreters are a part of a professional group through Bowling Green State University.

**Provision (c):**
The agency shall not rely on resident interpreters, resident readers, or other types of resident assistants except in limited circumstances where an extended delay in obtaining an effective interpreter could compromise the resident's safety, the performance of first-response duties under §115.364, or the investigation of the resident's allegations.

According to Policy 7.20, resident readers and resident interpreters are not used except in limited circumstances where an extended delay in obtaining an interpreter could compromise a resident's safety; performance of first responder duties; or investigation of allegations of sexual abuse or sexual harassment. The facility documents that there is access to services. The school system, facility mental health staff members, and community resources have the capabilities to provide support services. Information regarding reporting allegations of sexual abuse and sexual harassment is posted and accessible in both English and Spanish. The facility has the resources available to get the PREA information translated and printed in additional languages as needed.

**Conclusion:**
Based upon the review and analysis of the evidence, the Auditor determined the facility is compliant with this standard.

## Standard 115.317: Hiring and Promotion Decisions

**All Yes/No Questions Must Be Answered by the Auditor to Complete the Report**

**115.317 (a)**

- Does the agency prohibit the hiring or promotion of anyone who may have contact with residents who: Has engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility, or other institution (as defined in 42 U.S.C. 1997)? ☒ Yes ☐ No

- Does the agency prohibit the hiring or promotion of anyone who may have contact with residents who: Has been convicted of engaging or attempting to engage in sexual activity in the community facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse? ☒ Yes ☐ No

- Does the agency prohibit the hiring or promotion of anyone who may have contact with residents who: Has been civilly or administratively adjudicated to have engaged in the activity described in the question immediately above? ☒ Yes ☐ No

- Does the agency prohibit the enlistment of services of any contractor who may have contact with residents who: Has engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility, or other institution (as defined in 42 U.S.C. 1997)? ☒ Yes ☐ No

- Does the agency prohibit the enlistment of services of any contractor who may have contact with residents who: Has been convicted of engaging or attempting to engage in sexual activity in the community facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse? ☒ Yes ☐ No

- Does the agency prohibit the enlistment of services of any contractor who may have contact with residents who: Has been civilly or administratively adjudicated to have engaged in the activity described in the question immediately above? ☒ Yes ☐ No

**115.317 (b)**

- Does the agency consider any incidents of sexual harassment in determining whether to hire or promote anyone, or to enlist the services of any contractor, who may have contact with residents? ☒ Yes ☐ No

**115.317 (c)**

- Before hiring new employees, who may have contact with residents, does the agency: Perform a criminal background records check? ☒ Yes ☐ No

- Before hiring new employees, who may have contact with residents, does the agency: Consult any child abuse registry maintained by the State or locality in which the employee would work? ☒ Yes ☐ No

- Before hiring new employees, who may have contact with residents, does the agency: Consistent with Federal, State, and local laws, makes its best efforts to contact all prior institutional employers for information on substantiated allegations of sexual abuse or any resignation during a pending investigation of an allegation of sexual abuse? ☒ Yes ☐ No

**115.317 (d)**

- Does the agency perform a criminal background records check before enlisting the services of any contractor who may have contact with residents? ☒ Yes ☐ No

- Does the agency consult applicable child abuse registries before enlisting the services of any contractor who may have contact with residents? ☒ Yes ☐ No

**115.317 (e)**

- Does the agency either conduct criminal background records checks at least every five years of current employees and contractors who may have contact with residents or have in place a system for otherwise capturing such information for current employees? ☒ Yes ☐ No

**115.317 (f)**

- Does the agency ask all applicants and employees who may have contact with residents directly about previous misconduct described in paragraph (a) of this section in written applications or interviews for hiring or promotions? ☒ Yes ☐ No

- Does the agency ask all applicants and employees who may have contact with residents directly about previous misconduct described in paragraph (a) of this section in any interviews or written self-evaluations conducted as part of reviews of current employees? ☒ Yes ☐ No

- Does the agency impose upon employees a continuing affirmative duty to disclose any such misconduct? ☒ Yes ☐ No

**115.317 (g)**

- Does the agency consider material omissions regarding such misconduct, or the provision of materially false information, grounds for termination? ☒ Yes ☐ No

**115.317 (h)**

- Unless prohibited by law, does the agency provide information on substantiated allegations of sexual abuse or sexual harassment involving a former employee upon receiving a request from an institutional employer for whom such employee has applied to work? (N/A if providing information on substantiated allegations of sexual abuse or sexual harassment involving a former employee is prohibited by law.) ☒ Yes ☐ No ☐ NA

**Auditor Overall Compliance Determination**

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

**Instructions for Overall Compliance Determination Narrative**

*The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.*

**Documents Reviewed:**
Facility Policy 2.01, Recruitment and Hiring
Criminal History Record Checks
Pre-Hire Questions: New Applicant

**Interview:**
Director

**Provision (a) & (f):**
**Provision (a):** The agency shall not hire or promote anyone who may have contact with residents, and shall not enlist the services of any contractor who may have contact with residents, who—
(1) Has engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility, or other institution (as defined in 42 U.S.C. 1997);
(2) Has been convicted of engaging or attempting to engage in sexual activity in the community facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse; or
(3) Has been civilly or administratively adjudicated to have engaged in the activity described in paragraph (a)(2) of this section.
**Provision (f):** The agency shall also ask all applicants and employees who may have contact with residents directly about previous misconduct described in paragraph (a) of this section in written applications or interviews for hiring or promotions and in any interviews or written self-evaluations conducted as part of reviews of current employees. The agency shall also impose upon employees a continuing affirmative duty to disclose any such misconduct.

Policy addresses hiring and other personnel matters, including and not limited to promotion processes and decisions, position descriptions, and background checks, including child abuse registries. The background checks occur initially and every five years thereafter, aligned with Policy. The personnel files include the completed background checks and hiring documents. The background checks include but are not limited to images of fingerprints; national web check; FBI database check; and state and child abuse registry checks. Background checks with accompanying personnel records were reviewed.

Through the screening process, prior to hire and promotion, applicants are asked to verify, the following information which supports the background screening information packet:

- Have engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility, or other institution;
- Have been convicted of engaging or attempting to engage in sexual activity in the community facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse; or,
- Have been civilly or administratively adjudicated to have engaged in the activity described above.

The interview and a review of Policy provide details about the hiring process, completion of background checks, and grounds for termination or disqualification. The forms completed and included in the

personnel files are responsive to the provisions of this standard. All applicants are asked about any prior misconduct involving any sexual activity during the pre-hire process. The documentation, interview and Policy support that the facility does not hire anyone who has engaged in sexual abuse or anyone who has used or attempted to use force in the community to engage in sexual abuse. This documentation is a part of the personnel records and the required information for conducting the background checks.

**Provision (b):**
The agency shall consider any incidents of sexual harassment in determining whether to hire or promote anyone, or to enlist the services of any contractor, who may have contact with residents.

The Policy support that the facility does not hire or promote anyone who has been civilly or administratively adjudicated or have been convicted of engaging in or attempted to engage in sexual activity by any means. The interview was aligned with the standard and the documentation shows the inquiries made during the application and interview processes regarding previous misconduct.

Policy and the interview indicate the facility considers any incidents of sexual harassment in determining whether to hire or promote anyone, or to enlist the services of any contractor or volunteer, who may have contact with residents. No applicant will be considered for employment if a background check reveals any history of inappropriate sexual behavior or arrest for inappropriate sexual behavior.

**Provisions (c) & (d):**
**Provision (c):** Before hiring new employees, who may have contact with residents, the agency shall:
(1) Perform a criminal background records check;
(2) Consult any child abuse registry maintained by the State or locality in which the employee would work; and
(3) Consistent with Federal, State, and local law, make its best efforts to contact all prior institutional employers for information on substantiated allegations of sexual abuse or any resignation during a pending investigation of an allegation of sexual abuse.
**Provision (d):** The agency shall also perform a criminal background records check, and consult applicable child abuse registries, before enlisting the services of any contractor who may have contact with residents.

The background check process includes consulting a child abuse registry as confirmed during the interview. The prospective employee or contractor has to be cleared through the regular background check and the inquiries through the child abuse registry. Best efforts would be made to identify information of incidents or allegations of sexual abuse by a prospective employee. A review of personnel records and the interview confirmed the facility considers any incidents of sexual abuse or sexual harassment in determining whether to hire a person, contract for services, or whether to promote an employee

**Provision (e):**
The agency shall either conduct criminal background records checks at least every five years of current employees and contractors who may have contact with residents or have in place a system for otherwise capturing such information for current employees.

Initial background checks are conducted and are conducted every five years thereafter, in accordance with Policy. The interview, review of documentation and a review of the Policy provides guidance about the hiring process, completion of background checks, and the grounds for termination in accordance with the PREA standard.

**Provision (g):**

Material omissions regarding such misconduct, or the provision of materially false information, shall be grounds for termination.

Policy and the interview support that the omission of sexual misconduct information or providing false information is grounds for termination. The facility imposes upon employees the continuing affirmative duty to disclose any such misconduct.

**Provision (h):**
Unless prohibited by law, the agency shall provide information on substantiated allegations of sexual abuse or sexual harassment involving a former employee upon receiving a request from an institutional employer for whom such employee has applied to work.

A review of Policy and the interview revealed that when a former employee applies for work at another institution, upon the request from that institution, the facility provides all relevant information regarding substantiated allegations of sexual abuse as requested and where appropriate, unless prohibited by law.

**Conclusion:**
Based upon the review and analysis of the available evidence, the Auditor has determined the facility meets the provisions of the standard.

## Standard 115.318: Upgrades to Facilities and Technologies

**All Yes/No Questions Must Be Answered by the Auditor to Complete the Report**

**115.318 (a)**

- If the agency designed or acquired any new facility or planned any substantial expansion or modification of existing facilities, did the agency consider the effect of the design, acquisition, expansion, or modification upon the agency's ability to protect residents from sexual abuse? (N/A if agency/facility has not acquired a new facility or made a substantial expansion to existing facilities since August 20, 2012, or since the last PREA audit, whichever is later.)
  ☐ Yes ☐ No ☒ NA

**115.318 (b)**

- If the agency installed or updated a video monitoring system, electronic surveillance system, or other monitoring technology, did the agency consider how such technology may enhance the agency's ability to protect residents from sexual abuse? (N/A if agency/facility has not installed or updated a video monitoring system, electronic surveillance system, or other monitoring technology since August 20, 2012, or since the last PREA audit, whichever is later.)
  ☐ Yes ☐ No ☒ NA

**Auditor Overall Compliance Determination**

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

**Instructions for Overall Compliance Determination Narrative**

*The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.*

**Document Reviewed:**
Facility Policy 10.12, Facility Design and Technology

**Interview:**
Director

**Provision (a):**
If the agency designed or acquired any new facility or planned any substantial expansion or modification of existing facilities, did the agency consider the effect of the design, acquisition, expansion, or modification upon the agency's ability to protect residents from sexual abuse?

The Policy requires for the consideration of this provision; however, there have not been any major renovations since the last PREA audit.

**Provision (b):**
If the agency installed or updated a video monitoring system, electronic surveillance system, or other monitoring technology, the agency considered how such technology may enhance the agency's ability to protect residents from sexual abuse.

The Policy requires for the consideration of this provision. The camera system continues to supplement direct supervision provided to residents by staff. The system has not received an update since the last PREA audit.

# RESPONSIVE PLANNING

## Standard 115.321: Evidence Protocol and Forensic Medical Examinations

**All Yes/No Questions Must Be Answered by the Auditor to Complete the Report**

**115.321 (a)**

- If the agency is responsible for investigating allegations of sexual abuse, does the agency follow a uniform evidence protocol that maximizes the potential for obtaining usable physical evidence for administrative proceedings and criminal prosecutions? (N/A if the agency/facility is not

responsible for conducting any form of criminal OR administrative sexual abuse investigations.)
☒ Yes ☐ No ☐ NA

**115.321 (b)**

- Is this protocol developmentally appropriate for youth where applicable? (N/A if the agency/facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations.) ☒ Yes ☐ No ☐ NA

- Is this protocol, as appropriate, adapted from or otherwise based on the most recent edition of the U.S. Department of Justice's Office on Violence Against Women publication, "A National Protocol for Sexual Assault Medical Forensic Examinations, Adults/Adolescents," or similarly comprehensive and authoritative protocols developed after 2011? (N/A if the agency/facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations.) ☒ Yes ☐ No ☐ NA

**115.321 (c)**

- Does the agency offer all residents who experience sexual abuse access to forensic medical examinations, whether on-site or at an outside facility, without financial cost, where evidentiarily or medically appropriate? ☒ Yes ☐ No

- Are such examinations performed by Sexual Assault Forensic Examiners (SAFEs) or Sexual Assault Nurse Examiners (SANEs) where possible? ☒ Yes ☐ No

- If SAFEs or SANEs cannot be made available, is the examination performed by other qualified medical practitioners (they must have been specifically trained to conduct sexual assault forensic exams)? ☒ Yes ☐ No

- Has the agency documented its efforts to provide SAFEs or SANEs? ☒ Yes ☐ No

**115.321 (d)**

- Does the agency attempt to make available to the victim a victim advocate from a rape crisis center? ☒ Yes ☐ No

- If a rape crisis center is not available to provide victim advocate services, does the agency make available to provide these services a qualified staff member from a community-based organization, or a qualified agency staff member? ☒ Yes ☐ No

- Has the agency documented its efforts to secure services from rape crisis centers?
☒ Yes ☐ No

**115.321 (e)**

- As requested by the victim, does the victim advocate, qualified agency staff member, or qualified community-based organization staff member accompany and support the victim through the forensic medical examination process and investigatory interviews? ☒ Yes ☐ No

- As requested by the victim, does this person provide emotional support, crisis intervention, information, and referrals? ☒ Yes ☐ No

**115.321 (f)**

- If the agency itself is not responsible for investigating allegations of sexual abuse, has the agency requested that the investigating entity follow the requirements of paragraphs (a) through (e) of this section? (N/A if the agency/facility is responsible for conducting criminal AND administrative sexual abuse investigations.) ☒ Yes ☐ No ☐ NA

**115.321 (g)**

- Auditor is not required to audit this provision.

**115.321 (h)**

- If the agency uses a qualified agency staff member or a qualified community-based staff member for the purposes of this section, has the individual been screened for appropriateness to serve in this role and received education concerning sexual assault and forensic examination issues in general? (Check N/A if agency attempts to make a victim advocate from a rape crisis center available to victims per 115.321(d) above.) ☐ Yes ☐ No ☒ NA

**Auditor Overall Compliance Determination**

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

**Instructions for Overall Compliance Determination Narrative**

*The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.*

**Documents Reviewed:**
Facility Policy 3.13, Evidence Protocol and Forensic Medical Examination
Wood County Hospital Sexual Assault Policy
Ohio Protocol for Sexual Assault/Forensic and Medical Examination
Wood County Protocols
Memorandum of Understanding (MOU), The Cocoon/Wood County Rape Crisis Center

**Interviews:**
Random Staff

Nurse
Director
PREA Coordinator
Intake Coordinator (Investigative Staff)
Counselor (Investigative Staff)

**Provisions (a) & (b):**
**Provision (a):** To the extent the agency is responsible for investigating allegations of sexual abuse, the agency shall follow a uniform evidence protocol that maximizes the potential for obtaining usable physical evidence for administrative proceedings and criminal prosecutions.
**Provision (b):** The protocol shall be developmentally appropriate for youth and, as appropriate, shall be adapted from or otherwise based on the most recent edition of the U.S. Department of Justice's Office on Violence Against Women publication, "A National Protocol for Sexual Assault Medical Forensic Examinations, Adults/Adolescents," or similarly comprehensive and authoritative protocols developed after 2011.

Policy 3.13 provides for the uniform Wood County Protocols to be followed. Administrative investigations are investigated by a facility-based investigator. Allegations that are criminal in nature are investigated by the Bowling Green Police Division. All allegations of sexual abuse are also reported to Wood County child welfare agency. The Policy will be followed regarding investigations of sexual abuse in accordance with the standard as supported by Policy and the interview with the investigative staff. The interviews with random staff and the investigative staff confirmed awareness of protocol for maintaining usable physical evidence and knowledge of the entities responsible for conducting investigations. The facility has six staff members identified as investigators. The Wood County protocols for investigations are appropriate for youth and followed by the Bowling Green Police Division. The facility has a Memorandum of Understanding with the Wood County Police Division. The hospital has protocols appropriate for adolescents and adults.

**Provision (c):**
The agency shall offer all residents who experience sexual abuse access to forensic medical examinations whether on-site or at an outside facility, without financial cost, where evidentiarily or medically appropriate. Such examinations shall be performed by Sexual Assault Forensic Examiners (SAFEs) or Sexual Assault Nurse Examiners (SANEs) where possible. If SAFEs or SANEs cannot be made available, the examination can be performed by other qualified medical practitioners. The agency shall document its efforts to provide SAFEs or SANEs.

The Policy states forensic medical examinations will be conducted at Wood County Hospital that employs Sexual Assault Nurse Examiners (SANE) and Sexual Assault Forensic Examiners (SAFE). The hospital's policy states that the medical forensic examination will be conducted by a SANE or SAFE. The Nurse's interview was aligned with the policies. Continuity of care will be provided at the facility to include medical and mental health follow-up services. Forensic examinations will be provided at no cost to the victim. No forensic medical examinations were conducted during this audit period. Information regarding advocacy services is posted in each housing unit and common area of the facility, accessible to residents, staff and visitors.

**Provisions (d) & (e):**
**Provision (d):** The agency shall attempt to make available to the victim a victim advocate from a rape crisis center. If a rape crisis center is not available to provide victim advocate services, the agency shall make available to provide these services a qualified staff member from a community-based organization

or a qualified agency staff member. Agencies shall document efforts to secure services from rape crisis centers. For the purpose of this standard, a rape crisis center refers to an entity that provides intervention and related assistance, such as the services specified in 42 U.S.C. 14043g(b)(2)(C), to victims of sexual assault of all ages. The agency may utilize a rape crisis center that is part of a governmental unit as long as the center is not part of the criminal justice system (such as a law enforcement agency) and offers a comparable level of confidentiality as a nongovernmental entity that provides similar victim services.
**Provision (e):** As requested by the victim, the victim advocate, qualified agency staff member, or qualified community-based organization staff member shall accompany and support the victim through the forensic medical examination process and investigatory interviews and shall provide emotional support, crisis intervention, information, and referrals.

Victim advocacy services have been arranged and outlined in a Memorandum of Understanding between the facility and the agency, The Cocoon/Wood County Rape Crisis Center. The advocacy agency provides a range of advocacy services including for survivors of sexual assault. The advocacy agency follows all applicable laws and regulations with respect to confidentiality.

The victim advocacy services include but are not limited to the following:

- 24-hour hotline;
- Access to Information and Resources;
- Referrals;
- Crisis Intervention;
- Accompaniment services;
- Follow-up support services; and
- Emotional Support

Information regarding victim advocacy services is initially provided to the residents during the intake process and is provided through the accessibility of posted information and refresher education sessions. Victim advocacy services are provided at no cost to the victim. Auxiliary aids, interpreter/language services and accommodations due to a disability will be provided as needed and also at no cost to the victim. The interviews confirmed the residents are able to utilize the hotline to request advocacy services.

**Provisions (f) & (g):**
**Provision (f):** To the extent the agency itself is not responsible for investigating allegations of sexual abuse, the agency shall request that the investigating agency follow the requirements of paragraphs (a) through (f) of this section.
**Provision (g):** The requirements of paragraphs (a) through (f) of this section shall also apply to:
(1) Any State entity outside of the agency that is responsible for investigating allegations of sexual abuse in juvenile facilities; and
(2) Any Department of Justice component that is responsible for investigating allegations of sexual abuse in juvenile facilities.

A facility-based investigator will conduct administrative investigations in accordance with agency Policy, and the protocols which are aligned with the PREA Standard. Investigations of allegations of sexual abuse or sexual harassment that are criminal in nature are investigated by the Bowling Green Police Division which will follow the Wood County Protocol, adapted from the Ohio Protocol of Sexual Assault/Forensic and Medical Examination.

**Provision (h):**

For the purposes of this standard, a qualified agency staff member or a qualified community-based staff member shall be an individual who has been screened for appropriateness to serve in this role and has received education concerning sexual assault and forensic examination issues in general.

The facility has made arrangements for victim advocacy services with The Cocoon/Wood County Rape crisis center confirmed through the interviews and written agreement. The advocacy services were also confirmed by a supervisor at The Cocoon. The background and training of some treatment staff provide them with familiarity of general sexual assault and forensic examination issues and they may be of service to a resident as an advocate if needed.

**Conclusion:**
Based upon the review and analysis of the available evidence, the Auditor determined the facility is in compliance with the provisions of this standard.

## Standard 115.322: Policies to Ensure Referrals of Allegations for Investigations

**All Yes/No Questions Must Be Answered by the Auditor to Complete the Report**

**115.322 (a)**

- Does the agency ensure an administrative or criminal investigation is completed for all allegations of sexual abuse? ☒ Yes ☐ No

- Does the agency ensure an administrative or criminal investigation is completed for all allegations of sexual harassment? ☒ Yes ☐ No

**115.322 (b)**

- Does the agency have a policy and practice in place to ensure that allegations of sexual abuse or sexual harassment are referred for investigation to an agency with the legal authority to conduct criminal investigations, unless the allegation does not involve potentially criminal behavior? ☒ Yes ☐ No

- Has the agency published such policy on its website or, if it does not have one, made the policy available through other means? ☒ Yes ☐ No

- Does the agency document all such referrals? ☒ Yes ☐ No

**115.322 (c)**

- If a separate entity is responsible for conducting criminal investigations, does such publication describe the responsibilities of both the agency and the investigating entity? [N/A if the agency/facility is responsible for criminal investigations. See 115.321(a).]
  ☒ Yes ☐ No ☐ NA

**115.322 (d)**

- Auditor is not required to audit this provision.

**115.322 (e)**

- Auditor is not required to audit this provision.

**Auditor Overall Compliance Determination**

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

**Instructions for Overall Compliance Determination Narrative**

*The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.*

**Documents Reviewed:**
Facility Policy 3.11, PREA: Coordinated Response
Memorandum of Understanding, Bowling Green Police Division
Letter of Information, Chief of Police
Investigation Reports
Website

**Interviews:**
Director
Random Staff
PREA Coordinator
Investigative Staff

**Provision (a):**
The agency shall ensure that an administrative or criminal investigation is completed for all allegations of sexual abuse and sexual harassment.

Policies provide that staff report all allegations of sexual abuse and sexual harassment and to document reports; staff members are aware of the requirements. Sexual abuse and sexual harassment allegations that are criminal in nature are referred to the Bowling Green Police Division and a letter from the Police Chief provides information regarding the investigations and training and background of the investigators. Policies and interviews provide for investigations of all allegations of sexual abuse and sexual harassment. Administrative investigations are conducted by a facility-based investigator. The facility reports and a review of documentation revealed no allegations of resident-on-resident sexual abuse or sexual harassment during this audit period.

**Provision (b) and (c):**

**Provision (b):** The agency shall have in place a policy to ensure that allegations of sexual abuse or sexual harassment are referred for investigation to an agency with the legal authority to conduct criminal investigations, unless the allegation does not involve potentially criminal behavior. The agency shall publish such policy on its website or, if it does not have one, make the policy available through other means. The agency shall document all such referrals.
**Provision (c):** If a separate entity is responsible for conducting criminal investigations, such publication shall describe the responsibilities of both the agency and the investigating entity.

Policy and reporting information are located on the facility's website and information is posted within the facility and accessible to the public. Policies, documents and interviews confirmed allegations of sexual abuse and sexual harassment will be investigated. Administrative investigations are conducted by trained investigators within the facility. Allegations of sexual abuse and sexual harassment that are criminal in nature are referred to law enforcement, which is confirmed by the MOU with the Wood County Police Division and letter from the Police Chief. Allegations are also reported to the Wood County child welfare agency.

**Provision (d):**
Any State entity responsible for conducting administrative or criminal investigations of sexual abuse or sexual harassment in juvenile facilities shall have in place a policy governing the conduct of such investigations.

Policy and training provide guidance governing investigations. The facility and law enforcement agency utilize trained investigators. The interview with two investigators and documentation confirm that all investigations are conducted by a trained investigator.

**Provision (e):**
Any Department of Justice component responsible for conducting administrative or criminal investigations of sexual abuse or sexual harassment in juvenile facilities shall have in place a policy governing the conduct of such investigations.

The Department of Justice is not responsible for conducting administrative or criminal investigations of sexual abuse or sexual harassment in this facility.

**Conclusion:**
Based upon the review and analysis of the available evidence, the Auditor determined the facility is compliant with this standard.

# TRAINING AND EDUCATION

## Standard 115.331: Employee Training

**All Yes/No Questions Must Be Answered by the Auditor to Complete the Report**

**115.331 (a)**

- Does the agency train all employees who may have contact with residents on: Its zero-tolerance policy for sexual abuse and sexual harassment? ☒ Yes ☐ No

- Does the agency train all employees who may have contact with residents on: How to fulfill their responsibilities under agency sexual abuse and sexual harassment prevention, detection, reporting, and response policies and procedures? ☒ Yes ☐ No
- Does the agency train all employees who may have contact with residents on: Residents' right to be free from sexual abuse and sexual harassment ☒ Yes ☐ No

- Does the agency train all employees who may have contact with residents on: The right of residents and employees to be free from retaliation for reporting sexual abuse and sexual harassment? ☒ Yes ☐ No

- Does the agency train all employees who may have contact with residents on: The dynamics of sexual abuse and sexual harassment in juvenile facilities? ☒ Yes ☐ No

- Does the agency train all employees who may have contact with residents on: The common reactions of juvenile victims of sexual abuse and sexual harassment? ☒ Yes ☐ No

- Does the agency train all employees who may have contact with residents on: How to detect and respond to signs of threatened and actual sexual abuse and how to distinguish between consensual sexual contact and sexual abuse between residents? ☒ Yes ☐ No

- Does the agency train all employees who may have contact with residents on: How to avoid inappropriate relationships with residents? ☒ Yes ☐ No

- Does the agency train all employees who may have contact with residents on: How to communicate effectively and professionally with residents, including lesbian, gay, bisexual, transgender, intersex, or gender nonconforming residents? ☒ Yes ☐ No

- Does the agency train all employees who may have contact with residents on: How to comply with relevant laws related to mandatory reporting of sexual abuse to outside authorities? ☒ Yes ☐ No

- Does the agency train all employees who may have contact with residents on: Relevant laws regarding the applicable age of consent? ☒ Yes ☐ No

**115.331 (b)**

- Is such training tailored to the unique needs and attributes of residents of juvenile facilities? ☒ Yes ☐ No

- Is such training tailored to the gender of the residents at the employee's facility? ☒ Yes ☐ No

- Have employees received additional training if reassigned from a facility that houses only male residents to a facility that houses only female residents, or vice versa? ☒ Yes ☐ No

**115.331 (c)**

- Have all current employees who may have contact with residents received such training? ☒ Yes ☐ No

- Does the agency provide each employee with refresher training every two years to ensure that all employees know the agency's current sexual abuse and sexual harassment policies and procedures? ☒ Yes ☐ No

- In years in which an employee does not receive refresher training, does the agency provide refresher information on current sexual abuse and sexual harassment policies? ☒ Yes ☐ No

**115.331 (d)**

- Does the agency document, through employee signature or electronic verification that employees understand the training they have received? ☒ Yes ☐ No

**Auditor Overall Compliance Determination**

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

**Instructions for Overall Compliance Determination Narrative**
*The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.*

**Documents Reviewed:**
Facility Policy 2.08-1, Training and Staff Development
Acknowledgement Statements
Sign-In Sheets
Training Log

**Interviews:**
Random Staff
PREA Coordinator

**Provisions (a) and (c):**
**Provision (a):** The agency shall train all employees who may have contact with residents on:
(1) Its zero-tolerance policy for sexual abuse and sexual harassment;
(2) How to fulfill their responsibilities under agency sexual abuse and sexual harassment prevention, detection, reporting, and response policies and procedures;
(3) Residents' right to be free from sexual abuse and sexual harassment;
(4) The right of residents and employees to be free from retaliation for reporting sexual abuse and sexual harassment;

(5) The dynamics of sexual abuse and sexual harassment in juvenile facilities;
(6) The common reactions of juvenile victims of sexual abuse and sexual harassment;
(7) How to detect and respond to signs of threatened and actual sexual abuse and how to distinguish between consensual sexual contact and sexual abuse between residents;
(8) How to avoid inappropriate relationships with residents;
(9) How to communicate effectively and professionally with residents, including lesbian, gay, bisexual, transgender, intersex, or gender nonconforming residents; and
(10) How to comply with relevant laws related to mandatory reporting of sexual abuse to outside authorities;
(11) Relevant laws regarding the applicable age of consent.
**Provision (c):** All current employees who have not received such training shall be trained within one year of the effective date of the PREA standards, and the agency shall provide each employee with refresher training every two years to ensure that all employees know the agency's current sexual abuse and sexual harassment policies and procedures. In years in which an employee does not receive refresher training, the agency shall provide refresher information on current sexual abuse and sexual harassment policies.

The Policy addresses PREA related training for staff which is provided initially upon employment and annually. Interviewed staff members were familiar with the PREA information and tenets of the training. PREA training is provided to staff, as indicated by a review of facility Policy, training documents and interviews. The facility reports 34 staff members that may have contact with residents were trained or re-trained on the PREA requirements.

**Provision (b):**
Such training shall be tailored to the unique needs and attributes of residents of juvenile facilities and to the gender of the residents at the employee's facility. The employee shall receive additional training if the employee is reassigned from a facility that houses only male residents to a facility that houses only female residents, or vice versa.

The facility houses males and staff training does consider the needs of the population served. The training is tailored to the needs and attributes of the population served. All staff within the facility are provided PREA training. Policy states the training shall be tailored to the needs and attributes to the population served.

**Provision (d):**
The agency shall document, through employee signature or electronic verification that employees understand the training they have received.

The PREA training received is documented electronically; sign-in sheets; training logs; certificates; acknowledgement statements; and verified through staff interviews.

**Conclusion:**
Based upon the review and analysis of the available evidence, the Auditor determined the facility is in compliance with the standard.

## Standard 115.332: Volunteer and Contractor Training

**All Yes/No Questions Must Be Answered by the Auditor to Complete the Report**

**115.332 (a)**

- Has the agency ensured that all volunteers and contractors who have contact with residents have been trained on their responsibilities under the agency's sexual abuse and sexual harassment prevention, detection, and response policies and procedures? ☒ Yes ☐ No

**115.332 (b)**

- Have all volunteers and contractors who have contact with residents been notified of the agency's zero-tolerance policy regarding sexual abuse and sexual harassment and informed how to report such incidents (the level and type of training provided to volunteers and contractors shall be based on the services they provide and level of contact they have with residents)? ☒ Yes ☐ No

**115.332 (c)**

- Does the agency maintain documentation confirming that volunteers and contractors understand the training they have received? ☒ Yes ☐ No

**Auditor Overall Compliance Determination**

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

**Instructions for Overall Compliance Determination Narrative**

*The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.*

**Documents Reviewed:**
Facility Policy 2.11-1, Volunteer and Contractor Training
Training Curriculum
Sign-In Sheets
Acknowledgement Statements
Training Curriculum

**Interviews:**
Contractors (3)
PREA Coordinator

**Provision (a):**
The agency shall ensure that all volunteers and contractors who have contact with residents have been trained on their responsibilities under the agency's sexual abuse and sexual harassment prevention, detection, and response policies and procedures.

Volunteers and contractors who have contact with residents must be trained on PREA and their responsibilities regarding sexual assault prevention, detection, and response to allegations of sexual abuse and sexual harassment. A review of documents, training curriculum, interviews and observation confirm the training occurs. The training curriculum includes but is not limited to information in the following areas: reporting allegations of sexual abuse and sexual harassment; related definitions; dynamics of sexual abuse; detecting sexual abuse and sexual harassment; and maintaining professional relationships with residents. There are no volunteers providing services in the facility during this time due to COVID 19 concerns.

**Provision (b):**
The level and type of training provided to volunteers and contractors shall be based on the services they provide and level of contact they have with residents, but all volunteers and contractors who have contact with residents shall be notified of the agency's zero-tolerance policy regarding sexual abuse and sexual harassment and informed how to report such incidents.

The interviews and review of documentation revealed the PREA training informs the participants of their role in reporting allegations of sexual abuse and sexual harassment. The participants are informed of their responsibilities, including but not limited to sexual abuse prevention; zero-tolerance; resident rights; inappropriate relationships; and response to an allegation of sexual abuse or sexual harassment. The training is relative to the services provided by the participants.

The interviews with the contractors revealed their familiarity with the zero-tolerance policy regarding sexual abuse and sexual harassment of residents, including how to report. The interviews confirmed that the review of the zero-tolerance policy for the facility and agency is included in the PREA training along with other subject matter. The contractors interviewed provide education and medical services to the residents. There were no volunteers providing services within the facility during the time of the PREA audit

**Provision (c):**
The agency shall maintain documentation confirming that volunteers and contractors understand the training they have received.

The training documentation, including acknowledgement statements, and interviews confirmed the receipt and awareness of PREA training by the contractors and accessibility by volunteers when applicable. The interviews indicated the contractors understand the training received.

**Conclusion:**
Based upon the review and analysis of the available evidence, the Auditor determined the facility is compliant with the provisions of this standard.

## Standard 115.333: Resident Education

**All Yes/No Questions Must Be Answered by the Auditor to Complete the Report**

**115.333 (a)**

- During intake, do residents receive information explaining the agency's zero-tolerance policy regarding sexual abuse and sexual harassment? ☒ Yes ☐ No

- During intake, do residents receive information explaining how to report incidents or suspicions of sexual abuse or sexual harassment? ☒ Yes ☐ No

- Is this information presented in an age-appropriate fashion? ☒ Yes ☐ No

**115.333 (b)**

- Within 10 days of intake, does the agency provide age-appropriate comprehensive education to residents either in person or through video regarding: Their rights to be free from sexual abuse and sexual harassment? ☒ Yes ☐ No

- Within 10 days of intake, does the agency provide age-appropriate comprehensive education to residents either in person or through video regarding: Their rights to be free from retaliation for reporting such incidents? ☒ Yes ☐ No

- Within 10 days of intake, does the agency provide age-appropriate comprehensive education to residents either in person or through video regarding: Agency policies and procedures for responding to such incidents? ☒ Yes ☐ No

**115.333 (c)**

- Have all residents received such education? ☒ Yes ☐ No

- Do residents receive education upon transfer to a different facility to the extent that the policies and procedures of the resident's new facility differ from those of the previous facility? ☒ Yes ☐ No

**115.333 (d)**

- Does the agency provide resident education in formats accessible to all residents including those who: Are limited English proficient? ☒ Yes ☐ No

- Does the agency provide resident education in formats accessible to all residents including those who: Are deaf? ☒ Yes ☐ No

- Does the agency provide resident education in formats accessible to all residents including those who: Are visually impaired? ☒ Yes ☐ No

- Does the agency provide resident education in formats accessible to all residents including those who: Are otherwise disabled? ☒ Yes ☐ No

- Does the agency provide resident education in formats accessible to all residents including those who: Have limited reading skills? ☒ Yes ☐ No

**115.333 (e)**

- Does the agency maintain documentation of resident participation in these education sessions? ☒ Yes ☐ No

**115.333 (f)**

- In addition to providing such education, does the agency ensure that key information is continuously and readily available or visible to residents through posters, resident handbooks, or other written formats? ☒ Yes ☐ No

**Auditor Overall Compliance Determination**

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

**Instructions for Overall Compliance Determination Narrative**

*The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.*

**Documents Reviewed:**
Facility Policy 3.12-1, Resident PREA Education
PREA Pamphlets
Acknowledgement Statements
Resident Handbook
Posted Information
Orientation Group Schedule
Memorandum of Understanding, Wood County Education Service Center
Memorandum of Understanding, Bowling Green State University

**Interviews:**
Intake Coordinator
Residents
PREA Coordinator

**Provisions (a) and (b):**
**Provision (a):** During the intake process, residents shall receive information explaining, in an age-appropriate fashion, the agency's zero tolerance policy regarding sexual abuse and sexual harassment and how to report incidents or suspicions of sexual abuse or sexual harassment.
**Provision (b):** Within 10 days of intake, the agency shall provide comprehensive age-appropriate education to residents either in person or through video regarding their rights to be free from sexual abuse and sexual harassment and to be free from retaliation for reporting such incidents, and regarding agency policies and procedures for responding to such incidents.

Policy provides that all residents admitted receive PREA education. Residents receive directions on how to report allegations of sexual abuse and sexual harassment; and the right to be free from retaliation for

reporting, according to the documentation and interviews. A review of the education materials indicated the information provided to the residents is age-appropriate. PREA refresher education sessions are conducted periodically in group sessions whenever residents have questions or staff deems a review of PREA information is warranted.

The residents sign acknowledgement statements which represent receipt of the PREA information provided. The interviews with the residents revealed their understanding of the information covered in the PREA education sessions. The initial PREA education is generally conducted on the first day of admission to the facility. The interviews with the residents and Policy revealed that the PREA education sessions are conducted by the Intake Coordinator.

The PREA education packet provided to youth contains an information sheet about advocacy services and a brochure. PREA information, including how to report, is also contained in the resident handbook which is reviewed with the youth. The brochure defines PREA, explains sexual assault; provides information regarding avoiding an attack; what to do if sexually assaulted; provides safety tips; and other helpful related information. A part of PREA education includes information about third-party reporting.

Although reporting information is posted, as well as contact information for requesting advocacy services, the printed information is also manually provided to the youth. Policy provides that residents receive a comprehensive age-appropriate PREA education session within 10 days of admission to the facility. After the intake process, the assigned Counselor will provide additional PREA information once the youth are placed in their assigned unit.

**Provision (c):**
Current residents who have not received such education shall be educated within one year of the effective date of the PREA standards, and shall receive education upon transfer to a different facility to the extent that the policies and procedures of the resident's new facility differ from those of the previous facility.

Based on the evidence shown documenting the PREA education sessions in Provisions (a) and (b), including interviews, residents received PREA education. The facility reports that all youth admitted to the facility during the past 12 months participated in PREA education sessions. Acknowledgement statements, observed posted information, interviews and other documentation indicate that PREA education is provided to residents.

**Provision (d):**
The agency shall provide resident education in formats accessible to all residents, including those who are limited English proficient, deaf, visually impaired, or otherwise disabled, as well as to residents who have limited reading skills.

The facility has the capability to provide the PREA education in formats accessible to all residents including those who may be hearing impaired; Deaf; have intellectual, psychiatric and speech disabilities; low vision; blind; limited reading, limited English proficient, and based on the individual need of the resident. The education unit is also a resource for accessibility of translation services and other accommodations.
The MOU acknowledges that available resources exist from the Wood County Educational Service Center. The MOU and facility Policy address the provision of support services for limited English proficient and disabled residents by providing residents the 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 Policy and MOU provide for interpreter and translation services, including the services for the Deaf. The education staff also provides support services through certified teachers with the educational

background to modify/adapt information for all residents to understand. An Intervention Specialist is on sight through the Wood County Educational Service Center. Assistance may also be provided by the treatment staff to ensure all residents' understanding of the PREA information. Posted and other PREA information is in English and Spanish. Reporting information is posted within the facility, accessible to residents, staff and visitors.

The facility also has a MOU for interpreter services through the Bowling Green State University. The staff revealed a practice of residents not used as translators or readers for other residents. The facility has knowledge of the youth's arrival to the facility prior to the admission date. This time period provides for the identified staff to make plans to accommodate the special needs of residents and coordinate with the school and others where needed.

Residents are asked about feelings of safety during informal encounters with staff and during formal treatment sessions. The PREA information and resident handbook are accessible in languages other than English, as needed. Residents with cognitive disabilities revealed an understanding of the PREA information provided.

**Provision (e):**
The agency shall maintain documentation of resident participation in these education sessions.

Signed acknowledgement statements were reviewed which supported the residents' involvement in PREA education sessions. The residents' interviews confirmed that PREA education sessions occur. The residents were aware of how to report allegations of sexual abuse and sexual harassment and that they would not be punished for reporting such. The residents are aware of their PREA related rights and are aware of the advocacy services available if they are sexually abused.

**Provision (f):**
In addition to providing such education, the agency shall ensure that key information is continuously and readily available or visible to residents through posters, resident handbooks, or other written formats.

The interviews with the residents and observations confirmed that PREA information is provided initially and continuously and is readily available and visible to residents during their stay in the facility. The PREA education materials provide residents information on how to report allegations of sexual harassment and sexual abuse and how to request advocacy services. PREA information is posted and provided to residents to assist in eliminating incidents of sexual abuse and sexual harassment.

The printed materials include but are not limited to information on sexual abuse and sexual harassment; steps victims may take; and reporting information. Each resident is provided a resident handbook which also contains PREA information. The resident interviews supported that refresher PREA education sessions are conducted in the facility as needed. PREA related information is provided to staff in policies and procedures, training and staff meetings.

**Conclusion:**
Based upon the review and analysis of the available evidence, interviews, and observations, the Auditor determined the facility is compliant with this standard.

## Standard 115.334: Specialized Training: Investigations

**All Yes/No Questions Must Be Answered by the Auditor to Complete the Report**

**115.334 (a)**

- In addition to the general training provided to all employees pursuant to §115.331, does the agency ensure that, to the extent the agency itself conducts sexual abuse investigations, its investigators have received training in conducting such investigations in confinement settings? [N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.321(a).] ☒ Yes ☐ No ☐ NA

**115.334 (b)**

- Does this specialized training include: Techniques for interviewing juvenile sexual abuse victims? [N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.321(a).] ☒ Yes ☐ No ☐ NA

- Does this specialized training include: Proper use of Miranda and Garrity warnings? [N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.321(a).] ☒ Yes ☐ No ☐ NA

- Does this specialized training include: Sexual abuse evidence collection in confinement settings? [N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.321(a).] ☒ Yes ☐ No ☐ NA

- Does this specialized training include: The criteria and evidence required to substantiate a case for administrative action or prosecution referral? [N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.321(a).] ☒ Yes ☐ No ☐ NA

**115.334 (c)**

- Does the agency maintain documentation that agency investigators have completed the required specialized training in conducting sexual abuse investigations? [N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.321(a).] ☒ Yes ☐ No ☐ NA

**115.334 (d)**

- Auditor is not required to audit this provision.

**Auditor Overall Compliance Determination**

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

**Instructions for Overall Compliance Determination Narrative**

*The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.*

**Documentation Reviewed:**
Facility Policy 2.08-3, Specialized Training: Investigations
Training Log
Training Certificates
Training Curriculum
Memorandum of Understanding, Bowling Green Police Division
Letter, Chief of Police

**Interviews:**
Counselor/Investigative Staff
Intake Coordinator/Investigative Staff

**Provision (a) & (b):**
**Provision (a):** In addition to the general training provided to all employees pursuant to §115.331, the agency shall ensure that, to the extent the agency itself conducts sexual abuse investigations, its investigators have received training in conducting such investigations in confinement settings. **Provision (b):** Specialized training shall include techniques for interviewing juvenile sexual abuse victims, proper use of Miranda and Garrity warnings, sexual abuse evidence collection in confinement settings, and the criteria and evidence required to substantiate a case for administrative action or prosecution referral.

Administrative investigations are conducted by facility-based investigators. PREA training is required in addition to the specialized training regarding conducting administrative investigations. Allegations that are criminal in nature are investigated by the Bowling Green Police Division. The interview and review of documents and training certificates confirmed administrative investigations are conducted by trained investigators within the facility.

The specialized training includes but is not limited to interviewing techniques; proper use of Garrity and Miranda warnings; preserving evidence; and criteria for supporting a finding of substantiated, unsubstantiated or unfounded. Six staff members have been identified as administrative investigators. Documentation and interviews support the required training received by the administrative investigators.

**Provision (c):**
The agency shall maintain documentation that agency investigators have completed the required specialized training in conducting sexual abuse investigations.

Documentation of training certificates of the investigators are maintained and confirmed by the interviews. The investigators have received online training courses through the National Institute of Corrections as documented by interviews and reviewed certificates. Among the six investigators, all have taken a course, Investigating Sexual Abuse in a Confinement Setting, and one has taken the advanced investigating course. Allegations of sexual abuse or sexual harassment that are criminal in nature are referred to local law enforcement for an investigation, in accordance with Policy and the interviews.

**Provision (d):**
Any State entity or Department of Justice component that investigates sexual abuse in juvenile confinement settings shall provide such training to its agents and investigators who conduct such investigations.

The facility-based investigators have received online training courses through the National Institute of Corrections as documented by interviews and training certificates. The Bowling Green Police Division provides training to their investigators who may conduct investigations at the facility, as confirmed by the Chief of Police's letter. The Department of Justice does not conduct investigations in this facility.

**Conclusion:**
Based upon the review and analysis of the available evidence, the Auditor determined the facility is compliant with this standard.

## Standard 115.335: Specialized Training: Medical and Mental Health Care

**All Yes/No Questions Must Be Answered by the Auditor to Complete the Report**

**115.335 (a)**

- Does the agency ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in: How to detect and assess signs of sexual abuse and sexual harassment? ☒ Yes ☐ No

- Does the agency ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in: How to preserve physical evidence of sexual abuse? ☒ Yes ☐ No

- Does the agency ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in: How to respond effectively and professionally to juvenile victims of sexual abuse and sexual harassment? ☒ Yes ☐ No

- Does the agency ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in: How and to whom to report allegations or suspicions of sexual abuse and sexual harassment? ☒ Yes ☐ No

**115.335 (b)**

- If medical staff employed by the agency conduct forensic examinations, do such medical staff receive appropriate training to conduct such examinations? (N/A if agency medical staff at the facility do not conduct forensic exams.) ☐ Yes ☐ No ☒ NA

**115.335 (c)**

- Does the agency maintain documentation that medical and mental health practitioners have received the training referenced in this standard either from the agency or elsewhere? ☒ Yes ☐ No

**115.335 (d)**

- Do medical and mental health care practitioners employed by the agency also receive training mandated for employees by §115.331? ☒ Yes ☐ No

- Do medical and mental health care practitioners contracted by and volunteering for the agency also receive training mandated for contractors and volunteers by §115.332? ☒ Yes ☐ No

**Auditor Overall Compliance Determination**

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

**Instructions for Overall Compliance Determination Narrative**

*The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.*

**Documents Reviewed:**
Facility Policy 2.08-2, Specialized Training for Medical and Mental Health Care
Training Certificates
Training Logs
Acknowledgement Statements

**Interviews:**
Nurse
Counselor

**Provision (a):**
The agency shall ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in:
(1) How to detect and assess signs of sexual abuse and sexual harassment;
(2) How to preserve physical evidence of sexual abuse;
(3) How to respond effectively and professionally to juvenile victims of sexual abuse and sexual harassment; and
(4) How and to whom to report allegations or suspicions of sexual abuse and sexual harassment.
The Policy and facility practice provide medical and mental health staff members receive the regular PREA training as well as the training as well as the specialized training. The specialized training is provided through the National Institute of Corrections (NIC) and other venues. Electronic training logs, certificates and interviews document regular PREA training and the specialized training for medical and mental health staff members; the interviews confirmed the training. The specialized training provides guidance based on the tenets of this provision.

**Provision (b):**
If medical staff employed by the agency conduct forensic examinations, such medical staff shall receive the appropriate training to conduct such examinations.

Forensic examinations are not conducted by facility staff; they will be conducted at Wood County Hospital.

**Provision (c):**
The agency shall maintain documentation that medical and mental health practitioners have received the training referenced in this standard either from the agency or elsewhere.

Electronic training logs, certificates from NIC and elsewhere, and the interviews confirmed receipt of the regular and specialized training. Forensic medical examinations are not conducted at this facility.

**Provision (d):**
Medical and mental health care practitioners shall also receive the training mandated for employees under Standard 115.331 or for contractors and volunteers under Standard 115.332, depending upon the practitioner's status at the agency.

Medical and mental health staff completed the general training that is provided for all employees The standard PREA training is provided to all employees and the specialized training is provided through NIC or elsewhere as determined from the document review.

**Conclusion:**
Based upon the review and analysis of the available evidence, the Auditor determined the facility is compliant with this standard.

# SCREENING FOR RISK OF SEXUAL VICTIMIZATION AND ABUSIVENESS

## Standard 115.341: Screening for Risk of Victimization and Abusiveness

**All Yes/No Questions Must Be Answered by the Auditor to Complete the Report**

**115.341 (a)**

- Within 72 hours of the resident's arrival at the facility, does the agency obtain and use information about each resident's personal history and behavior to reduce risk of sexual abuse by or upon a resident? ☒ Yes ☐ No

- Does the agency also obtain this information periodically throughout a resident's confinement? ☒ Yes ☐ No

**115.341 (b)**

- Are all PREA screening assessments conducted using an objective screening instrument? ☒ Yes ☐ No

**115.341 (c)**

- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Prior sexual victimization or abusiveness? ☒ Yes ☐ No

- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Any gender nonconforming appearance or manner or identification as lesbian, gay, bisexual, transgender, or intersex, and whether the resident may therefore be vulnerable to sexual abuse? ☒ Yes ☐ No

- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Current charges and offense history? ☒ Yes ☐ No
- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Age? ☒ Yes ☐ No

- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Level of emotional and cognitive development? ☒ Yes ☐ No

- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Physical size and stature? ☒ Yes ☐ No

- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Mental illness or mental disabilities? ☒ Yes ☐ No

- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Intellectual or developmental disabilities? ☒ Yes ☐ No

- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Physical disabilities? ☒ Yes ☐ No

- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: The resident's own perception of vulnerability? ☒ Yes ☐ No

- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Any other specific information about individual residents that may indicate heightened needs for supervision, additional safety precautions, or separation from certain other residents? ☒ Yes ☐ No

**115.341 (d)**

- Is this information ascertained: Through conversations with the resident during the intake process and medical mental health screenings? ☒ Yes ☐ No

- Is this information ascertained: During classification assessments? ☒ Yes ☐ No

- Is this information ascertained: By reviewing court records, case files, facility behavioral records, and other relevant documentation from the resident's files? ☒ Yes ☐ No

**115.341 (e)**

- Has the agency implemented appropriate controls on the dissemination within the facility of responses to questions asked pursuant to this standard in order to ensure that sensitive information is not exploited to the resident's detriment by staff or other residents? ☒ Yes ☐ No

**Auditor Overall Compliance Determination**

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

**Instructions for Overall Compliance Determination Narrative**

*The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.*

**Documents Reviewed:**
Facility Policy 5.01-01, Assessment, Housing and Programming Assignments
Vulnerability Assessments
Juvenile Sexual Offender Assessments
PREA Education and Screening Logs
PREA Auditing Form

**Interviews:**
Counselor
Residents
PREA Coordinator

**Provision (a):**
The Policy provides that upon arrival or within 72 hours of the resident's arrival at the facility and periodically throughout a resident's confinement, the agency shall obtain and use information about each resident's personal history and behavior to reduce the risk of sexual abuse by or upon a resident.

The Policy provides for each resident to be screened for risk of victimization or abusiveness prior to room assignment in order to reduce the risk of sexual abuse by or upon a resident. The interviews and practice indicate the risk assessment is completed on the day of admission. The information is gathered through conversation with residents during the intake process and during the medical and mental health screenings. The youth is interviewed to obtain information about personal history and behavior. The court packet for the youth is also reviewed to gather pertinent information prior to the resident being admitted to the facility.

The Vulnerability Assessment: Risk of Victimization and/or Sexual Aggressiveness screening assessment is administered to each youth during the admission process. Additional assessments are administered to determine risk levels. The interviews revealed the practice of the risk screening being conducted in accordance with the Policy and Standard, within 72 hours. The documents and interviews

indicate the Vulnerability Screening Assessment: Risk of Victimization and/or Sexual Aggressiveness instrument is generally administered much sooner and for sure within 72 hours. The interviews with the Counselor and residents confirmed the collective information obtained includes but is not limited to:

- Prior sexual victimization or abusiveness;
- Resident's own perception of vulnerability;
- Current charges and offense history;
- Self-identification of resident;
- Intellectual or developmental disabilities;
- Physical disabilities;
- Mental illness or mental disabilities
- Information regarding relationships with other youth
- Confirmation of size and stature
- Confirmation of Age

Facility Policy addresses the occurrence and criteria regarding formal reassessments of residents. It is reported that the number of youths admitted to the facility within the past 12 months who were screened during the admission process for risk of sexual victimization and the risk of sexually abusing other residents is 40. The risk assessments are accessible to management staff, select supervisory staff and clinicians. Resident risk levels are reassessed 30 days after the initial assessment and periodically after that and when there is an incident.

**Provision (b):**
Such assessments shall be conducted using an objective screening instrument.

An objective screening instrument is used to obtain the information required by the standard, including but not limited to prior sexual victimization or abusiveness; self-identification; current charges and offense history; disabilities; and a resident's concern regarding his own safety. The instrument is tabulated based on the information received where identified responses can identify any special needs and safety concerns. Assessments are conducted through the use of the objective primary instrument containing items that collectively provide a presumptive determination of risk for victimization or abusiveness. Additional assessment tools are used by clinical staff which lends information regarding risk factors.

**Provision (c):**
At a minimum, the agency shall attempt to ascertain information about:
(1) Prior sexual victimization or abusiveness;
(2) Any gender nonconforming appearance or manner or identification as lesbian, gay, bisexual, transgender, or intersex, and whether the resident may therefore be vulnerable to sexual abuse;
(3) Current charges and offense history;
(4) Age;
(5) Level of emotional and cognitive development;
(6) Physical size and stature;
(7) Mental illness or mental disabilities;
(8) Intellectual or developmental disabilities;
(9) Physical disabilities;
(10) The residents' own perception of vulnerability; and
(11) Any other specific information about individual residents that may indicate heightened needs for supervision, additional safety precautions, or separation from certain other residents.

The Auditor reviewed the screening instruments and determined the items required by this provision of the standard are included within the instrument. The interview with the Counselor confirmed awareness

of the elements of the risk screening instrument and the application and use of the instrument was explained. The resident interviews also confirmed the administration of the screening instrument and the general inquiries made. The interviews revealed the practice is that the instrument is administered generally on the first day of admission to the facility.

Disclosure of prior victimization or perpetrated sexual abuse is addressed in a timely manner. The resident is referred to a Counselor following the disclosure of the information. Residents are referred to a Counselor by the Intake Coordinator after disclosure within the required time period. According to the Counselor, a resident is seen as soon as possible and well within 14 days. Disclosed prior sexual victimization during the risk screening is reported in accordance with facility policy and the standard. The actions by staff were verified through the interviews.

**Provision (d):**
This information shall be ascertained through conversations with the resident during the intake process and medical and mental health screenings; during classification assessments; and by reviewing court records, case files, facility behavioral records, and other relevant documentation from the resident's files.

The information to complete the risk screening instrument is gleaned from various sources. Information in determining the risk for victimization or abusiveness is obtained through interviewing the residents and review of the court packet. Additional information may be obtained from interviews with parents/guardians. The facility is aware of the youth's pending arrival to the facility and treatment staff has the opportunity to review the court records, case files, and behavior records in an effort to prepare for a youth's needs prior to arrival. Additional assessments are completed after the youth is admitted to the facility to obtain supportive information for treatment planning and keeping the youth safe.

**Provision (e):**
The agency shall implement appropriate controls on the dissemination within the facility of responses to questions asked pursuant to this standard in order to ensure that sensitive information is not exploited to the resident's detriment by staff or other residents.

The Policy provides for appropriate controls to be taken to ensure that sensitive information is protected and not exploited. Staff also take appropriate controls to ensure that sensitive information is protected and not exploited by maintaining the files in a secure manner under lock and key. The information is accessible to the Intake Coordinator, Counselors, PREA Coordinator, and Director. The online information on computers is password protected and is only accessible to identified staff. Staff training includes information regarding confidentiality of information concerning residents.

**Conclusion:**
Based upon the review and analysis of the available evidence, the Auditor determined the facility is compliant with this standard.

## Standard 115.342: Use of Screening Information

**All Yes/No Questions Must Be Answered by the Auditor to Complete the Report**

**115.342 (a)**

- Does the agency use all of the information obtained pursuant to §115.341 and subsequently, with the goal of keeping all residents safe and free from sexual abuse, to make: Housing Assignments? ☒ Yes ☐ No

- Does the agency use all of the information obtained pursuant to §115.341 and subsequently, with the goal of keeping all residents safe and free from sexual abuse, to make: Bed assignments? ☒ Yes ☐ No

- Does the agency use all of the information obtained pursuant to § 115.341 and subsequently, with the goal of keeping all residents safe and free from sexual abuse, to make: Work Assignments? ☒ Yes ☐ No

- Does the agency use all of the information obtained pursuant to § 115.341 and subsequently, with the goal of keeping all residents safe and free from sexual abuse, to make: Education Assignments? ☒ Yes ☐ No

- Does the agency use all of the information obtained pursuant to § 115.341 and subsequently, with the goal of keeping all residents safe and free from sexual abuse, to make: Program Assignments? ☒ Yes ☐ No

**115.342 (b)**

- Are residents isolated from others only as a last resort when less restrictive measures are inadequate to keep them and other residents safe, and then only until an alternative means of keeping all residents safe can be arranged? ☒ Yes ☐ No

- During any period of isolation, does the agency always refrain from denying residents daily large-muscle exercise? ☒ Yes ☐ No

- During any period of isolation, does the agency always refrain from denying residents any legally required educational programming or special education services? ☒ Yes ☐ No

- Do residents in isolation receive daily visits from a medical or mental health care clinician? ☒ Yes ☐ No
- Do residents also have access to other programs and work opportunities to the extent possible? ☒ Yes ☐ No

**115.342 (c)**

- Does the agency always refrain from placing: Lesbian, gay, and bisexual residents in particular housing, bed, or other assignments solely on the basis of such identification or status? ☒ Yes ☐ No

- Does the agency always refrain from placing: Transgender residents in particular housing, bed, or other assignments solely on the basis of such identification or status? ☒ Yes ☐ No

- Does the agency always refrain from placing: Intersex residents in particular housing, bed, or other assignments solely on the basis of such identification or status? ☒ Yes ☐ No

- Does the agency always refrain from considering lesbian, gay, bisexual, transgender, or intersex identification or status as an indicator or likelihood of being sexually abusive? ☒ Yes ☐ No

**115.342 (d)**

- When deciding whether to assign a transgender or intersex resident to a facility for male or female residents, does the agency consider on a case-by-case basis whether a placement would ensure the resident's health and safety, and whether a placement would present management or security problems (NOTE: if an agency by policy or practice assigns residents to a male or female facility on the basis of anatomy alone, that agency is not in compliance with this standard)? ☒ Yes ☐ No

- When making housing or other program assignments for transgender or intersex residents, does the agency consider on a case-by-case basis whether a placement would ensure the resident's health and safety, and whether a placement would present management or security problems? ☒ Yes ☐ No

**115.342 (e)**

- Are placement and programming assignments for each transgender or intersex resident reassessed at least twice each year to review any threats to safety experienced by the resident? ☒ Yes ☐ No

**115.342 (f)**

- Are each transgender or intersex resident's own views with respect to his or her own safety given serious consideration when making facility and housing placement decisions and programming assignments? ☒ Yes ☐ No

**115.342 (g)**

- Are transgender and intersex residents given the opportunity to shower separately from other residents? ☒ Yes ☐ No

**115.342 (h)**

- If a resident is isolated pursuant to paragraph (b) of this section, does the facility clearly document: The basis for the facility's concern for the resident's safety? (N/A for h and i if facility doesn't use isolation?) ☐ Yes ☐ No ☒ NA

- If a resident is isolated pursuant to paragraph (b) of this section, does the facility clearly document: The reason why no alternative means of separation can be arranged? (N/A for h and i if facility doesn't use isolation?) ☐ Yes ☐ No ☒ NA

**115.342 (i)**

- In the case of each resident who is isolated as a last resort when less restrictive measures are inadequate to keep them and other residents safe, does the facility afford a review to determine whether there is a continuing need for separation from the general population EVERY 30 DAYS? ☐ Yes ☐ No ☒ NA

**Auditor Overall Compliance Determination**

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

**Instructions for Overall Compliance Determination Narrative**

*The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.*

**Documents Reviewed:**
Facility Policy 5.01-01
Vulnerability Assessments
Housing Roster

**Interviews:**
Nurse
Counselor
Director
Residents
Random Staff
PREA Coordinator

**Provision (a):**
The agency shall use all information obtained pursuant to §115.341 and subsequently to make housing, bed, program, education, and work assignments for residents with the goal of keeping all residents safe and free from sexual abuse.

Policy provides guidance to staff regarding the use of the information obtained from the vulnerability assessment. The interviews with the Nurse and Counselor indicate the screening information is used to inform staff of information housing and program regarding assignments, and assist in identifying treatment and any special services.

**Provision (b):**
Residents may be isolated from others only as a last resort when less restrictive measures are inadequate to keep them and other residents safe, and then only until an alternative means of keeping all residents safe can be arranged. During any period of isolation, agencies shall not deny residents daily large-muscle exercise and any legally required educational programming or special education services. Residents in isolation shall receive daily visits from a medical or mental health care clinician. Residents shall also have access to other programs and work opportunities to the extent possible.

The Policy states any use of segregated housing to protect a resident who is alleged to have suffered sexual abuse must comply with the standard. The use of isolation would be documented and residents would receive any legally required educational programming, clinical care and large-muscle exercise. Protective custody was not used during the previous 12 months regarding a potential victim or victim of sexual abuse. The staff interviews indicated that protective measures would be taken immediately when needed and includes separating residents; notifying other staff, including supervisors and administrators; and document the situation.

**Provision (c):**
Lesbian, gay, bisexual, transgender, or intersex residents shall not be placed in particular housing, bed, or other assignments solely on the basis of such identification or status, nor shall agencies consider lesbian, gay, bisexual, transgender, or intersex identification or status as an indicator of likelihood of being sexually abusive.

Gay, bisexual, transgender, or intersex residents are not placed in specific housing solely based on how the residents identify or their status. Staff members are prohibited from considering the identification as an indicator that these residents may be more likely to be sexually abusive. During the site review, there were no rooms or units observed or identified to be reserved for LGBTI youth. Housing assignments are made on a case-by-case basis as supported by Policy and interviews.

**Provision (d):**
In deciding whether to assign a transgender or intersex resident to a facility for male or female residents, and in making other housing and programming assignments, the agency shall consider on a case-by-case basis whether a placement would ensure residents' health and safety, and whether the placement would present management or security problems.

Policy and interviews support that housing and program assignments for transgender or intersex residents are made on a case-by-case basis which was evident from staff interviews and observations. The interview with the Counselor confirmed that staff considers on a case-by-case basis whether a placement would ensure a resident's health and safety, and whether the placement would present management or security problems. The interviews indicate staffs' awareness and efforts in keeping residents safe, including transgender and intersex youth.

**Provision (e):**
Placement and programming assignments for each transgender or intersex resident shall be reassessed at least twice each year to review any threats to safety experienced by the resident.

Policy provides placement and programming assignments for each transgender or intersex resident be reassessed twice per year to determine any threats to safety experienced by the resident. The interview with the Counselor confirmed awareness of Policy.

**Provision (f):**
A transgender or intersex resident's own views with respect to his or her own safety shall be given serious consideration.

The resident's concern for his own safety is taken into account through the administration of the vulnerability assessment and other screening instruments, treatment sessions, and informal interactions with Counselors and other staff. The interviews with staff and review of documentation were aligned with the Policy. The interviews did not reveal or identify any issues in this area.

**Provision (g):**

Transgender and intersex residents shall be given the opportunity to shower separately from other residents.

Transgender or intersex residents are given the opportunity to shower separately from other residents which is supported by interviews, Policy and observations during the site review. The facility has not housed a transgender or intersex youth during this audit period.

**Provision (h):**
If a resident is isolated pursuant to paragraph (b) of this section, the facility shall clearly document:
(1) The basis for the facility's concern for the resident's safety; and
(2) The reason why no alternative means of separation can be arranged.

The Policy is inclusive of this provision if there were to be an emergency situation. Policy provides that a resident would only be placed in isolation as a last resort for protection and it would only be until other arrangements could be made to keep the resident safe. The provisions of this standard would be provided if such occurs as required by Policy. No residents were determined at risk of sexual victimization and placed in isolation in the 12 months preceding the audit. During the onsite review, no residents were observed in isolation.

**Provision (i):**
Every 30 days, the facility shall afford each resident described in paragraph (h) of this section a review to determine whether there is a continuing need for separation from the general population.

The Policy states that every 30 days, staff shall afford each resident described in provision (b) of this section a review to determine whether there is a continuing need for separation from the general population. The staff interviews support that a resident in protective custody will have daily access to medical staff, a Counselor, and treatment and education programming. No residents at risk of sexual victimization were placed in isolation in the 12 months preceding the audit.

**Conclusion:**
Based upon the review and analysis of the available evidence, the Auditor determined the facility is compliant with this standard.

# REPORTING

## Standard 115.351: Resident Reporting

**All Yes/No Questions Must Be Answered by the Auditor to Complete the Report**

**115.351 (a)**

- Does the agency provide multiple internal ways for residents to privately report: Sexual abuse and sexual harassment? ☒ Yes ☐ No
- Does the agency provide multiple internal ways for residents to privately report: Retaliation by other residents or staff for reporting sexual abuse and sexual harassment? ☒ Yes ☐ No
- Does the agency provide multiple internal ways for residents to privately report: Staff neglect or violation of responsibilities that may have contributed to such incidents? ☒ Yes ☐ No

**115.351 (b)**

- Does the agency also provide at least one way for residents to report sexual abuse or sexual harassment to a public or private entity or office that is not part of the agency? ☒ Yes ☐ No
- Is that private entity or office able to receive and immediately forward resident reports of sexual abuse and sexual harassment to agency officials? ☒ Yes ☐ No
- Does that private entity or office allow the resident to remain anonymous upon request? ☒ Yes ☐ No
- Are residents detained solely for civil immigration purposes provided information on how to contact relevant consular officials and relevant officials at the Department of Homeland Security to report sexual abuse or harassment? ☒ Yes ☐ No

**115.351 (c)**

- Do staff members accept reports of sexual abuse and sexual harassment made verbally, in writing, anonymously, and from third parties? ☒ Yes ☐ No
- Do staff members promptly document any verbal reports of sexual abuse and sexual harassment? ☒ Yes ☐ No

**115.351 (d)**

- Does the facility provide residents with access to tools necessary to make a written report? ☒ Yes ☐ No
- Does the agency provide a method for staff to privately report sexual abuse and sexual harassment of residents? ☒ Yes ☐ No

**Auditor Overall Compliance Determination**

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

**Instructions for Overall Compliance Determination Narrative**

*The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.*

**Documents Reviewed:**

Facility Policy 3.12, Resident Reporting of PREA Violations
Grievance Forms
Grievance Log
Medical Request Form
Third-Party Reporting Form
Resident Handbook
Posted Information
PREA Pamphlet
MOU, The Cocoon/Wood County Rape Crisis Center

**Interviews:**
Random Staff
Residents
PREA Coordinator

**Provision (a):**
The agency shall provide multiple internal ways for residents to privately report sexual abuse and sexual harassment, retaliation by other residents or staff for reporting sexual abuse and sexual harassment, and staff neglect or violation of responsibilities that may have contributed to such incidents.

Policy provides for internal ways a resident may report allegations of sexual abuse and sexual harassment, including how to privately report sexual abuse and sexual harassment; retaliation for reporting; and staff neglect or violations of responsibilities that may have contributed to such. Residents may report allegations of sexual abuse or sexual harassment by telephone through the 24-hour abuse reporting hotline. Telephones are made accessible to residents for reporting allegations of sexual abuse and sexual harassment. Staff members' interviews confirmed that they cannot impede a resident's use of the telephone which is accessible for residents to report allegations of sexual abuse and sexual harassment, and staff neglect or violation of responsibilities that may have contributed to such incidents. Policy, posters, brochures, and the Resident Handbook collectively provide telephone numbers and instructions for reporting allegations of sexual abuse or sexual harassment. In addition to accessing a telephone, residents are also informed in the PREA education sessions, determined from the interviews, that they may tell staff; tell a family member or other person that does not work at the facility; submit a complaint in writing utilizing the use of a Grievance Form; or use the abuse reporting hotline regarding allegations of sexual abuse or sexual harassment. The residents interviewed identified someone who did not work at the facility that they could report to about sexual abuse or sexual harassment. The random staff and resident interviews collectively revealed residents may use a telephone, file a formal grievance; or talk to staff to privately report allegations of sexual abuse and sexual harassment. The resident is provided the hotline number in writing in the Resident Handbook, brochures, and posted information.

Residents have access to writing materials; Grievance Forms; Medical Request Forms; and locked boxes for receipt of the forms which are accessible to all residents for reporting allegations. When a Grievance Form is used to make a written allegation of sexual abuse, the reporting procedures will be implemented in accordance with Policy. All PREA related incidents will be handled directly by a facility-based investigator. If the allegation is criminal in nature, it will be reported to and investigated by law enforcement. PREA information is posted and each resident is provided a Handbook which contains reporting and other PREA related information. Residents sign an acknowledgement statement confirming receipt of PREA education and other information. Staff members receive information on how to report

allegations of sexual abuse or sexual harassment through policies and procedures, training, and staff meetings.

**Provision (b):**
The agency shall also provide at least one way for residents to report abuse or harassment to a public or private entity or office that is not part of the agency and that is able to receive and immediately forward resident reports of sexual abuse and sexual harassment to agency officials, allowing the resident to remain anonymous upon request. Residents detained solely for civil immigration purposes shall be provided information on how to contact relevant consular officials and relevant officials at the Department of Homeland Security.

The abuse reporting hotline may be used by residents and staff to report allegations of sexual abuse and sexual harassment. The facility has recently changed agencies for reporting allegations of sexual abuse or sexual harassment when it was learned that The Cocoon/Wood County Rape Crisis Center would require consent from a resident prior to reporting the allegation to agency officials. The reports of sexual abuse or sexual harassment will be accepted and now will be automatically reported to an agency official. The residents may report allegations to the abuse reporting hotline and will not be approached about consent for the operator to report the allegations made. Telephones are located on each housing unit and in the common area and other telephones may be used by the residents for reporting. The facility does not detain residents solely for civil immigration purposes.

*Corrective Action*: It was learned that The Cocoon/Wood County Rape Crisis Center staff could not report allegations of sexual abuse or sexual harassment without the consent of the resident. A corrective action was implemented by the Quality Assurance/PREA Coordinator and facility Director. The ODYS PREA Administrator assisted in obtaining services from the Office of the Chief Inspector, Ohio Department of Rehabilitation and Correction, an outside agency which is used by ODYS state run and funded community facilities for reporting allegations of sexual abuse and sexual harassment. The Quality Assurance/PREA Coordinator provided training to residents and staff on the identification and purpose of new reporting agency, updated the resident handbook and facility policy, posted the new reporting information, and facilitated the telephone work for reconfiguration of the lines to add the new number as a separate line. The change in agencies will ensure that resident reports of sexual abuse or sexual harassment will be immediately forwarded to agency officials, allowing the resident to remain anonymous upon request.

**Provision (c):**
Staff shall accept reports made verbally, in writing, anonymously, and from third-parties and shall promptly document any verbal reports.

The staff interviews confirmed the methods available to residents for reporting allegations of sexual abuse and sexual harassment. Staff members are required to accept reports made anonymously, third-party reports and to document verbal reports. The resident interviews collectively indicated awareness of reporting either in person, in writing, by telephone, or through a third-party. Interviewed staff members are aware of their duty to receive and document the receipt of verbal reports and that the documentation must be done as soon as possible. A third-party reporting form is located on the facility's website, accessible to the public.

*Corrective Action*: During the pre-audit phase, it was discovered that residents were instructed on the Grievance Form to use an alternative method other than the completion of a Grievance Form for weekends and holidays. Use of the alternative method was due to the grievance boxes

not being routinely checked on weekends and holidays. A corrective action was implemented by assigning a designated shift supervisor to routinely check all grievance boxes on weekends and holidays to ensure daily checks in the event an emergency grievance is deposited on any day. The Quality Assurance/PREA Coordinator has removed the language from the grievance form regarding use of an alternative method on weekends and holidays and it has been put in writing that grievance boxes will be checked by a first shift Supervisor or other designated supervisor on weekends and holidays. Staff and residents are now aware that the grievance boxes will be checked daily.

**Provision (d):**
The facility shall provide residents with access to tools necessary to make a written report.

Observations during the site review and interviews revealed writing materials are available for residents to complete Grievance and other forms. Each resident is provided a Resident Handbook and PREA information, including reporting allegations. The residents are informed of the reporting methods during PREA education sessions. The interviews, review of documents and facility practices revealed that residents are provided the tools to make written allegations of sexual abuse and sexual harassment.

**Provision (e):**
The agency shall provide a method for staff to privately report sexual abuse and sexual harassment of residents.

The staff interviews collectively revealed staff can privately report allegations of sexual abuse by calling the Police; utilizing the Third-Party Reporting Form located on the facility's website; writing a note; tell the Director; or tell the PREA Coordinator.

**Conclusion:**
Based upon the review and analysis of the available evidence and interviews, the Auditor determined the facility is compliant with this standard.

## Standard 115.352: Exhaustion of Administrative Remedies

**All Yes/No Questions Must Be Answered by the Auditor to Complete the Report**

**115.352 (a)**

- Is the agency exempt from this standard? NOTE: The agency is exempt ONLY if it does not have administrative procedures to address resident grievances regarding sexual abuse. This does not mean the agency is exempt simply because a resident does not have to or is not ordinarily expected to submit a grievance to report sexual abuse. This means that as a matter of explicit policy, the agency does not have an administrative remedies process to address sexual abuse. ☐ Yes ☒ No ☐ NA

**115.352 (b)**

- Does the agency permit residents to submit a grievance regarding an allegation of sexual abuse without any type of time limits? (The agency may apply otherwise-applicable time limits to any portion of a grievance that does not allege an incident of sexual abuse.) (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

- Does the agency always refrain from requiring a resident to use any informal grievance process, or to otherwise attempt to resolve with staff, an alleged incident of sexual abuse? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

**115.352 (c)**

- Does the agency ensure that: A resident who alleges sexual abuse may submit a grievance without submitting it to a staff member who is the subject of the complaint? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

- Does the agency ensure that: Such grievance is not referred to a staff member who is the subject of the complaint? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

**115.352 (d)**

- Does the agency issue a final agency decision on the merits of any portion of a grievance alleging sexual abuse within 90 days of the initial filing of the grievance? (Computation of the 90-day time period does not include time consumed by residents in preparing any administrative appeal.) (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

- If the agency determines that the 90-day timeframe is insufficient to make an appropriate decision and claims an extension of time [the maximum allowable extension of time to respond is 70 days per 115.352(d)(3)], does the agency notify the resident in writing of any such extension and provide a date by which a decision will be made? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

- At any level of the administrative process, including the final level, if the resident does not receive a response within the time allotted for reply, including any properly noticed extension, may a resident consider the absence of a response to be a denial at that level? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

**115.352 (e)**

- Are third parties, including fellow residents, staff members, family members, attorneys, and outside advocates, permitted to assist residents in filing requests for administrative remedies relating to allegations of sexual abuse? (N/A if agency is exempt from this standard.)
  ☒ Yes ☐ No ☐ NA

- Are those third parties also permitted to file such requests on behalf of residents? (If a third party, other than a parent or legal guardian, files such a request on behalf of a resident, the facility may require as a condition of processing the request that the alleged victim agree to have the request filed on his or her behalf, and may also require the alleged victim to personally pursue any subsequent steps in the administrative remedy process.) (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

- If the resident declines to have the request processed on his or her behalf, does the agency document the resident's decision? (N/A if agency is exempt from this standard.)
  ☒ Yes ☐ No ☐ NA

- Is a parent or legal guardian of a juvenile allowed to file a grievance regarding allegations of sexual abuse, including appeals, on behalf of such juvenile? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

- If a parent or legal guardian of a juvenile files a grievance (or an appeal) on behalf of a juvenile regarding allegations of sexual abuse, is it the case that those grievances are not conditioned upon the juvenile agreeing to have the request filed on his or her behalf? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

**115.352 (f)**

- Has the agency established procedures for the filing of an emergency grievance alleging that a resident is subject to a substantial risk of imminent sexual abuse? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

- After receiving an emergency grievance alleging a resident is subject to a substantial risk of imminent sexual abuse, does the agency immediately forward the grievance (or any portion thereof that alleges the substantial risk of imminent sexual abuse) to a level of review at which immediate corrective action may be taken? (N/A if agency is exempt from this standard.). ☒ Yes ☐ No ☐ NA

- After receiving an emergency grievance described above, does the agency provide an initial response within 48 hours? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

- After receiving an emergency grievance described above, does the agency issue a final agency decision within 5 calendar days? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

- Does the initial response and final agency decision document the agency's determination whether the resident is in substantial risk of imminent sexual abuse? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

- Does the initial response document the agency's action(s) taken in response to the emergency grievance? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

- Does the agency's final decision document the agency's action(s) taken in response to the emergency grievance? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

**115.352 (g)**

- If the agency disciplines a resident for filing a grievance related to alleged sexual abuse, does it do so ONLY where the agency demonstrates that the resident filed the grievance in bad faith? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

**Auditor Overall Compliance Determination**

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

**Instructions for Overall Compliance Determination Narrative**

*The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.*

**Documents Reviewed:**
Facility Policy 6.01-1, Resident Grievances
Grievance Forms
Medical Request Form
Resident Handbook
Grievance Log

**Interviews:**
Random Staff
Residents
PREA Coordinator
Director

**Provision (a):**
An agency shall be exempt from this standard if it does not have administrative procedures to address resident grievances regarding sexual abuse.
The Policy contains procedures regarding the process for dealing with resident grievances related to sexual abuse and sexual harassment. Residents may submit a grievance related to PREA allegations at any time regardless of when the incident is alleged to have occurred and residents are not required to use the informal process for any situation regarding sexual abuse. When an emergency grievance is received that contains an allegation of sexual abuse or sexual harassment, the policy and procedures for reporting and/or investigating allegations of sexual abuse or sexual harassment are initiated and a report is made as required by policy. An investigation will be conducted by a facility-based investigator or law enforcement.

**Provision (b):**
(1) The agency shall not impose a time limit on when a resident may submit a grievance regarding an allegation of sexual abuse.
(2) The agency may apply otherwise-applicable time limits on any portion of a grievance that does not allege an incident of sexual abuse.
(3) The agency shall not require a resident to use any informal grievance process, or to otherwise attempt to resolve with staff, an alleged incident of sexual abuse.
(4) Nothing in this section shall restrict the agency's ability to defend against a lawsuit filed by a resident on the ground that the applicable statute of limitations has expired.

Policy provides that there is no time limit for completing a Grievance Form to report allegations of sexual abuse. Residents are not required to use an informal process or give the Grievance Form to any staff

member regarding allegations of sexual abuse. Locked boxes are located on the housing units and in the common area for residents to deposit forms or notes. Policy does not restrict the facility's ability to defend against a lawsuit filed by a resident on the ground that the applicable statute of limitations has expired.

**Provision (c):**
The agency shall ensure that—
(1) A resident who alleges sexual abuse may submit a grievance without submitting it to a staff member who is the subject of the complaint, and
(2) Such grievance is not referred to a staff member who is the subject of the complaint.

Residents are not required to use an informal process or give the grievance to any staff member regarding allegations of sexual abuse. The staff member involved in the grievance will not be involved in handling the grievance. To assist in the prompt and proper handling of the allegation of sexual abuse or sexual harassment, residents may put the Form directly in the grievance box, unimpeded by staff.

The resident handbook explains the regular grievance system and contains information regarding reporting allegations of sexual abuse and sexual harassment. The Grievance Form informs the resident to check a block acknowledging if is a PREA related grievance or a regular grievance. The resident is further instructed to place the completed Form in the locked box, not requiring the details requested for a non-PREA related grievance. The resident is also informed that if they are comfortable a detailed account of the allegation may be included on the form.

**Provision (d):**
(1) The agency shall issue a final agency decision on the merits of any portion of a grievance alleging sexual abuse within 90 days of the initial filing of the grievance.
(2) Computation of the 90-day time period shall not include time consumed by residents in preparing any administrative appeal.
(3) The agency may claim an extension of time to respond, of up to 70 days, if the normal time period for response is insufficient to make an appropriate decision. The agency shall notify the resident in writing of any such extension and provide a date by which a decision will be made.
(4) At any level of the administrative process, including the final level, if the resident does not receive a response within the time allotted for reply, including any properly noticed extension, the resident may consider the absence of a response to be a denial at that level.

The Policy provides details about the administrative remedies including the timelines which are aligned with the standard. Initial response is required within 48 hours to inform the resident of receipt or results of the grievance containing an allegation of sexual abuse or sexual harassment. The interview with the PREA Coordinator and review of documentation revealed familiarity with the Policy.

**Provision (e):**
(1) Third parties, including fellow residents, staff members, family members, attorneys, and outside advocates, shall be permitted to assist residents in filing requests for administrative remedies relating to allegations of sexual abuse, and shall also be permitted to file such requests on behalf of residents.
(2) If a third party, other than a parent or legal guardian, files such a request on behalf of a resident, the facility may require as a condition of processing the request that the alleged victim agree to have the request filed on his or her behalf, and may also require the alleged victim to personally pursue any subsequent steps in the administrative remedy process.
(3) If the resident declines to have the request processed on his or her behalf, the agency shall document the resident's decision.

Policy supports third-party grievances and appeals however there have been no grievances alleging sexual abuse filed on behalf of a resident by a third-party.

**Provision (f):**
(1) The agency shall establish procedures for the filing of an emergency grievance alleging that a resident is subject to a substantial risk of imminent sexual abuse.
(2) After receiving an emergency grievance alleging a resident is subject to a substantial risk of imminent sexual abuse, the agency shall immediately forward the grievance (or any portion thereof that alleges the substantial risk of imminent sexual abuse) to a level of review at which immediate corrective action may be taken, shall provide an initial response within 48 hours, and shall issue a final agency decision within five calendar days. The initial response and final agency decision shall document the agency's determination whether the resident is in substantial risk of imminent sexual abuse and the action taken in response to the emergency grievance.

Policy provides for emergency grievances to be responded to within 48 hours. If a grievance alleging sexual abuse is received, it is reviewed by a facility-based investigator and/or reported by staff to the appropriate investigative entity. The response to the grievance will include measures to ensure safety and also include but not limited to determining an immediate corrective action that would be implemented where applicable to ensure the safety of the resident.

Residents and staff interviewed identified the use of a grievance form as one of the methods that may be used to report allegations of sexual abuse or sexual harassment. The residents are aware of how emergency grievances are handled regarding sexual abuse or sexual harassment. There have been no grievances alleging sexual abuse filed by residents in the past 12 months.

**Provision (g):**
The agency may discipline a resident for filing a grievance related to alleged sexual abuse only where the agency demonstrates that the resident filed the grievance in bad faith.

A resident may be disciplined when it has been determined that a report alleging sexual abuse has been made in bad faith. Residents understand they will not be punished if a report is made in good faith, as determined through the interviews. There has not been a grievance submitted alleging sexual abuse during this audit period.

**Conclusion:**
Based upon the review and analysis of the available evidence and interviews, the Auditor determined the facility is compliant with this standard.

## Standard 115.353: Resident Access to Outside Confidential Support Services and Legal Representation

**All Yes/No Questions Must Be Answered by the Auditor to Complete the Report**

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

**Instructions for Overall Compliance Determination Narrative**

(4) A parent or legal guardian of a juvenile shall be allowed to file a grievance regarding allegations of sexual abuse, including appeals, on behalf of such juvenile. Such a grievance shall not be conditioned upon the juvenile agreeing to have the request filed on his or her behalf.

When third-party reports of allegations of sexual abuse or sexual harassment are received, the policy and procedures for reporting and investigating allegations of sexual abuse or sexual harassment are initiated and a report is made as required by Policy. The content of the grievance is reviewed by a facility-based investigator and an investigation will be conducted by an investigative entity as appropriate. The

**115.353 (a)**

- Does the facility provide residents with access to outside victim advocates for emotional support services related to sexual abuse by providing, posting, or otherwise making accessible mailing addresses and telephone numbers, including toll-free hotline numbers where available, of local, State, or national victim advocacy or rape crisis organizations? ☒ Yes ☐ No

- Does the facility provide persons detained solely for civil immigration purposes mailing addresses and telephone numbers, including toll-free hotline numbers where available of local, State, or national immigrant services agencies? ☒ Yes ☐ No

- Does the facility enable reasonable communication between residents and these organizations and agencies, in as confidential a manner as possible? ☒ Yes ☐ No

**115.353 (b)**

- Does the facility inform residents, prior to giving them access, of the extent to which such communications will be monitored and the extent to which reports of abuse will be forwarded to authorities in accordance with mandatory reporting laws? ☒ Yes ☐ No

**115.353 (c)**

- Does the agency maintain or attempt to enter into memoranda of understanding or other agreements with community service providers that are able to provide residents with confidential emotional support services related to sexual abuse? ☒ Yes ☐ No
- Does the agency maintain copies of agreements or documentation showing attempts to enter into such agreements? ☒ Yes ☐ No

**115.353 (d)**

- Does the facility provide residents with reasonable and confidential access to their attorneys or other legal representation? ☒ Yes ☐ No

- Does the facility provide residents with reasonable access to parents or legal guardians? ☒ Yes ☐ No

**Auditor Overall Compliance Determination**

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the*

*The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.*

**Documents Reviewed:**
Facility Policy 3.12
Memorandum of Understanding (MOU), The Cocoon
PREA Pamphlet
Resident Handbook
Posted Information
Acknowledgement Statements
Resident Communication Logs

**Interviews:**
Residents
PREA Coordinator
Director
Advocacy Agency Representative

**Provision (a):**
The facility shall provide residents with access to outside victim advocates for emotional support services related to sexual abuse, by providing, posting, or otherwise making accessible mailing addresses and telephone numbers, including toll free hotline numbers where available, of local, State, or national victim advocacy or rape crisis organizations, and, for persons detained solely for civil immigration purposes, immigrant services agencies. The facility shall enable reasonable communication between residents and these organizations and agencies, in as confidential a manner as possible.

Interviews revealed that residents are familiar with the victim advocacy agency, The Cocoon, and the services provided for residents if needed. The MOU was mutually agreed upon and outline the services that will be provided, according to the agency representative and Director. The interview with the advocacy agency representative confirmed the services to be provided when needed. The Resident Handbook includes contact information for the agency, including mailing address and telephone number. Residents are also provided address labels for written contact to The Cocoon.

The information to the resident regarding The Cocoon outlines how the resident will make contact for emotional support and other advocacy services related to sexual abuse. The information is also posted in the housing units, accessible to all residents. The hotline telephone was observed in each housing unit and the information posted by each telephone with the contact information for The Cocoon, hotline number and address. The telephone was tested; the operator answered the call promptly. On a later call, the supervisor explained the role of the operator and how calls are handled.

**Provision (b):**
The facility shall inform residents, prior to giving them access, of the extent to which such communications will be monitored and the extent to which reports of abuse will be forwarded to authorities in accordance with mandatory reporting laws.

Policy, facility staff interviews and the PREA education sessions provide that there will be adherence to confidentiality measures and that the related information is provided to residents during PREA education

sessions. The resident interviews, Policy and PREA documents confirmed the provision of confidential services for residents if needed. Contact information for advocacy services is a part of the PREA education sessions and is available to the residents in the Resident Handbook; and through postings in housing units.

**Provision (c):**
The agency shall maintain or attempt to enter into memoranda of understanding or other agreements with community service providers that are able to provide residents with confidential emotional support services related to sexual abuse. The agency shall maintain copies of agreements or documentation showing attempts to enter into such agreements.

The advocacy agency representative's interview and the MOU document the provision of advocacy services including but not limited to emotional support; accompaniment through the forensic medical examination and investigative interview; crisis intervention; and referrals. The agency representative and facility interviews confirmed the information contained in the MOU.

**Provision (d):**
The facility shall also provide residents with reasonable and confidential access to their attorneys or other legal representation and reasonable access to parents or legal guardians.

The residents have reasonable and confidential access to attorneys and court workers and reasonable access to their parents/legal guardians which is supported by Policy and the Resident Handbook. Communication logs show where residents have access to telephone calls, mail and visitation. During a phase of the pandemic when visitation to the facility was suspended or limited, residents have been provided the opportunity for alternative communication with parents or guardians and with attorneys and court workers where requested. All residents interviewed confirmed communication opportunities occur. The interviews confirmed access to attorneys and court representatives and reasonable access to parents/legal guardians. The onsite review revealed areas where residents could meet privately with legal representatives and engage in visitation with approved visitors.

**Conclusion:**
Based upon the review and analysis of the available evidence and interviews, the Auditor determined the facility meets this standard.

## Standard 115.354: Third-Party Reporting

**All Yes/No Questions Must Be Answered by the Auditor to Complete the Report**

**115.354 (a)**

- Has the agency established a method to receive third-party reports of sexual abuse and sexual harassment? ☒ Yes ☐ No

- Has the agency distributed publicly information on how to report sexual abuse and sexual harassment on behalf of a resident? ☒ Yes ☐ No

**Auditor Overall Compliance Determination**

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

**Instructions for Overall Compliance Determination Narrative**

*The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.*

**Documents Reviewed:**
Facility Policy 3.14, PREA Reporting by Third Parties
Resident Handbook
PREA Information to Visitors
Acknowledgement Statements
Third Party Reporting Form

**Interviews:**
Random Staff
Residents

**Standard 115.354:**
The agency shall establish a method to receive third-party reports of sexual abuse and sexual harassment and shall distribute publicly information on how to report sexual abuse and sexual harassment on behalf of a resident.

Staff members are to receive, document and report allegations of sexual abuse and sexual harassment made by a third-party. The staff members are aware third-party reporting of sexual abuse or sexual harassment can be done and indicated the information will be accepted and reported. Staff members are to document all verbal reports received. The interviews collectively revealed staffs are aware of the location of the Third-Party Reporting Form on the facility's website as a way to report allegations of sexual abuse or sexual harassment. The facility website contains the information needed for third-parties to report allegations of sexual abuse and sexual harassment.

Parents/guardians are provided a Third-Party Reporting Form and other PREA information; they sign an acknowledgement statement confirming such. Information regarding reporting is posted within the facility and accessible to residents, staff and visitors. Reporting information is also contained in the Resident Handbook. The residents indicated knowing someone who did not work at the facility that they have contact with on the outside. It was determined that a person outside of the facility may report allegations of sexual abuse and may make a report for a resident without giving the resident's name. There have been no third-party reports were received during this audit period.

**Conclusion:**
Based upon the review and analysis of the available evidence and interviews, the Auditor determined the facility is in compliance with this standard.

# OFFICIAL RESPONSE FOLLOWING A RESIDENT REPORT

## Standard 115.361: Staff and Agency Reporting Duties

**All Yes/No Questions Must Be Answered by the Auditor to Complete the Report**

**115.361 (a)**

- Does the agency require all staff to report immediately and according to agency policy any knowledge, suspicion, or information regarding an incident of sexual abuse or sexual harassment that occurred in a facility, whether or not it is part of the agency? ☒ Yes ☐ No

- Does the agency require all staff to report immediately and according to agency policy any knowledge, suspicion, or information regarding retaliation against residents or staff who reported an incident of sexual abuse or sexual harassment? ☒ Yes ☐ No

- Does the agency require all staff to report immediately and according to agency policy any knowledge, suspicion, or information regarding any staff neglect or violation of responsibilities that may have contributed to an incident of sexual abuse or sexual harassment or retaliation? ☒ Yes ☐ No

**115.361 (b)**

- Does the agency require all staff to comply with any applicable mandatory child abuse reporting laws? ☒ Yes ☐ No

**115.361 (c)**

- Apart from reporting to designated supervisors or officials and designated State or local services agencies, are staff prohibited from revealing any information related to a sexual abuse report to anyone other than to the extent necessary, as specified in agency policy, to make treatment, investigation, and other security and management decisions? ☒ Yes ☐ No

**115.361 (d)**

- Are medical and mental health practitioners required to report sexual abuse to designated supervisors and officials pursuant to paragraph (a) of this section as well as to the designated State or local services agency where required by mandatory reporting laws? ☒ Yes ☐ No

- Are medical and mental health practitioners required to inform residents of their duty to report, and the limitations of confidentiality, at the initiation of services? ☒ Yes ☐ No

**115.361 (e)**

- Upon receiving any allegation of sexual abuse, does the facility head or his or her designee promptly report the allegation to the appropriate office? ☒ Yes ☐ No

- Upon receiving any allegation of sexual abuse, does the facility head or his or her designee promptly report the allegation to the alleged victim's parents or legal guardians unless the facility has official documentation showing the parents or legal guardians should not be notified? ☒ Yes ☐ No

- If the alleged victim is under the guardianship of the child welfare system, does the facility head or his or her designee promptly report the allegation to the alleged victim's caseworker instead of the parents or legal guardians? (N/A if the alleged victim is not under the guardianship of the child welfare system.) ☒ Yes ☐ No ☐ NA

- If a juvenile court retains jurisdiction over the alleged victim, does the facility head or designee also report the allegation to the juvenile's attorney or other legal representative of record within 14 days of receiving the allegation? ☒ Yes ☐ No

**115.361 (f)**

- Does the facility report all allegations of sexual abuse and sexual harassment, including third-party and anonymous reports, to the facility's designated investigators? ☒ Yes ☐ No

**Auditor Overall Compliance Determination**

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

**Instructions for Overall Compliance Determination Narrative**

*The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.*

**Documents Reviewed:**
Facility Policy 2.09, Employee Reporting Obligation
Facility Policy 3.11
Counselor's Notes
Incident Report

**Interviews:**
Random Staff
Director

PREA Coordinator
Nurse
Counselor

**Provision (a) and (b):**
**Provision (a):** The agency shall require all staff to report immediately and according to agency policy any knowledge, suspicion, or information they receive regarding an incident of sexual abuse or sexual harassment that occurred in a facility, whether or not it is part of the agency; retaliation against residents or staff who reported such an incident; and any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation.
**Provision (b):** The agency shall also require all staff to comply with any applicable mandatory child abuse reporting laws.

Staff members are deemed as mandated reporters by the State and understand what this designation means. Trained facility-based investigators conduct administrative investigations and allegations that are criminal in nature are investigated by trained personnel from the Bowling Green Police Division. The facility Policies provides guidance to staff on reporting allegations of sexual abuse and sexual harassment and the duties of the first responder.

Policy support that all staff report any knowledge, suspicion, information, or receipt of information regarding an incident or allegation of sexual abuse, sexual harassment or incidents of retaliation. During the site review a sign was prominent in a Counselor's office identifying the person as a mandated reporter and what that means. Documentation demonstrates that when such information is received the facility's reporting policy is implemented.

**Provision (c):**
Apart from reporting to designated supervisors or officials and designated State or local services agencies, staff shall be prohibited from revealing any information related to a sexual abuse report to anyone other than to the extent necessary, as specified in agency policy, to make treatment, investigation, and other security and management decisions.

Policy addresses the conditions for providing information. Policy prohibits staff from revealing any related information to anyone other than to the extent necessary to make treatment, investigation and other security and management decisions. Staff is expected to continue to abide by the confidentiality requirements of the facility. Interviews with staff indicated their knowledge of the prohibition of revealing any information related to a sexual abuse report to anyone other than to the extent necessary as described above.

**Provision (d):**
(1) Medical and mental health practitioners shall be required to report sexual abuse to designated supervisors and officials pursuant to paragraph (a) of this section, as well as to the designated State or local services agency where required by mandatory reporting laws.
(2) Such practitioners shall be required to inform residents at the initiation of services of their duty to report and the limitations of confidentiality.

The clinical staff interviewed indicated residents are informed at the initiation of services of the limitations of confidentiality and their duty to report. The clinical staff members are also mandated reporters and required by the State to report allegations received regarding sexual abuse and sexual harassment, in accordance with Policy and State requirements.

**Provision (e):**
(1) Upon receiving any allegation of sexual abuse, the facility head or his or her designee shall promptly report the allegation to the appropriate agency office and to the alleged victim's parents or legal guardians, unless the facility has official documentation showing the parents or legal guardians should not be notified.
(2) If the alleged victim is under the guardianship of the child welfare system, the report shall be made to the alleged victim's caseworker instead of the parents or legal guardians.
(3) If a juvenile court retains jurisdiction over the alleged victim, the facility head or designee shall also report the allegation to the juvenile's attorney or other legal representative of record within 14 days of receiving the allegation.

Reports of allegations of sexual abuse are made as soon as possible to the investigative entities, parents/legal guardians, Wood County Juvenile Court Judge, other appropriate Judge due to catchment area, and ODYS. Policy and the interview with the Director confirmed that a resident's caseworker rather than a parent would be notified where indicated by the resident being under the guardianship of a child welfare agency. Policy provides the appropriate timelines and directions to staff for reporting allegations.

**Provision (f):**
The facility shall report all allegations of sexual abuse and sexual harassment, including third-party and anonymous reports, to the facility's designated investigators.

The collective Policies and interviews provide for all allegations to be reported to a facility-based investigator and subsequently to other appropriate investigative entity. Administrative investigations are conducted by one of the facility-based investigators. Sexual abuse and sexual harassment allegations that are criminal in nature are referred for investigation to local law enforcement. Allegations may also be reported to the child welfare agency and ODYS. Third-party and anonymous reports received must be reported and documented by staff as confirmed through interviews. The interviews and policy require that reporting allegations include those made anonymously and through third-parties.

**Conclusion:**
The review of evidence and interviews indicate the facility is in compliance with this standard.

## Standard 115.362: Agency Protection Duties

**All Yes/No Questions Must Be Answered by the Auditor to Complete the Report**

**115.362 (a)**

- When the agency learns that a resident is subject to a substantial risk of imminent sexual abuse, does it take immediate action to protect the resident? ☒ Yes ☐ No

**Auditor Overall Compliance Determination**

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

**Instructions for Overall Compliance Determination Narrative**

*The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.*

**Documents Reviewed:**
Facility Policy 3.11, PREA Coordinated Response Plan
Grievance Log
Grievances
PREA Administrative Review/Investigation Checklist
Event Triggering Coordinated Response Plan
Vulnerability Assessments

**Interviews:**
Director
Random Staff
PREA Coordinator
Residents

**Provision (a):**
When an agency learns that a resident is subject to a substantial risk of imminent sexual abuse, it shall take immediate action to protect the resident.
Facility Policy requires staff to protect the residents through implementing protective measures. The expectation is that any action to protect a resident would be taken immediately as deemed from interviews. Protective measures include but are not limited to separation and alert supervisors and management staff. Administration of the Vulnerability Assessment provides information that assists and guide staff in keeping residents safe through housing and program assignments.

During the intake process, residents are asked about how they feel about their safety as part of the inquiries by staff completing the vulnerability assessment, as evident by the document and the resident interviews. Administration of the risk screening instrument provides information that assists and guide staff in keeping residents safe through housing and program assignments. Additional assessment instruments provide information which offer supporting information in determining risk levels. A resident was not identified to be at substantial risk of imminent sexual abuse in the past 12 months.

**Conclusion:**
Based upon the review and analysis of the available evidence and interviews, the Auditor determined the facility is compliant with this standard.

## Standard 115.363: Reporting to Other Confinement Facilities

**All Yes/No Questions Must Be Answered by the Auditor to Complete the Report**

**115.363 (a)**

- Upon receiving an allegation that a resident was sexually abused while confined at another facility, does the head of the facility that received the allegation notify the head of the facility or appropriate office of the agency where the alleged abuse occurred? ☒ Yes ☐ No

- Does the head of the facility that received the allegation also notify the appropriate investigative agency? ☒ Yes ☐ No

**115.363 (b)**

- Is such notification provided as soon as possible, but no later than 72 hours after receiving the allegation? ☒ Yes ☐ No

**115.363 (c)**

- Does the agency document that it has provided such notification? ☒ Yes ☐ No

**115.363 (d)**

- Does the facility head or agency office that receives such notification ensure that the allegation is investigated in accordance with these standards? ☒ Yes ☐ No

**Auditor Overall Compliance Determination**

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

**Instructions for Overall Compliance Determination Narrative**

*The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.*

**Documents Reviewed:**
Facility Policy 2.09, Employees Reporting Obligation
Incident Reports
Timeline Sheet
Case Notes
Written Notification

**Interview:**
Director

**Provisions (a) - (d):**

**Provision (a):** Upon receiving an allegation that a resident was sexually abused while confined at another facility, the head of the facility that received the allegation shall notify the head of the facility or appropriate office of the agency where the alleged abuse occurred and shall also notify the appropriate investigative agency.
**Provision (b):** Such notification shall be provided as soon as possible, but no later than 72 hours after receiving the allegation.
**Provision (c):** The agency shall document that it has provided such notification.
**Provision (d):** The facility head or agency office that receives such notification shall ensure that the allegation is investigated in accordance with these standards.

Documentation and interviews confirm when an allegation of sexual abuse is received that a resident was sexually abused while confined at another facility, the Director notifies the head of the facility where the alleged abuse occurred. The notification is made as soon as possible and within 72 hours in accordance with Policy. The Director is aware of the requirements and the duties regarding reporting to other confinement facilities and the requirement of allegations received from other facilities must be investigated.

The Policy, incident reports, written notification, Counselor's Case Notes, Timeline Sheet, and interview support allegations of sexual abuse or sexual harassment from a resident regarding his stay in another facility will be reported and investigated as required. In the past 12 months, there was one allegation reported from another facility and the incident as reported and tenets of the Policy, aligned with the standard, were followed.

**Conclusion:**
Based upon the information received and interviews, the Auditor determined the facility is compliant with this standard.

## Standard 115.364: Staff First Responder Duties

**All Yes/No Questions Must Be Answered by the Auditor to Complete the Report**

**115.364 (a)**

- Upon learning of an allegation that a resident was sexually abused, is the first security staff member to respond to the report required to: Separate the alleged victim and abuser?
  ☒ Yes ☐ No

- Upon learning of an allegation that a resident was sexually abused, is the first security staff member to respond to the report required to: Preserve and protect any crime scene until appropriate steps can be taken to collect any evidence? ☒ Yes ☐ No

- Upon learning of an allegation that a resident was sexually abused, is the first security staff member to respond to the report required to: Request that the alleged victim not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating, if the abuse occurred within a time period that still allows for the collection of physical evidence? ☒ Yes ☐ No

- Upon learning of an allegation that a resident was sexually abused, is the first security staff member to respond to the report required to: Ensure that the alleged abuser does not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth,

changing clothes, urinating, defecating, smoking, drinking, or eating, if the abuse occurred within a time period that still allows for the collection of physical evidence? ☒ Yes ☐ No

**115.364 (b)**

- If the first staff responder is not a security staff member, is the responder required to request that the alleged victim not take any actions that could destroy physical evidence, and then notify security staff? ☒ Yes ☐ No

**Auditor Overall Compliance Determination**

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

**Instructions for Overall Compliance Determination Narrative**

*The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.*

**Documents Reviewed:**
Facility Policy 3.11
PREA Criminal Investigation Checklist
Event Triggering Coordinated Response Plan

**Interviews:**
Random Staff

**Provision (a):**
Upon learning of an allegation that a resident was sexually abused, the first staff member to respond to the report shall be required to:
(1) Separate the alleged victim and abuser;
(2) Preserve and protect any crime scene until appropriate steps can be taken to collect any evidence;
(3) If the abuse occurred within a time period that still allows for the collection of physical evidence, request that the alleged victim not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating; and
(4) If the abuse occurred within a time period that still allows for the collection of physical evidence, ensure that the alleged abuser does not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating.

The interviews and staff training information support the training provided to staff related to this standard. The PREA Criminal Investigation Checklist serves as guide for the actions to take when there is an

allegation of sexual abuse and provides for confirming the actions were taken. The PREA Criminal Investigation Checklist documents the steps to take when an identified staff member is the first to respond including the steps to take to preserve evidence from the victim and the perpetrator and staff and notifications to make. According to the Policy and Wood County Protocols, the time period for the collection of physical evidence is 96 hours. There were no allegations or incidents where staff had to act as a first responder in the last 12 months.

Policy, training and use of the Checklist provide that upon learning of an allegation that a resident was sexually abused the general staff response would basically include but not be limited to the following:

a. Separate the victim and alleged perpetrator.
b. Notify Shift Supervisor and administrative staff, as required.
c. Obtain medical attention as needed
d. Preserve and protect the scene until appropriate steps can be taken to collect any evidence.
e. Request that the alleged victim and alleged abuser not take any actions that could destroy physical evidence, if the abuse occurred within a time period that still allows for the collection of physical evidence. These actions include but are not limited to: washing, brushing teeth, changing clothes, drinking, or eating.

**Provision (b):**
If the first staff responder is not a security staff member, the responder shall be required to request that the alleged victim not take any actions that could destroy physical evidence, and then notify security staff.

The Policy provides for non-security staff who may act as a first responder to immediately notify security staff of the incident and that all staff will follow the appropriate security protocols. There were no incidents where a non-security staff member had to act as a first responder to an incident or allegation of sexual abuse in the last 12 months.

**Conclusion:**
Based upon the review and analysis of the available evidence and interviews, the Auditor determined the facility is compliant with this standard.

## Standard 115.365: Coordinated Response

**All Yes/No Questions Must Be Answered by the Auditor to Complete the Report**

**115.365 (a)**

- Has the facility developed a written institutional plan to coordinate actions among staff first responders, medical and mental health practitioners, investigators, and facility leadership taken in response to an incident of sexual abuse? ☒ Yes ☐ No

**Auditor Overall Compliance Determination**

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

**Instructions for Overall Compliance Determination Narrative**

*The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.*

**Documents Reviewed:**
Facility Policy 3.11
Event Triggering Coordinated Response Plan
PREA Administrative Review/Investigation Checklist
PREA Criminal Investigation Checklist

**Interviews:**
Random Staff
Director
Nurse
Counselor

**Provision (a):**
The facility shall develop a written institutional plan to coordinate actions taken in response to an incident of sexual abuse among staff first responders, medical and mental health practitioners, investigators, and facility leadership.
The Event Triggering Coordinated Response Plan is to be implemented in the event of an allegation or incident of sexual abuse. The Plan is aligned with the information contained in the facility Policy and is designed to elicit results as soon as possible. In the form of a flow chart, the Plan outlines the actions of staff members and roles of community resources. The Plan assists staff in confirming protocols are followed, including proper and timely notifications.

Policy provides guidance to staff regarding the actions to take when there is an alleged incident of sexual abuse. Staff members interviewed were familiar with their role regarding the response to an allegation of sexual abuse. The documents and interviews are aligned with the facility Policy. Staff members are directed to follow the steps outlined in the Event Triggering Coordinated Response Plan and to use the document in response to an incident of sexual abuse.

Forensic medical examinations will be provided, at no cost to the victim, at the Wood County Hospital by a Sexual Assault Nurse Examiner (SANE). A qualified medical professional will perform a forensic medical examination if there is no SANE available as stated in the Hospital's Sexual Assault Policy. The victim will be provided unimpeded access to crisis intervention and medical services as determined from review of Policy and how the information will be documented; staff interviews, documented responses to other situations; observed due process safeguards; and observed staff and resident interactions.

**Conclusion:**
Based upon the review and analysis of the available evidence and interviews, the Auditor determined the facility is compliant with the standard.

## Standard 115.366: Preservation of Ability to Protect Residents from Contact with Abusers

**All Yes/No Questions Must Be Answered by the Auditor to Complete the Report**

**115.366 (a)**

- Are both the agency and any other governmental entities responsible for collective bargaining on the agency's behalf prohibited from entering into or renewing any collective bargaining agreement or other agreement that limits the agency's ability to remove alleged staff sexual abusers from contact with any residents pending the outcome of an investigation or of a determination of whether and to what extent discipline is warranted? ☒ Yes ☐ No

**115.366 (b)**

- Auditor is not required to audit this provision.

**Auditor Overall Compliance Determination**

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

**Instructions for Overall Compliance Determination Narrative**
*The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.*

**Document Reviewed**
Facility Policy 2.19, PREA: Staff Discipline for Sexual Abuse or Sexual Harassment

**Interview:**
Director

**Provision (a) and (b):**
**Provision(a):** Neither the agency nor any other governmental entity responsible for collective bargaining on the agency's behalf shall enter into or renew any collective bargaining agreement or other agreements that limits the agency's ability to remove alleged staff sexual abusers form contact with residents pending the outcome of an investigation or of a determination of whether and to what extent discipline is warranted.
**Provision (b):** Nothing is this standard shall restrict the entering into on renewal of agreements that govern:
(1) The conduct of the disciplinary process, at long as such agreements are not inconsistent with the provisions of §115.372 and §115.376; or

(2) 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.

According to the Policy and interview, the facility is not involved in any collective bargaining agreements.

## Standard 115.367: Agency Protection Against Retaliation

**All Yes/No Questions Must Be Answered by the Auditor to Complete the Report**

**115.367 (a)**

- Has the agency established a policy to protect all residents and staff who report sexual abuse or sexual harassment or cooperate with sexual abuse or sexual harassment investigations from retaliation by other residents or staff? ☒ Yes ☐ No

- Has the agency designated which staff members or departments are charged with monitoring retaliation? ☒ Yes ☐ No

**115.367 (b)**

- Does the agency employ multiple protection measures for residents or staff who fears retaliation for reporting sexual abuse or sexual harassment or for cooperating with investigations, such as housing changes or transfers for resident victims or abusers, removal of alleged staff or resident abusers from contact with victims, and emotional support services? ☒ Yes ☐ No

**115.367 (c)**

- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor the conduct and treatment of residents or staff who reported the sexual abuse to see if there are changes that may suggest possible retaliation by residents or staff? ☒ Yes ☐ No

- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor the conduct and treatment of residents who were reported to have suffered sexual abuse to see if there are changes that may suggest possible retaliation by residents or staff? ☒ Yes ☐ No

- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Act promptly to remedy any such retaliation? ☒ Yes ☐ No

- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor: Any resident disciplinary reports? ☒ Yes ☐ No

- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor: Resident housing changes? ☒ Yes ☐ No

- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor: Resident program changes? ☒ Yes ☐ No

- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor: Negative performance reviews of staff? ☒ Yes ☐ No

- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor: Reassignments of staff? ☒ Yes ☐ No

- Does the agency continue such monitoring beyond 90 days if the initial monitoring indicates a continuing need? ☒ Yes ☐ No

**115.367 (d)**

- In the case of residents, does such monitoring also include periodic status checks? ☒ Yes ☐ No

**115.367 (e)**

- If any other individual who cooperates with an investigation expresses a fear of retaliation, does the agency take appropriate measures to protect that individual against retaliation? ☒ Yes ☐ No

**115.367 (f)**

- Auditor is not required to audit this provision.

**Auditor Overall Compliance Determination**

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

**Instructions for Overall Compliance Determination Narrative**

*The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.*

**Documents Reviewed:**
Facility Policy 3.15, Protection from Retaliation for Reporting PREA Violations
Alleged Sexual Abuse and Sexual Assault Retaliation Monitoring Checklist

**Interviews:**
PREA Coordinator
Director

**Provision (a):**
The agency shall establish a policy to protect all residents and staff who report sexual abuse or sexual harassment or cooperate with sexual abuse or sexual harassment investigations from retaliation by other residents or staff and shall designate which staff members or departments are charged with monitoring retaliation.

The Policy supports protecting residents and staff who report sexual abuse or sexual harassment, or cooperate with sexual abuse or sexual harassment investigations from retaliation by other residents, or staff. The PREA Coordinator is responsible for conducting and ensuring retaliation monitoring. The Alleged Sexual Abuse and Sexual Assault Retaliation Monitoring Checklist is used to document the monitoring activities. The PREA Coordinator is familiar with the role of retaliation monitor and its purpose.

There have been to evidence of sexual abuse or sexual harassment. A grievance was filed alleging sexual harassment. Upon review, the PREA Coordinator determined he could not attribute the inappropriate language and name-calling by some residents to the person accused; the inappropriate language was used generally. Proactive measures were implemented by the PREA Coordinator by addressing the inappropriate language and name-calling in general among members of the population. The resident that filed the grievance and the accused were kept separate during education and other programming activities to ensure the use of the language is stopped and to address the concern.

The PREA Coordinator informed the staff of the phrases being used and what they meant and the consequences that should be issued to any resident using the illicit language. The Counselors were made aware of the allegation in order to provide any additional opportunities for processing should it be needed. As a result of addressing the grievance, proactive measures were implemented to prevent the probability of a sexual harassment situation.

**Provision (b):**
The agency shall employ multiple protection measures, such as housing changes or transfers for resident victims or abusers, removal of alleged staff or resident abusers from contact with victims, and emotional support services for residents or staff that fear retaliation for reporting sexual abuse or sexual harassment or for cooperating with investigations.

Protective measures were generally identified during the interviews and were aligned with Policy. Implementation measures to protect residents from retaliation collectively include but are not limited to housing changes for resident victims or abusers; removing alleged staff or resident; separate programming activities; change in shift assignments; and emotional support services. The retaliation monitoring will be documented and follow-up checks with the parties involved will ensure safe feelings and identifies whether retaliation is occurring. The interviews confirmed the measures to detect and protect staff and residents from retaliation by others.

**Provision (c):**
For at least 90 days following a report of sexual abuse, the agency shall monitor the conduct or treatment of residents or staff who reported the sexual abuse and of residents who were reported to have suffered sexual abuse to see if there are changes that may suggest possible retaliation by residents or staff, and shall act promptly to remedy any such retaliation. Items the agency should monitor include any resident disciplinary reports, housing, or program changes, or negative performance reviews or reassignments of

staff. The agency shall continue such monitoring beyond 90 days if the initial monitoring indicates a continuing need.

Policy provides that the monitoring will occur for at least 90 days to see if there are any changes that may suggest possible retaliation is occurring. The monitoring period could last longer to ensure the resident and staff are protected from retaliation. The PREA Coordinator identified items that would be monitored to assess retaliation and some are attributed to staff and residents such as incident reports; staff/resident interactions; behavior reports; supervisor write-ups; grievances; and staff/supervisor interactions.

**Provision (d):**
In the case of residents, such monitoring shall also include periodic status checks.

Policy and the interview with the PREA Coordinator indicate that status checks will occur as a part of retaliation monitoring and would also include the Counselors. The dedicated monitoring form and the interview revealed that initial contact would be made and follow-up checks would be made and documented in accordance with Policy.

**Provision (e):**
If any other individual who cooperates with an investigation expresses a fear of retaliation, the agency shall take appropriate measures to protect that individual against retaliation.

The Policy application is extended to those who cooperate with an investigation if there is a concern regarding retaliation. The PREA Coordinator will ensure that the appropriate measures would be taken to protect any related individuals against retaliation.

**Provision (f):**
An agency's obligation to monitor shall terminate if the agency determines that the allegation is unfounded.

The Policy states that the obligation to monitor for retaliation terminates, if it is determined that the allegation is unfounded. The PREA Coordinator is familiar with the requirements regarding retaliation monitoring.

**Conclusion:**
Based upon the review and analysis of the available evidence, the Auditor determined the facility is compliant with this standard.

## Standard 115.368: Post-Allegation Protective Custody

**All Yes/No Questions Must Be Answered by the Auditor to Complete the Report**

**115.368 (a)**

- Is any and all use of segregated housing to protect a resident who is alleged to have suffered sexual abuse subject to the requirements of § 115.342? ☒ Yes ☐ No

**Auditor Overall Compliance Determination**

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

**Instructions for Overall Compliance Determination Narrative**

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**Documents Reviewed:**
Facility Policy 5.01-1, Assessment, Housing, and Programming Assignments

**Interviews**:
Director
Nurse
Counselor

**Provision (a):**
The use of segregated housing to protect a resident who is alleged to have suffered sexual abuse shall be subject to the requirements of §115.342.

The Policy provides for a resident who alleges to have suffered sexual abuse may only be separated from the general population as a last resort when less restrictive measures are inadequate to keep them and other residents safe and only until an alternative for keeping the resident safe can be arranged. The Policy requires that where a resident is placed in isolation because he alleged sexual abuse, he must have visits from medical or mental health staff, access to education and treatment services, and access to daily large muscle activity. Residents shall also have access to other programs and work opportunities to the extent possible. The interviews revealed that isolation or segregated housing has not been used to protect a resident who alleged sexual abuse during this audit period. Policy provides that a review of continued separation must be conducted every 30 days.

**Conclusion:**
Based upon the review of Policy, interviews, and observations, the Auditor determined the facility is compliant with this standard.

# INVESTIGATIONS

## Standard 115.371: Criminal and Administrative Agency Investigations

**All Yes/No Questions Must Be Answered by the Auditor to Complete the Report**

**115.371 (a)**

- When the agency conducts its own investigations into allegations of sexual abuse and sexual harassment, does it do so promptly, thoroughly, and objectively? [N/A if the agency/facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations. See 115.321(a).] ☒ Yes ☐ No ☐ NA

- Does the agency conduct such investigations for all allegations, including third party and anonymous reports? [N/A if the agency/facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations. See 115.321(a).] ☒ Yes ☐ No ☐ NA

**115.371 (b)**

- Where sexual abuse is alleged, does the agency use investigators who have received specialized training in sexual abuse investigations involving juvenile victims as required by 115.334? ☒ Yes ☐ No

**115.371 (c)**

- Do investigators gather and preserve direct and circumstantial evidence, including any available physical and DNA evidence and any available electronic monitoring data? ☒ Yes ☐ No

- Do investigators interview alleged victims, suspected perpetrators, and witnesses? ☒ Yes ☐ No

- Do investigators review prior reports and complaints of sexual abuse involving the suspected perpetrator? ☒ Yes ☐ No

**115.371 (d)**

- Does the agency always refrain from terminating an investigation solely because the source of the allegation recants the allegation? ☒ Yes ☐ No

**115.371 (e)**

- When the quality of evidence appears to support criminal prosecution, does the agency conduct compelled interviews only after consulting with prosecutors as to whether compelled interviews may be an obstacle for subsequent criminal prosecution? ☐ Yes ☒ No

**115.371 (f)**

- Do agency investigators assess the credibility of an alleged victim, suspect, or witness on an individual basis and not on the basis of that individual's status as resident or staff? ☒ Yes ☐ No

- Does the agency investigate allegations of sexual abuse without requiring a resident who alleges sexual abuse to submit to a polygraph examination or other truth-telling device as a condition for proceeding? ☒ Yes ☐ No

**115.371 (g)**

- Do administrative investigations include an effort to determine whether staff actions or failures to act contributed to the abuse? ☒ Yes ☐ No

- Are administrative investigations documented in written reports that include a description of the physical evidence and testimonial evidence, the reasoning behind credibility assessments, and investigative facts and findings? ☒ Yes ☐ No

**115.371 (h)**

- Are criminal investigations documented in a written report that contains a thorough description of the physical, testimonial, and documentary evidence and attaches copies of all documentary evidence where feasible? ☒ Yes ☐ No

**115.371 (i)**

- Are all substantiated allegations of conduct that appears to be criminal referred for prosecution? ☒ Yes ☐ No

**115.371 (j)**

- Does the agency retain all written reports referenced in 115.371(g) and (h) for as long as the alleged abuser is incarcerated or employed by the agency, plus five years unless the abuse was committed by a juvenile resident and applicable law requires a shorter period of retention? ☒ Yes ☐ No

**115.371 (k)**

- Does the agency ensure that the departure of an alleged abuser or victim from the employment or control of the agency does not provide a basis for terminating an investigation? ☒ Yes ☐ No

**115.371 (l)**

- Auditor is not required to audit this provision.

**115.371 (m)**

- When an outside entity investigates sexual abuse, does the facility cooperate with outside investigators and endeavor to remain informed about the progress of the investigation? (N/A if an outside agency does not conduct administrative or criminal sexual abuse investigations. See 115.321(a).) ☒ Yes ☐ No ☐ NA

**Auditor Overall Compliance Determination**

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

**Instructions for Overall Compliance Determination Narrative**

*The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.*

**Documents Reviewed:**
Facility Policy 3.11
Training Certificates
MOU, Bowling Green Police Division
Letter, Chief of Police

**Interviews:**
Intake Coordinator
Counselor
Random Staff
PREA Coordinator
Director

**Provision (a):**
When the agency conducts its own investigations into allegations of sexual abuse and sexual harassment, it shall do so promptly, thoroughly, and objectively for all allegations, including third-party and anonymous reports.

The administrative investigations are conducted by the facility-based investigators. Based on Policy, training certificates, and interviews, trained investigators conduct administrative investigations. Allegations that are criminal in nature are referred to the Bowling Green Police Division and Wood County Job and Family Services. Additionally, allegations of sexual abuse are reported to the Ohio Department of Youth Services. Investigations are conducted thoroughly and objectively based on the Policy, training provided and interviews.

**Provision (b) and (c):**
**Provision (b):** Where sexual abuse is alleged, the agency shall use investigators who have received special training in sexual abuse investigations involving juvenile victims pursuant to §115.334. **Provision (c):** Investigators shall gather and preserve direct and circumstantial evidence, including any available physical and DNA evidence and any available electronic monitoring data; shall interview alleged victims, suspected perpetrators, and witnesses; and shall review prior complaints and reports of sexual abuse involving the suspected perpetrator.

The investigative staff is trained through the online courses with the National Institute of Corrections. The Investigator gathers direct and circumstantial evidence that includes but is not limited to reviewing video,

gathering witness statements, and reviewing logs. The law enforcement investigator and/or qualified medical practitioner would be responsible for collecting direct physical and DNA evidence. The facility staff does not collect DNA evidence however the training includes how to assist in preserving evidence. The MOU and letter from the Police Chief provide for the law enforcement agency to conduct investigations that are criminal in nature and identifies the applicable PREA standards that will be followed.

**Provision (d):**
The agency shall not terminate an investigation solely because the source of the allegation recants the allegation.

The facility-based investigator interview and Policy confirm the provision that an investigation is not terminated if the source recants an allegation of sexual abuse or sexual harassment.

**Provision (e):**
When the quality of evidence appears to support criminal prosecution, the agency shall conduct compelled interviews only after consulting with prosecutors as to whether compelled interviews may be an obstacle for subsequent criminal prosecution.

The Bowling Green Police Division will consult with the prosecutor's office regarding compelled interviews based on the that agency's responsibility in conducting allegations that are criminal in nature. Facility-based investigators do not conduct compelled interviews.

**Provision (f):**
The credibility of an alleged victim, suspect, or witness shall be assessed on an individual basis and shall not be determined by the person's status as resident or staff. No agency shall require a resident who alleges sexual abuse to submit to a polygraph examination or other truth-telling device as a condition for proceeding with the investigation of such an allegation.

The credibility of an alleged victim, suspect, or witness is assessed on an individual basis and is not determined by the person's status as a resident or staff as supported by the interviews and training. No resident who alleges sexual abuse will be subjected to a polygraph examination or other truth telling device as a condition for proceeding with the investigation of the allegation.

**Provisions (g) and (h):**
**Provision (g):** Administrative investigations:
(1) Shall include an effort to determine whether staff actions or failures to act contributed to the abuse.
(2) Shall be documented in written reports that include a description of the physical and testimonial evidence, the reasoning behind credibility assessments, and investigative facts and findings.
**Provision (h):** Criminal investigations shall be documented in a written report that contains a thorough description of physical, testimonial, and documentary evidence and attaches copies of all documentary evidence where feasible.

The interviews revealed that PREA investigations include an effort to determine whether staff actions or failures to act contributed to the abuse. Investigations will be completed with written reports that include a description of the evidence and investigative facts and findings as gleaned from review of documentation and the interviews. The letter from the Police Chief of the Bowling Green Police Division confirms the appropriate training received by the Division's investigators and their experience to conduct

a professional investigation. There have been no criminal investigations conducted at the facility during this audit period.

**Provision (i):**
Substantiated allegations of conduct that appears to be criminal shall be referred for prosecution.

The Policy provides for this standard provision. The facility-based investigators do not conduct criminal investigations. It is the responsibility of the Bowling Green Police Division to refer cases for prosecution based on the outcome of the investigation.

**Provision (j):**
The agency shall retain all written reports referenced in paragraphs (g) and (h) of this section for as long as the alleged abuser is incarcerated or employed by the agency, plus five years, unless the abuse was committed by a juvenile resident and applicable law requires a shorter period of retention.

The written investigative reports are maintained in accordance with the Policy which defers to what is required by federal, state or local law. The Policy is aligned with the standard.

**Provision (k):**
The departure of the alleged abuser or victim from the employment or control of the facility or agency shall not provide a basis for terminating an investigation.

The interviews and Policy confirm that upon the start of an investigation, it will not end until the investigation has been completed. The departure of the alleged abuser or victim from the employment or control of the facility will not terminate the investigation.

**Provision (l):**
Any State entity or Department of Justice component that conducts such investigations shall do so pursuant to the above requirements.

The investigative agencies are aware of the PREA standards requirements through the initial sharing of PREA information, MOU and subsequent interactions. The Department of Justice does not conduct investigations in this facility.

**Provision (m):**
When outside agencies investigate sexual abuse, the facility shall cooperate with outside investigators and shall endeavor to remain informed about the progress of the investigation.

The Policy, MOU, letter from Police Chief, and interviews indicate that staff cooperate with investigators and that the facility is kept informed of the progress of an investigation. Communication is maintained between facility staff and the applicable investigative entity.

**Conclusion:**
Based upon the review and analysis of the available evidence and interviews, the Auditor determined the facility is compliant with this standard.

## Standard 115.372: Evidentiary Standard for Administrative Investigations

**All Yes/No Questions Must Be Answered by the Auditor to Complete the Report**

**115.372 (a)**

- Is it true that the agency does not impose a standard higher than a preponderance of the evidence in determining whether allegations of sexual abuse or sexual harassment are substantiated? ☒ Yes ☐ No

**Auditor Overall Compliance Determination**

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

**Instructions for Overall Compliance Determination Narrative**

*The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.*

**Document Reviewed:**
Facility Policy 3.11
**Interviews:**
Director
Intake Coordinator
Counselor

**Provision (a):**
The agency shall impose no standard higher than a preponderance of the evidence in determining whether allegations of sexual abuse or sexual harassment are substantiated.

The facility-based investigators, responsible for administrative investigations, impose a standard of a preponderance of the evidence for determining whether allegations of sexual abuse or sexual harassment are substantiated. The practice is aligned with Policy.

**Conclusion:**
Based upon the review and analysis of the evidence, the Auditor determined the facility is compliant with this standard.

## Standard 115.373: Reporting to Residents

**All Yes/No Questions Must Be Answered by the Auditor to Complete the Report**

**115.373 (a)**

- Following an investigation into a resident's allegation that he or she suffered sexual abuse in an agency facility, does the agency inform the resident as to whether the allegation has been determined to be substantiated, unsubstantiated, or unfounded? ☒ Yes ☐ No

**115.373 (b)**

- If the agency did not conduct the investigation into a resident's allegation of sexual abuse in an agency facility, does the agency request the relevant information from the investigative agency in order to inform the resident? (N/A if the agency/facility is responsible for conducting administrative and criminal investigations.) ☒ Yes ☐ No ☐ NA

**115.373 (c)**

- Following a resident's allegation that a staff member has committed sexual abuse against the resident, unless the agency has determined that the allegation is unfounded, or unless the resident has been released from custody, does the agency subsequently inform the resident whenever: The staff member is no longer posted within the resident's unit? ☒ Yes ☐ No

- Following a resident's allegation that a staff member has committed sexual abuse against the resident, unless the agency has determined that the allegation is unfounded, or unless the resident has been released from custody, does the agency subsequently inform the resident whenever: The staff member is no longer employed at the facility? ☒ Yes ☐ No

- Following a resident's allegation that a staff member has committed sexual abuse against the resident, unless the agency has determined that the allegation is unfounded, or unless the resident has been released from custody, does the agency subsequently inform the resident whenever: The agency learns that the staff member has been indicted on a charge related to sexual abuse in the facility? ☒ Yes ☐ No

- Following a resident's allegation that a staff member has committed sexual abuse against the resident, unless the agency has determined that the allegation is unfounded, or unless the resident has been released from custody, does the agency subsequently inform the resident whenever: The agency learns that the staff member has been convicted on a charge related to sexual abuse within the facility? ☒ Yes ☐ No

**115.373 (d)**

- Following a resident's allegation that he or she has been sexually abused by another resident, does the agency subsequently inform the alleged victim whenever: The agency learns that the alleged abuser has been indicted on a charge related to sexual abuse within the facility? ☒ Yes ☐ No

- Following a resident's allegation that he or she has been sexually abused by another resident, does the agency subsequently inform the alleged victim whenever: The agency learns that the alleged abuser has been convicted on a charge related to sexual abuse within the facility? ☒ Yes ☐ No

**115.373 (e)**

- Does the agency document all such notifications or attempted notifications? ☒ Yes ☐ No

**115.373 (f)**

- Auditor is not required to audit this provision.

**Auditor Overall Compliance Determination**

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

**Instructions for Overall Compliance Determination Narrative**

*The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.*

**Documents Reviewed:**
Facility Policy 3.12-2, PREA Reporting to Residents
Residents Notification of Findings Form
**Interviews:**
Director
PREA Coordinator
Investigative Staff (2)

**Provision (a):**
Following an investigation into a resident's allegation of sexual abuse suffered in an agency facility, the agency shall inform the resident as to whether the allegation has been determined to be substantiated, unsubstantiated, or unfounded.

Policy addresses the resident being informed when a sexual abuse investigation is completed and the outcome of the investigation provided in writing. The results of such investigations will be documented and provided to the resident. The Policy provides that any resident who makes an allegation of sexual abuse shall be informed verbally by the Director or Counselor and in writing following an investigation, as to whether or not the allegation was substantiated, unsubstantiated or unfounded. The interviews revealed awareness of the requirement.

**Provision (b):**
If the agency did not conduct the investigation, it shall request the relevant information from the investigative agency in order to inform the resident.

The Director and/or PREA Coordinator will remain abreast of an investigation conducted by any of the investigative entities by serving as the primary contact person/s and will be provided a copy of completed investigations. The results of the investigation will be provided to the resident in writing as discussed above.

**Provision (c):**
Following a resident's allegation that a staff member has committed sexual abuse against the resident, the agency shall subsequently inform the resident (unless the agency has determined that the allegation is unfounded) whenever:
(1) The staff member is no longer posted within the resident's unit;
(2) The staff member is no longer employed at the facility;
(3) The agency learns that the staff member has been indicted on a charge related to sexual abuse within the facility; or
(4) The agency learns that the staff member has been convicted on a charge related to sexual abuse within the facility.

Policy requires that following a resident's allegation that a staff member committed sexual abuse against the resident, the resident will be informed, in writing, of the following, unless it has been determined that the allegation is unfounded, whenever:

a. The staff member is no longer posted within the resident's housing unit;
b. The staff member is no longer employed at the facility;
c. The staff member has been indicted on a charge related to sexual abuse in the facility; or
d. The staff member has been convicted on a charge related to sexual abuse in the facility.

**Provision (d):**
Following a resident's allegation that he or she has been sexually abused by another resident, the agency shall subsequently inform the alleged victim whenever:
(1) The agency learns that the alleged abuser has been indicted on a charge related to sexual abuse within the facility; or
(2) The agency learns that the alleged abuser has been convicted on a charge related to sexual abuse within the facility.

Policy provides that following a resident's allegation of being sexually abused by another resident the alleged victim shall be informed whenever:

a. The alleged abuser is criminally charged related to the sexual abuse.
b. The alleged abuser is indicted related to the sexual abuse.
c. The alleged abuser is convicted on a charge related to sexual abuse.

**Provision (e):**
All such notifications or attempted notifications shall be documented.

Policy provides for the notification to the resident be documented. The Resident Notification of Findings Form has been created and will serve to notify the resident in writing of the results of an investigation and any disposition of the alleged perpetrator. The notification will be made by the Director and Counselor as prescribed by Policy. According to the interviews, there is familiarity with the Policy.

**Provision (f):**
An agency's obligation to report under this standard shall terminate if the resident is released from the agency's custody.

The agency's obligation to report under this standard terminates if the resident is released from the facility's custody, in accordance with Policy.

**Conclusion:**
The interviews and review of Policy and other documentation confirmed the facility is compliant with this standard.

# DISCIPLINE

## Standard 115.376: Disciplinary Sanctions for Staff

**All Yes/No Questions Must Be Answered by the Auditor to Complete the Report**

**115.376 (a)**

- Are staffs subject to disciplinary sanctions up to and including termination for violating agency sexual abuse or sexual harassment policies? ☒ Yes ☐ No

**115.376 (b)**

- Is termination the presumptive disciplinary sanction for staff who have engaged in sexual abuse? ☒ Yes ☐ No

**115.376 (c)**

- Are disciplinary sanctions for violations of agency policies relating to sexual abuse or sexual harassment (other than actually engaging in sexual abuse) commensurate with the nature and circumstances of the acts committed, the staff member's disciplinary history, and the sanctions imposed for comparable offenses by other staff with similar histories? ☒ Yes ☐ No

**115.376 (d)**

- Are all terminations for violations of agency sexual abuse or sexual harassment policies, or resignations by staff who would have been terminated if not for their resignation, reported to: Law enforcement agencies (unless the activity was clearly not criminal)? ☒ Yes ☐ No

- Are all terminations for violations of agency sexual abuse or sexual harassment policies, or resignations by staff that would have been terminated if not for their resignation, reported to: Relevant licensing bodies? ☒ Yes ☐ No

**Auditor Overall Compliance Determination**

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

**Instructions for Overall Compliance Determination Narrative**

*The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.*

**Document Reviewed:**
Facility Policy 2.19, PREA: Staff Discipline for Sexual Abuse or Sexual Harassment

**Interview:**
Director

**Provision (a):**
Staff shall be subject to disciplinary sanctions up to and including termination for violating agency sexual abuse or sexual harassment policies.

The Policy and interviews support that staff be subject to disciplinary sanctions up to and including termination for violating facility sexual abuse or sexual harassment policies. The interview with the Director, who is responsible for personnel duties, confirmed knowledge of the Policy.

**Provision (b):**
Termination shall be the presumptive disciplinary sanction for staff who has engaged in sexual abuse.

Termination is the presumptive disciplinary sanction for staff who has engaged in sexual abuse with a resident. The interview and Policy are aligned with this premise. The facility reports that no staff member violated Policy regarding sexual abuse or sexual harassment during this audit period.

**Provision (c):**
Disciplinary sanctions for violations of agency policies relating to sexual abuse or sexual harassment shall be commensurate with the nature and circumstances of the acts committed, the staff member's disciplinary history, and the sanctions imposed for comparable offenses by other staff with similar histories.

Any staff with findings other than actually engaging in sexual abuse will be subject to measures appropriate to the circumstance of the incident and the other components of the provision, in accordance with Policy. Disciplinary sanctions for violations of policies 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.

**Provision (d):**
All terminations for violations of agency sexual abuse or sexual harassment policies, or resignations by staff who would have been terminated if not for their resignation, shall be reported to law enforcement agencies, unless the activity was clearly not criminal, and to any relevant licensing bodies.

Policy provides that terminations for violations of the facility's sexual abuse or sexual harassment policies or resignations by staff that would have been terminated if not for their resignation, will be reported to law

enforcement, unless the activity is clearly not criminal. Such information will also be reported to relevant licensing bodies. No staff member has been terminated for violating the facility's sexual abuse or sexual harassment policies during this audit period.

**Conclusion:**
Based upon the review of documentation and the interview, the Auditor determined the facility is compliant with this standard.

## Standard 115.377: Corrective Action for Contractors and Volunteers

**All Yes/No Questions Must Be Answered by the Auditor to Complete the Report**

**115.377 (a)**

- Is any contractor or volunteer who engages in sexual abuse prohibited from contact with residents? ☒ Yes ☐ No
- Is any contractor or volunteer who engages in sexual abuse reported to: Law enforcement agencies (unless the activity was clearly not criminal)? ☒ Yes ☐ No
- Is any contractor or volunteer who engages in sexual abuse reported to: Relevant licensing bodies? ☒ Yes ☐ No

**115.377 (b)**

- In the case of any other violation of agency sexual abuse or sexual harassment policies by a contractor or volunteer, does the facility take appropriate remedial measures, and consider whether to prohibit further contact with residents? ☒ Yes ☐ No

**Auditor Overall Compliance Determination**

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

**Instructions for Overall Compliance Determination Narrative**

*The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.*

**Documents Reviewed:**
Facility Policy 2.20, PREA: Corrective Action for Contractors and Volunteers

Acknowledgement Forms

**Interviews:**
Contractors (3)

**Provision (a):**
Any contractor or volunteer who engages in sexual abuse shall be prohibited from contact with residents and shall be reported to law enforcement agencies, unless the activity was clearly not criminal, and to relevant licensing bodies.

The Policy provides for contractors and any volunteers who engage in sexual abuse with a resident to be reported to law enforcement and to relevant licensing bodies. Documentation and interviews with contractors confirm contractors and volunteers receive a clear understanding that sexual misconduct with a resident is prohibited. Any contractor or volunteer who violates the agency's sexual abuse or sexual harassment policies is prohibited from contact with residents. The acknowledgement statements confirm the details regarding PREA is provided to contractors and will be provided to volunteers. During this audit period, there have been no allegation of sexual abuse and no allegation of sexual harassment regarding a contractor or volunteer. Volunteers have been restricted due to COVID-19 concerns.

**Provision (b):**
The facility shall take appropriate remedial measures, and shall consider whether to prohibit further contact with residents, in the case of any other violation of agency sexual abuse or sexual harassment policies by a contractor or volunteer.

Policies and the interviews confirm that the appropriate remedial measures will be taken and include prohibiting further contact with residents in the case of any violation of the sexual abuse and sexual harassment Policy by a contractor or volunteer. Acknowledgement statements revealed that training provides contractors and volunteers a clear understanding that sexual misconduct with a resident is strictly prohibited. In the past 12 months, no contractors or volunteers were reported for allegations of sexual abuse or sexual harassment.

**Conclusion:**
Based upon the review of the documentation and interviews, the Auditor determined the facility is compliant with this standard.

## Standard 115.378: Interventions and Disciplinary Sanctions for Residents

**All Yes/No Questions Must Be Answered by the Auditor to Complete the Report**

**115.378 (a)**

- Following an administrative finding that a resident engaged in resident-on-resident sexual abuse, or following a criminal finding of guilt for resident-on-resident sexual abuse, may residents be subject to disciplinary sanctions only pursuant to a formal disciplinary process?
  ☒ Yes ☐ No

**115.378 (b)**

- Are disciplinary sanctions commensurate with the nature and circumstances of the abuse committed, the resident's disciplinary history, and the sanctions imposed for comparable offenses by other residents with similar histories? ☒ Yes ☐ No

- In the event a disciplinary sanction results in the isolation of a resident, does the agency ensure the resident is not denied daily large-muscle exercise? ☒ Yes ☐ No

- In the event a disciplinary sanction results in the isolation of a resident, does the agency ensure the resident is not denied access to any legally required educational programming or special education services? ☒ Yes ☐ No

- In the event a disciplinary sanction results in the isolation of a resident, does the agency ensure the resident receives daily visits from a medical or mental health care clinician? ☒ Yes ☐ No

- In the event a disciplinary sanction results in the isolation of a resident, does the resident also have access to other programs and work opportunities to the extent possible? ☒ Yes ☐ No

**115.378 (c)**

- When determining what types of sanction, if any, should be imposed, does the disciplinary process consider whether a resident's mental disabilities or mental illness contributed to his or her behavior? ☒ Yes ☐ No

**115.378 (d)**

- If the facility offers therapy, counseling, or other interventions designed to address and correct underlying reasons or motivations for the abuse, does the facility consider whether to offer the offending resident participation in such interventions? ☒ Yes ☐ No

- If the agency requires participation in such interventions as a condition of access to any rewards-based behavior management system or other behavior-based incentives, does it always refrain from requiring such participation as a condition to accessing general programming or education? ☒ Yes ☐ No

**115.378 (e)**

- Does the agency discipline a resident for sexual contact with staff only upon a finding that the staff member did not consent to such contact? ☒ Yes ☐ No

**115.378 (f)**

- For the purpose of disciplinary action does a report of sexual abuse made in good faith based upon a reasonable belief that the alleged conduct occurred NOT constitute falsely reporting an incident or lying, even if an investigation does not establish evidence sufficient to substantiate the allegation? ☒ Yes ☐ No

**115.378 (g)**

- Does the agency always refrain from considering non-coercive sexual activity between residents to be sexual abuse? (N/A if the agency does not prohibit all sexual activity between residents.)
  ☒ Yes ☐ No ☐ NA

**Auditor Overall Compliance Determination**

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

**Instructions for Overall Compliance Determination Narrative**

*The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.*

**Documents Reviewed:**
Facility Policy 6.02-1, PREA: Intervention and Discipline for Residents for Residents Who Engage in Sexual Abuse
Resident Handbook

**Interviews:**
Director
PREA Coordinator
Nurse
Counselor

**Provision (a):**
A resident may be subject to disciplinary sanctions only pursuant to a formal disciplinary process following an administrative finding that the resident engaged in resident-on-resident sexual abuse or following a criminal finding of guilt for resident-on-resident sexual abuse.

The Policy addresses an administrative process which exists for dealing with violations and residents being held accountable for their actions. Residents may be subject to disciplinary sanctions only after formal proceedings regarding resident-on-resident sexual abuse. Residents found in violation of facility rules are subject to sanctions pursuant to a formal process. Sanctions are directly related to the seriousness of the negative behavior.

The consequences will be administered through the administrative system, encompassing the behavior management system. Allegations of sexual abuse are referred for an investigation to the appropriate investigative entities and may result in charges being filed and the resident being removed from the facility where they may be criminal in nature. Sexual activity between residents is prohibited.

**Provision (b):**

Any disciplinary sanctions shall be commensurate with the nature and circumstances of the abuse committed, the resident's disciplinary history, and the sanctions imposed for comparable offenses by other residents with similar histories. In the event a disciplinary sanction results in the isolation of a resident, agencies shall not deny the resident daily large-muscle exercise or access to any legally required educational programming or special education services. Residents in isolation shall receive daily visits from a medical or mental health care clinician. Residents shall also have access to other programs and work opportunities to the extent possible.

Disciplinary sanctions, applicable to the offense, are commensurate with the nature and circumstances of the offense committed; considers resident's disciplinary history; and considers similar disciplinary history of other residents. There is consideration of mental disabilities or mental illness contributing to the behavior. PREA related violations may result in charges filed and the resident transported to a detention facility based on the circumstances of the incident. Allegations of sexual abuse are referred for an investigation to the appropriate investigative entities.

Isolation is not used as a disciplinary sanction in the facility as confirmed by facility Policy and the interviews. However, in the event a disciplinary sanction results in the isolation of a resident, he will not be denied daily large-muscle exercise or access to any legally required educational programming or special education services. Residents will also have access to other programs and work opportunities to the extent possible and receive daily visits from medical and mental health staff.

**Provision (c):**
The disciplinary process shall consider whether a resident's mental disabilities or mental illness contributed to his or her behavior when determining what type of sanction, if any, should be imposed.

Disciplinary and other processes consider whether a resident's mental disabilities or mental illness contributed to a resident's behavior regarding the application of disciplinary measures. The related interviews were aligned with this provision. Staff will examine a resident's behavior and disciplinary history when deciding disciplinary matters. Staff will consider whether a resident's mental disabilities or mental illness contributed to his behavior when determining the type of sanction, if any, should be imposed.

**Provision (d):**
If the facility offers therapy, counseling, or other interventions designed to address and correct underlying reasons or motivations for the abuse, the facility shall consider whether to offer the offending resident participation in such interventions. The agency may require participation in such interventions as a condition of access to any rewards-based behavior management system or other behavior-based incentives, but not as a condition to access to general programming or education.

The facility would consider whether to offer an offending resident intervention services designed to address and correct underlying reasons or motivations for the abuse participation. According to the interview with the Counselor, participation in such interventions is not required as a condition for participation in general programming or education or the awards-based behavior management system. Staff members within the mental health area are equipped to develop treatment planning and interventions to address underlying reasons or motivations for the abuse with alleged victims and offending residents.

**Provision (e):**
The agency may discipline a resident for sexual contact with staff only upon a finding that the staff member did not consent to such contact.

Policy provides that a resident may be disciplined for sexual contact with staff only upon a finding that the staff member did not consent to such contact.

**Provision (f):**
For the purpose of disciplinary action, a report of sexual abuse made in good faith based upon a reasonable belief that the alleged conduct occurred shall not constitute falsely reporting an incident or lying, even if an investigation does not establish evidence sufficient to substantiate the allegation.

Any resident reporting in good faith shall be immune from any civil or criminal liability. A report of sexual abuse made in good faith based on the belief that the alleged incident occurred does not constitute falsely reporting an incident or lying, even if an investigation does not establish evidence sufficient to substantiate the allegation, in accordance with Policy.

**Provision (g):**
An agency may, in its discretion, prohibit all sexual activity between residents and may discipline residents for such activity. An agency may not, however, deem such activity to constitute sexual abuse if it determines that the activity is not coerced.

Policy prohibits any sexual conduct between residents. All such conduct is subject to disciplinary action as a rule violation. Referrals are made to the investigative entities and court processes occur after determination that the sexual activity was coerced.

**Conclusion:**
Based on the available evidence and interviews, the Auditor concluded the facility is compliant with the standard.

# MEDICAL AND MENTAL CARE

## Standard 115.381: Medical and Mental Health Screenings; History of Sexual Abuse

**All Yes/No Questions Must Be Answered by the Auditor to Complete the Report**

**115.381 (a)**

- If the screening pursuant to § 115.341 indicates that a resident has experienced prior sexual victimization, whether it occurred in an institutional setting or in the community, do staff ensure that the resident is offered a follow-up meeting with a medical or mental health practitioner within 14 days of the intake screening? ☒ Yes ☐ No

**115.381 (b)**

- If the screening pursuant to § 115.341 indicates that a resident has previously perpetrated sexual abuse, whether it occurred in an institutional setting or in the community, do staff ensure that the resident is offered a follow-up meeting with a mental health practitioner within 14 days of the intake screening? ☒ Yes ☐ No

**115.381 (c)**

- Is any information related to sexual victimization or abusiveness that occurred in an institutional setting strictly limited to medical and mental health practitioners and other staff as necessary to inform treatment plans and security management decisions, including housing, bed, work, education, and program assignments, or as otherwise required by Federal, State, or local law? ☒ Yes ☐ No

**115.381 (d)**

- Do medical and mental health practitioners obtain informed consent from residents before reporting information about prior sexual victimization that did not occur in an institutional setting, unless the resident is under the age of 18? ☒ Yes ☐ No

**Auditor Overall Compliance Determination**

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

**Instructions for Overall Compliance Determination Narrative**

*The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.*

**Documents Reviewed:**
Facility Policy 4.05-1, Medical and Mental Health Screenings/Access for Services of Sexual Abuse Receiving Screening with Mental Health
Case Notes
Vulnerability Assessments
Informed Consent Form

**Interviews:**
Nurse
Counselors (2)
Residents

**Provision (a) and (b):**
**Provision (a):** If the screening pursuant to §115.341 indicates that a resident has experienced prior sexual victimization, whether it occurred in an institutional setting or in the community, staff shall ensure that the resident is offered a follow-up meeting with a medical or mental health practitioner within 14 days of the intake screening.

**Provision (b):** If the screening pursuant to §115.341 indicates that a resident has previously perpetrated sexual abuse, whether it occurred in an institutional setting or in the community, staff shall ensure that the resident is offered a follow-up meeting with a mental health practitioner within 14 days of the intake screening.

Policy and practice provide that a resident be referred to mental health or medical staff within 14 days if identified as having been a victim or perpetrator of sexual abuse. The interviews with clinical staff revealed that the issues are identified and addressed. The practice is residents are generally seen by medical and mental health staff on the same day of admission as part of the intake process and follow-up is provided immediately. Referrals are made to ensure the follow-up meeting with mental health staff. It is noted on the vulnerability assessment in the appropriate space that a meeting will be held within 14 days.

**Provision (c):**
Any information related to sexual victimization or abusiveness that occurred in an institutional setting shall be strictly limited to medical and mental health practitioners and other staff, as necessary, to inform treatment plans and security and management decisions, including housing, bed, work, education, and program assignments, or as otherwise required by Federal, State, or local law.

Policy supports that no information is to be shared with other staff unless it is required for security and management decisions regarding sexual victimization or abusiveness. Information related to sexual victimization or abusiveness that occurred in an institutional setting is limited to medical and mental health practitioners and other staff, based on their need to know. The resident files are maintained in a secure manner in a locked file cabinet behind a locked door.

**Provision (d):**
Medical and mental health practitioners shall obtain informed consent from residents before reporting information about prior sexual victimization that did not occur in an institutional setting, unless the resident is under the age of 18.

Policy addresses informed consent being obtained for residents 18 years or over prior to clinical personnel reporting information disclosed about prior sexual victimization that did not occur in an institutional setting. Clinical staff members understand the practice of informed consent as demonstrated by the interviews and their knowledge of the use of the Informed Consent Form.

**Conclusion:**
Based upon the review and analysis of the available evidence, the Auditor determined the facility is compliant with this standard.

## Standard 115.382: Access to Emergency Medical and Mental Health Services

**All Yes/No Questions Must Be Answered by the Auditor to Complete the Report**

**115.382 (a)**

- Do resident victims of sexual abuse receive timely, unimpeded access to emergency medical treatment and crisis intervention services, the nature and scope of which are determined by medical and mental health practitioners according to their professional judgment? ☒ Yes ☐ No

**115.382 (b)**

- If no qualified medical or mental health practitioners are on duty at the time a report of recent sexual abuse is made, do staff first responders take preliminary steps to protect the victim pursuant to §115.362? ☒ Yes ☐ No

- Do staff first responders immediately notify the appropriate medical and mental health practitioners? ☒ Yes ☐ No

**115.382 (c)**

- Are resident victims of sexual abuse offered timely information about and timely access to emergency contraception and sexually transmitted infections prophylaxis, in accordance with professionally accepted standards of care, where medically appropriate? ☒ Yes ☐ No

**115.382 (d)**

- Are treatment services provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident? ☒ Yes ☐ No

**Auditor Overall Compliance Determination**

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

**Instructions for Overall Compliance Determination Narrative**

*The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.*

**Documentation Reviewed:**
Facility Policy 4.05-1, Medical and Mental Screenings/Access for Services of Sexual Abuse
Resident Handbook
Staff On-Call Rosters
Event Triggering Coordinated Response Plan
MOU, The Cocoon

**Interviews:**
Nurse
Counselor

Director
Advocacy Agency Representative

**Provision (a):**
Resident victims of sexual abuse shall receive timely, unimpeded access to emergency medical treatment and crisis intervention services, the nature and scope of which are determined by medical and mental health practitioners according to their professional judgment.

The collective interviews, Policy and MOU support the alleged victim will receive timely and unimpeded access to emergency medical treatment and crisis intervention services. The collective interviews were aligned with the Policy and MOU. The facility's clinical staff members included that the nature and scope of their services are determined according to their professional judgment. Residents are informed of clinical services, meet with those practitioners and are provided services during the intake process and during their stay in the facility. The alleged victim will get services within the facility as well as timely services in the community, as needed.

An alleged victim will be transported to the Wood County Hospital for a forensic medical examination. The examination will be performed at no cost to the victim and in accordance with the Policy, in response to an allegation of sexual abuse. The clinical staff acknowledged that their services are determined based on their professional judgment. Medical and mental health staff members maintain secondary materials and documentation of encounters with residents.

Residents are informed of medical, mental health and counseling services during intake and sign acknowledgement statements indicating key information reviewed in the PREA education sessions which include treatment services. The residents have access to request forms in their housing units. Additionally, residents have access to an outside victim advocacy agency for services which is The Cocoon/Wood County Rape Crisis Center. The MOU provides for but is not limited to emotional support and accompaniment through the forensic examination and investigative interviews. There have been no allegations of sexual abuse during this audit period.

**Provision (b):**
If no qualified medical or mental health practitioners are on duty at the time a report of recent abuse is made, staff first responders shall take preliminary steps to protect the victim pursuant to §115.362 and shall immediately notify the appropriate medical and mental health practitioners.

The interviews with clinical staff revealed residents have access to unimpeded access to emergency services, onsite and in the community. Policies provide guidance to staff in protecting residents and for contacting the appropriate staff and agencies regarding allegations or incidents of sexual abuse, including contacting administrative and treatment staffs and investigative entities. A review of the Policies; observations of the interactions among residents and staff during the site review; and the interviews indicated unimpeded medical and crisis intervention services are available to an alleged victim of sexual abuse.

Staff training also prepare staff members to appropriately report sexual abuse, protect the alleged victim and notify the appropriate staff and investigative entities. The Policy and written coordinated response plan exist for protecting residents and for contacting the appropriate staff regarding allegations or incidents of sexual abuse, including contacting medical and mental health staff onsite and through the on-call rosters.

**Provision (c):**

Resident victims of sexual abuse while incarcerated shall be offered timely information about and timely access to emergency contraception and sexually transmitted infections prophylaxis, in accordance with professionally accepted standards of care, where medically appropriate.

The Policy and interviews confirmed processes and services are in place for an alleged victim to receive timely access to sexually transmitted infection prophylaxis, where medically appropriate. If needed after an incident, follow-up services may be provided by the facility's medical and mental health staff members to provide follow-up and support services as needed. The standard of care and continuity of treatment practices within the facility, ensures the appropriate medical and mental health follow-up as needed.

**Provision (d):**
Treatment services shall be provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident.

Policy and interviews provide that treatment services will be provided to the victim without financial cost to the victim regardless of whether the victim names the abuser, or cooperate with any investigation arising out of the incident.

**Conclusion:**
Based on the evidence reviewed and interviews, the Auditor determined the facility is compliant with this standard.

## Standard 115.383: Ongoing Medical and Mental Health Care for Sexual Abuse Victims and Abusers

**All Yes/No Questions Must Be Answered by the Auditor to Complete the Report**

**115.383 (a)**

- Does the facility offer medical and mental health evaluation and, as appropriate, treatment to all residents who have been victimized by sexual abuse in any prison, jail, lockup, or juvenile facility? ☒ Yes ☐ No

**115.383 (b)**

- Does the evaluation and treatment of such victims include, as appropriate, follow-up services, treatment plans, and, when necessary, referrals for continued care following their transfer to, or placement in, other facilities, or their release from custody? ☒ Yes ☐ No

**115.383 (c)**

- Does the facility provide such victims with medical and mental health services consistent with the community level of care? ☒ Yes ☐ No

**115.383 (d)**

- Are resident victims of sexually abusive vaginal penetration while incarcerated offered pregnancy tests? (N/A if all-male facility.) ☐ Yes ☐ No ☒ NA

**115.383 (e)**

- If pregnancy results from the conduct described in paragraph § 115.383(d), do such victims receive timely and comprehensive information about and timely access to all lawful pregnancy-related medical services? (N/A if all-male facility.) ☐ Yes ☐ No ☒ NA

**115.383 (f)**

- Are resident victims of sexual abuse while incarcerated offered tests for sexually transmitted infections as medically appropriate? ☒ Yes ☐ No

**115.383 (g)**

- Are treatment services provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident? ☒ Yes ☐ No

**115.383 (h)**

- Does the facility attempt to conduct a mental health evaluation of all known resident-on-resident abusers within 60 days of learning of such abuse history and offer treatment when deemed appropriate by mental health practitioners? ☒ Yes ☐ No

**Auditor Overall Compliance Determination**

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

**Instructions for Overall Compliance Determination Narrative**

*The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.*

**Documents Reviewed:**
Facility Policy 4.05-02, Ongoing Medical and Mental Health Care for Sexual Abuse Victims or Abusers
Vulnerability Assessments
Follow-up Notification & Housing Information
Event Triggering Coordinated Response Plan

**Interviews:**

Nurse
Counselor
Director

**Provision (a):**
The facility shall offer medical and mental health evaluation and, as appropriate, treatment to all residents who have been victimized by sexual abuse in any prison, jail, lockup, or juvenile facility.

The Policy, coordinated response plan and interviews support that medical and mental health evaluation and treatment will be offered to resident victims of sexual abuse. The interviews support that follow-up and ongoing assessment and treatment services will be provided as needed and advocacy services are also available. Request and grievance forms and locked box receptacles for the receipt of the forms are located in each housing unit. Medical and treatment services are reviewed during the admissions process and referred to in the Resident Handbook.

**Provision (b):**
The evaluation and treatment of such victims shall include, as appropriate, follow-up services, treatment plans, and, when necessary, referrals for continued care following their transfer to, or placement in, other facilities, or their release from custody.

Policy provides that follow-up services will be provided. Interviews and documentation practice of regular encounters confirm on-going medical and treatment services will be provided as appropriate and will include but not be limited to treatment planning; evaluations; medication management; and other clinical follow-up and referrals as needed. Any directions contained in a hospital discharge summary will also be followed.

**Provision (c):**
The facility shall provide such victims with medical and mental health services consistent with the community level of care.

Review of Policy, interviews with the Counselor and Nurse, and observations during the site review indicated medical and treatment services are consistent with the community level of care. These services may be provided by facility staff and community services if needed. The interviews and observations during the site review underscored the treatment services at the facility are consistent with the community level of care.

**Provision (d):**
Resident victims of sexually abusive vaginal penetration while incarcerated shall be offered pregnancy tests.

The facility houses male residents only.

**Provision (e):**
If pregnancy results from conduct specified in paragraph (d) of this section, such victims shall receive timely and comprehensive information about and timely access to all lawful pregnancy-related medical services.

The facility houses male residents only.

**Provision (f):**

Resident victims of sexual abuse while incarcerated shall be offered tests for sexually transmitted infections as medically appropriate.

The interview with the Nurse ensures that victims of sexual abuse will be provided tests for sexually transmitted infections as medically appropriate. The test would be done at the hospital and additional follow-up services may be done at or through the facility. There have been no allegations of sexual abuse during this audit period.

**Provision (g):**
Treatment services shall be provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident.

All treatment services will be provided at no cost to the victim, in accordance with Policy. Whether or not the victim names the abuser or cooperates with the investigation, it remains that there is no cost to the victim regarding treatment.

**Provision (h):**
The facility shall attempt to conduct a mental health evaluation of all known resident-on-resident abusers within 60 days of learning of such abuse history and offer treatment when deemed appropriate by mental health practitioners.

Policy provides for attempts to be made for a mental health practitioner to conduct a mental health evaluation within 60 days of all known resident-on-resident abusers and offer appropriate treatment by mental health staff. Medical and mental health evaluation and treatment will be offered to resident victims of sexual abuse.

**Conclusion:**
Based upon the review and analysis of the documentation, the Auditor determined the facility is compliant with this standard.

# DATA COLLECTION AND REVIEW

## Standard 115.386: Sexual Abuse Incident Reviews

**All Yes/No Questions Must Be Answered by the Auditor to Complete the Report**

**115.386 (a)**

- Does the facility conduct a sexual abuse incident review at the conclusion of every sexual abuse investigation, including where the allegation has not been substantiated, unless the allegation has been determined to be unfounded? ☒ Yes ☐ No

**115.386 (b)**

- Does such review ordinarily occur within 30 days of the conclusion of the investigation? ☒ Yes ☐ No

**115.386 (c)**

- Does the review team include upper-level management officials, with input from line supervisors, investigators, and medical or mental health practitioners? ☒ Yes ☐ No

**115.386 (d)**

- Does the review team: Consider whether the allegation or investigation indicates a need to change policy or practice to better prevent, detect, or respond to sexual abuse? ☒ Yes ☐ No
- Does the review team: Consider whether the incident or allegation was motivated by race; ethnicity; gender identity; lesbian, gay, bisexual, transgender, or intersex identification, status, or perceived status; gang affiliation; or other group dynamics at the facility? ☒ Yes ☐ No
- Does the review team: Examine the area in the facility where the incident allegedly occurred to assess whether physical barriers in the area may enable abuse? ☒ Yes ☐ No
- Does the review team: Assess the adequacy of staffing levels in that area during different shifts? ☒ Yes ☐ No
- Does the review team: Assess whether monitoring technology should be deployed or augmented to supplement supervision by staff? ☒ Yes ☐ No
- Does the review team: Prepare a report of its findings, including but not necessarily limited to determinations made pursuant to §§ 115.386 (d) (1) - (d)(5), and any recommendations for improvement and submit such report to the facility head and PREA compliance manager? ☒ Yes ☐ No

**115.386 (e)**

- Does the facility implement the recommendations for improvement, or document its reasons for not doing so? ☒ Yes ☐ No

**Auditor Overall Compliance Determination**

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

**Instructions for Overall Compliance Determination Narrative**

*The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.*

**Documents Reviewed:**
Facility Policy 12.01, Sexual Abuse Incident Review
Alleged Sexual Abuse & Sexual Assault Post Incident Review Form

**Interviews:**
Counselor
Director

**Provision (a):**
The facility shall conduct a sexual abuse incident review at the conclusion of every sexual abuse investigation, including where the allegation has not been substantiated, unless the allegation has been determined to be unfounded.

The facility is required to conduct a sexual abuse incident review at the conclusion of an investigation, unless the allegation was unfounded. The interviews reflected an understanding of the role of the incident review team. A review of the Policy and designated form and interviews confirmed incident reviews will be conducted regarding the investigation of an allegation of sexual abuse, unless unfounded. The interviews confirm this premise and the understanding of the function of the incident review team.

**Provision (b):**
Such review shall ordinarily occur within 30 days of the conclusion of the investigation.
Policy requires that the review occurs within 30 days of the conclusion of the investigation. The interviews confirmed incident reviews will occur within the stated time period. The interviews revealed knowledge of the purpose of the incident review process.

**Provision (c):**
The incident review team shall include upper-level management officials, with input from line supervisors, investigators, and medical or mental health practitioners.

Policy and interviews collectively identify members of the incident review team: management; input from supervisors, investigators and clinical staff. The additional staff members will attend the meeting as needed, related to the incident.

**Provision (d):**
The review team shall:
(1) Consider whether the allegation or investigation indicates a need to change policy or practice to better prevent, detect, or respond to sexual abuse;
(2) Consider whether the incident or allegation was motivated by race; ethnicity; gender identity; lesbian, gay, bisexual, transgender, or intersex identification, status, or perceived status; or, gang affiliation; or was motivated or otherwise caused by other group dynamics at the facility;
(3) Examine the area in the facility where the incident allegedly occurred to assess whether physical barriers in the area may enable abuse.
(4) Assess the adequacy of staffing levels in that area during different shifts;
(5) Assess whether monitoring technology should be deployed or augmented to supplement supervision by staff; and

(6) Prepare a report of its findings, including but not necessarily limited to determinations made pursuant to paragraphs (d)(1)-(d)(5) of this section, and any recommendations for improvement and submit such report to the facility head and PREA compliance manager.

Policy and interviews collectively outline the requirements of the standard for the areas to be assessed by the incident review team. The interviews and review of Policy confirmed the incident review team is charged with considering the factors identified in this standard provision regarding the results of the investigation. The incident review process is documented through the use of the dedicated instrument, Alleged Sexual Abuse & Sexual Assault Post Incident Review Form.

The meeting minutes are recorded and the written report includes the assessment of the circumstances surrounding the incident and any recommendations for improvement. The review of the form demonstrates that the incident review team meeting documents that consideration will be given by team members in accordance with this provision of the Policy and Standard.

**Provision (e):**
The facility shall implement the recommendations for improvement, or shall document its reasons for not doing so.

Policy provides that the facility will implement the recommendations for improvement and that the reasons for not following recommendations are documented. The interviews revealed familiarity with the Policy requirements. The incident review process allows for the assessment of the circumstances surrounding the incident. The format for documenting the incident review process has been developed and includes recommendations if indicated, as determined from a review of the form and the interviews. The form provides for all incident review team members in attendance to sign the minutes, add job title and date to confirm participation in the meeting.

**Conclusion:**
Based upon the review of Policy and other documentation and interviews, the Auditor has determined the facility is compliant with this standard.

## Standard 115.387: Data Collection

**All Yes/No Questions Must Be Answered by the Auditor to Complete the Report**

**115.387 (a)**

- Does the agency collect accurate, uniform data for every allegation of sexual abuse at facilities under its direct control using a standardized instrument and set of definitions? ☒ Yes ☐ No

**115.387 (b)**

- Does the agency aggregate the incident-based sexual abuse data at least annually? ☒ Yes ☐ No

**115.387 (c)**

- Does the incident-based data include, at a minimum, the data necessary to answer all questions from the most recent version of the Survey of Sexual Violence conducted by the Department of Justice? ☒ Yes ☐ No

**115.387 (d)**

- Does the agency maintain, review, and collect data as needed from all available incident-based documents, including reports, investigation files, and sexual abuse incident reviews?
  ☒ Yes ☐ No

**115.387 (e)**

- Does the agency also obtain incident-based and aggregated data from every private facility with which it contracts for the confinement of its residents? (N/A if agency does not contract for the confinement of its residents.) ☐ Yes ☐ No ☒ NA

**115.387 (f)**

- Does the agency, upon request, provide all such data from the previous calendar year to the Department of Justice no later than June 30? (N/A if DOJ has not requested agency data.)
  ☒ Yes ☐ No ☐ NA

**Auditor Overall Compliance Determination**

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

**Instructions for Overall Compliance Determination Narrative**

*The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.*

**Documents Reviewed:**
Facility Policy 12.02, PREA Data Collection, Review and Storage
Annual PREA Report

**Interviews:**
PREA Coordinator
Director

**Provisions (a) & (c):**
**Provision (a):** The agency shall collect accurate, uniform data for every allegation of sexual abuse at facilities under its direct control using a standardized instrument and set of definitions.
**Provision (c):** The incident-based data collected shall include, at a minimum, the data necessary to answer all questions from the most recent version of the Survey of Sexual Violence conducted by the Department of Justice.

The Policy provides for the collection of accurate and uniform data for every allegation of sexual abuse from incident-based documents. The data is compiled into an annual report with the compilation of data gleaned from any PREA related and supporting documents. The ODYS collects data from its State run and its State funded facilities through a central reporting system. Policy contains a standardized set of definitions and provides support for the collection of accurate and uniform data. The agency maintains incident-based data complete enough to complete the most recent version of the instrument formerly identified as the Survey of Sexual Violence and now identified as the Survey of Sexual Victimization, upon request.

**Provision (b):**
The agency shall aggregate the incident-based sexual abuse data at least annually.

The facility and ODYS aggregate the incident-based, uniform data regarding allegations of sexual abuse and sexual harassment. The aggregated data contributes to the development of the annual report for the facility which is supported by the Policy.

**Provision (d):**
The agency shall maintain, review, and collect data as needed from all available incident-based documents, including reports, investigation files, and sexual abuse incident reviews.

The data is collected and various types of data are identified and related documents regarding PREA information as applicable. Policy requires that statistical information is maintained for various service areas and occurrences, including major incidents and medical and mental health emergencies. The facility maintains data and aggregates the data which culminates into the annual report.

**Provision (e):**
The agency also shall obtain incident-based and aggregated data from every private facility with which it contracts for the confinement of its residents.
The facility does not contract for the confinement of its residents. The facility receives funding from ODYS to house and provide treatment services for youth who would otherwise be in an ODYS correctional facility.

**Provision (f):**
Upon request, the agency shall provide all such data from the previous calendar year to the Department of Justice no later than June 30.

Upon request, the facility completes all such data from the previous calendar year and submits to the Department of Justice in a timely manner based on the year of the most recent version of the Survey of Sexual Victimization and upon request.

**Conclusion:**
Based upon the review and analysis of the documentation and the interviews, the Auditor determined the facility is compliant with this standard.

## Standard 115.388: Data Review for Corrective Action

**All Yes/No Questions Must Be Answered by the Auditor to Complete the Report**

**115.388 (a)**

- Does the agency review data collected and aggregated pursuant to § 115.387 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training, including by: Identifying problem areas? ☒ Yes ☐ No

- Does the agency review data collected and aggregated pursuant to § 115.387 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training, including by: Taking corrective action on an ongoing basis? ☒ Yes ☐ No

- Does the agency review data collected and aggregated pursuant to § 115.387 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training, including by: Preparing an annual report of its findings and corrective actions for each facility, as well as the agency as a whole? ☒ Yes ☐ No

**115.388 (b)**

- Does the agency's annual report include a comparison of the current year's data and corrective actions with those from prior years and provide an assessment of the agency's progress in addressing sexual abuse ☒ Yes ☐ No

**115.388 (c)**

- Is the agency's annual report approved by the agency head and made readily available to the public through its website or, if it does not have one, through other means? ☒ Yes ☐ No

**115.388 (d)**

- Does the agency indicate the nature of the material redacted where it redacts specific material from the reports when publication would present a clear and specific threat to the safety and security of a facility? ☒ Yes ☐ No

**Auditor Overall Compliance Determination**

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

**Instructions for Overall Compliance Determination Narrative**

*The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.*

**Documents Reviewed:**
Facility Policy 12.02
Annual Report

**Interviews:**
PREA Coordinator
Director

**Provision (a):**
The agency shall review data collected and aggregated pursuant to §115.387 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training, including:
(1) Identifying problem areas;
(2) Taking corrective action on an ongoing basis; and
(3) Preparing an annual report of its findings and corrective actions for each facility, as well as this agency as a whole.

The interviews support the review of data and that it is used to improve the agency's PREA efforts. The interviews and review of documentation revealed the collection of various types of data that is PREA related. Data is reviewed to assess and improve the effectiveness of prevention, detection and response within the agency as well as individual facilities. The review of reports and the lack of related data is primary to preparing annual reports for the facility and Ohio Department of Youth Services.

**Provisions (b)-(d):**
**Provision (b):** Such report shall include a comparison of the current year's data and corrective actions with those from prior years and shall provide an assessment of the agency's progress in addressing sexual abuse.
**Provision (c):** The agency's report shall be approved by the agency head and made readily available to the public through its website or, if it does not have one, through other means.
**Provision (d):** The agency may redact specific material from the reports when publication would present a clear and specific threat to the safety and security of a facility, but must indicate the nature of the material redacted.

The annual reports are reviewed and approved by the Director. There are no personal identifiers in the report and it did not require any redactions. The annual report contains PREA related data that represents the previous calendar years allowing for the comparison of data. The overarching annual report for the facility is posted on its website, accessible to the public.

**Conclusion:**
Based upon the review and analysis of the documentation, the Auditor determined the agency is compliant with this standard.

## Standard 115.389: Data Storage, Publication, and Destruction

**All Yes/No Questions Must Be Answered by the Auditor to Complete the Report**

**115.389 (a)**

- Does the agency ensure that data collected pursuant to § 115.387 are securely retained?
  ☒ Yes ☐ No

**115.389 (b)**

- Does the agency make all aggregated sexual abuse data, from facilities under its direct control and private facilities with which it contracts, readily available to the public at least annually through its website or, if it does not have one, through other means? ☒ Yes ☐ No

**115.389 (c)**

- Does the agency remove all personal identifiers before making aggregated sexual abuse data publicly available? ☒ Yes ☐ No

**115.389 (d)**

- Does the agency maintain sexual abuse data collected pursuant to § 115.387 for at least 10 years after the date of the initial collection, unless Federal, State, or local law requires otherwise? ☒ Yes ☐ No

**Auditor Overall Compliance Determination**

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

**Instructions for Overall Compliance Determination Narrative**

*The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.*

**Documents Reviewed:**
Facility Policy 12.02
Annual Report

**Interviews:**
Director
PREA Coordinator

**Provision (a)-(d):**
**Provision (a):** The agency shall ensure that data collected pursuant to §115.387 are securely retained.
**Provision (b):** The agency shall make all aggregated sexual abuse data, from facilities under its direct control and private facilities with which it contracts, readily available to the public at least annually through its website or, if it does not have one, through other means.

**Provision (c):** Before making aggregated sexual abuse data publicly available, the agency shall remove all personal identifiers.
**Provision (d):** The agency shall maintain sexual abuse data collected pursuant to §115.387 for at least 10 years after the date of its initial collection unless Federal, State, or local law requires otherwise.

Policy provides that the data collected is securely stored and maintained for at least 10 years after the initial date of collection unless a State or local statutes require otherwise. The annual report is available to the public through the facility website in accordance with Policy. Personal identifiers are not included in the annual report; a review of the annual report verified there are no personal identifiers. The PREA records are securely stored in a locked cabinet behind a lockable door and electronic records are password protected. The interviews and Policy support this premise.

**Conclusion:**
Based upon the review and analysis of the documentation, interviews and observations, the Auditor determined the facility is compliant with this standard.

# AUDITING AND CORRECTIVE ACTION

## Standard 115.401: Frequency and Scope of Audits

**All Yes/No Questions Must Be Answered by the Auditor to Complete the Report**

**115.401 (a)**

- During the prior three-year audit period, did the agency ensure that each facility operated by the agency, or by a private organization on behalf of the agency, was audited at least once? (*Note: The response here is purely informational. A "no" response does not impact overall compliance with this standard.*) ☒ Yes ☐ No

**115.401 (b)**

- Is this the first year of the current audit cycle? (*Note: a "no" response does not impact overall compliance with this standard.*) ☐ Yes ☒ No

- If this is the second year of the current audit cycle, did the agency ensure that at least one-third of each facility type operated by the agency, or by a private organization on behalf of the agency, was audited during the first year of the current audit cycle? (N/A if this is **not** the *second* year of the current audit cycle.) ☒ Yes ☐ No ☐ NA

- If this is the third year of the current audit cycle, did the agency ensure that at least two-thirds of each facility type operated by the agency, or by a private organization on behalf of the agency, were audited during the first two years of the current audit cycle? (N/A if this is **not** the *third* year of the current audit cycle.) ☐ Yes ☐ No ☒ NA

**115.401 (h)**

- Did the auditor have access to, and the ability to observe, all areas of the audited facility? ☒ Yes ☐ No

**115.401 (i)**

- Was the auditor permitted to request and receive copies of any relevant documents (including electronically stored information)? ☒ Yes ☐ No

**115.401 (m)**

- Was the auditor permitted to conduct private interviews with inmates, residents, and detainees? ☒ Yes ☐ No

**115.401 (n)**

- Were residents permitted to send confidential information or correspondence to the auditor in the same manner as if they were communicating with legal counsel? ☒ Yes ☐ No

**Auditor Overall Compliance Determination**

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

**Instructions for Overall Compliance Determination Narrative**

*The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.*

The PREA Pre-Audit Questionnaire and supporting documentation was initially provided to the Auditor on a flash drive. The Auditor was provided additional information by email and onsite, as requested. During the post audit phase, the Quality Assurance/PREA Coordinator provided the Auditor with evidence that the corrective actions were implemented. The Ohio Department of Youth Services ensures the completion of PREA audits for each state-run and identified State funded correctional facility as required, including this facility. The facility's previous PREA audit was conducted in 2018.

The site review was led by the Director and Quality Assurance/PREA Coordinator; all areas of the facility where residents go were included. The areas containing posted information were observed, including the areas where the virtual interviews were conducted. The Director, Quality Assurance/ PREA Coordinator, and ODYS PREA Administrator were cooperative in providing information and participating in or assisting in coordinating the identified staff interviews.

The virtual interviews were conducted in private with supervisory and management staffs. The PREA notices provided the general information and included instructions and Auditor contact information regarding how to provide confidential information to the Auditor. The facility has a process in place for confidential correspondence for the residents however no correspondence was received by the Auditor from residents or from staff.

## Standard 115.403: Audit Contents and Findings

**All Yes/No Questions Must Be Answered by the Auditor to Complete the Report**

**115.403 (f)**

- The agency has published on its agency website, if it has one, or has otherwise made publicly available, all Final Audit Reports within 90 days of issuance by auditor. The review period is for prior audits completed during the past three years PRECEDING THIS AGENCY AUDIT. In the case of single facility agencies, the auditor shall ensure that the facility's last audit report was published. The pendency of any agency appeal pursuant to 28 C.F.R. § 115.405 does not excuse noncompliance with this provision. (N/A if there have been no Final Audit Reports issued in the past three years, or in the case of single facility agencies that there has never been a Final Audit Report issued.) ☒ Yes ☐ No ☐ NA

**Auditor Overall Compliance Determination**

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

**Instructions for Overall Compliance Determination Narrative**

*The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.*

**Documents Reviewed:**
Policy 12.02
Annual Reports

**Interviews:**
Quality Assurance/PREA Coordinator
ODYS PREA Administrator

**Provision (f):**

The agency shall ensure that the auditor's final report is published on the agency's website if it has one, or is otherwise made readily available to the public.

The posted PREA reports do not contain any personal identifying information other than selected names and job titles. The facility policies and additional documentation, practices and staff interviews were reviewed regarding compliance with the standards and have been identified in the reports.

The audit findings were based on the triangulation of the data sources: review of policies, procedures, and supporting documentation; observations; and interviews with residents, staff and community agency representative. There were no conflicts of interest regarding the completion of this audit. This report does not contain any personal identifying information other than names and job titles of facility management staff and ODYS PREA Administrator.

# 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 resident or staff member, except where the names of administrative personnel are specifically requested in the report template.

## Auditor Instructions:

Type your full name in the text box below for Auditor Signature. This will function as your official electronic signature. Auditors must deliver their final report to the PREA Resource Center as a

searchable PDF format to ensure accessibility to people with disabilities. Save this report document into a PDF format prior to submission.[1] Auditors are not permitted to submit audit reports that have been scanned.[2] See the PREA Auditor Handbook for a full discussion of audit report formatting requirements.

Shirley L. Turner — July 27, 2021

**Auditor Signature** **Date**

[1] See additional instructions here: https://support.office.com/en-us/article/Save-or-convert-to-PDF-d85416c5-7d77-4fd6-a216-6f4bf7c7c110 .

[2] See *PREA Auditor Handbook*, Version 1.0, August 2017; Pages 68-69.