

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

☐ Interim ☒ Final

**Date of Interim Audit Report:** December 10, 2019 ☐ N/A

*If no Interim Audit Report, select N/A*

**Date of Final Audit Report:** May 11, 2020

## Auditor Information

**Name:** Robert B. Latham

**Email:** robertblatham@icloud.com

**Company Name:** Latham Corrections Consulting

**Mailing Address:** 677 Idlewild Circle

**City, State, Zip:** Birmingham, Alabama, 35205

**Telephone:** 205-746-1905

**Date of Facility Visit:** October 24-25, 2019

## Agency Information

**Name of Agency:** Mississippi Department of Human Services - Division of Youth Services

**Governing Authority or Parent Agency (If Applicable):** N/A

**Address:** 200 Lamar Street

**City, State, Zip:** Jackson, Mississippi 39201

**Mailing Address:** same as physical address

**City, State, Zip:** same as physical address

**The Agency Is:**

☐ Military

☐ Private for Profit

☐ Private not for Profit

☐ Municipal

☐ County

☒ State

☐ Federal

**Agency Website with PREA Information:** <https://www.mdhs.ms.gov/youth-services/>

## Agency Chief Executive Officer

**Name:** Christopher Freeze

**Email:** Christopher.freeze@mdhs.ms.gov

**Telephone:** 601-359-4500

## Agency-Wide PREA Coordinator

**Name:** Mary Claire Giffin

**Email:** maryclaire.giffin@gmail.com

**Telephone:** 601-473-7587

**PREA Coordinator Reports to:**

Dr. Dennis Daniels

**Number of Compliance Managers who report to the PREA Coordinator:**

0

## Facility Information

**Name of Facility:** Oakley Youth Development Center

**Physical Address:** 2375 Oakley Road

**City, State, Zip:** Raymond, Mississippi 39154

**Mailing Address:** same as physical address

**City, State, Zip:** 601-857-8031

**The Facility Is:**

☐ Military

☐ Private for Profit

☐ Private not for Profit

☐ Municipal

☐ County

☒ State

☐ Federal

**Facility Website with PREA Information:** <https://www.mdhs.ms.gov/youth-services/>

**Has the facility been accredited within the past 3 years?** ☐ Yes ☒ No

**If the facility has been accredited within the past 3 years, select the accrediting organization(s) – select all that apply (N/A if the facility has not been accredited within the past 3 years):**

☐ ACA

☐ NCCHC

☐ CALEA

☐ Other (please name or describe: [Click or tap here to enter text.](#))

☒ N/A

**If the facility has completed any internal or external audits other than those that resulted in accreditation, please describe:**  
N/A

### Facility Administrator/Superintendent/Director

**Name:** Dr. Dennis Daniels

**Email:** dennis.daniels@mdhs.ms.gov

**Telephone:** 601-857-7596

### Facility PREA Compliance Manager

**Name:** Mary Claire Giffin

**Email:** maryclaire.giffin@gmail.com

**Telephone:** 601-473-7587

**Facility Health Service Administrator** ☐ N/A

**Name:** Angela Peters

**Email:** angela.peters@mdhs.ms.gov

**Telephone:** 601-857-7673

### Facility Characteristics

**Designated Facility Capacity:**

112

Current Population of Facility:	53	
Average daily population for the past 12 months:	50	
Has the facility been over capacity at any point in the past 12 months?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Which population(s) does the facility hold?	<input type="checkbox"/> Females <input type="checkbox"/> Males <input checked="" type="checkbox"/> Both Females and Males	
Age range of population:	10-18	
Average length of stay or time under supervision	6 months	
Facility security levels/resident custody levels	medium	
Number of residents admitted to facility during the past 12 months	113	
Number of residents admitted to facility during the past 12 months whose length of stay in the facility was for 72 hours or more:	113	
Number of residents admitted to facility during the past 12 months whose length of stay in the facility was for 10 days or more:	113	
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)?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> 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):	<input type="checkbox"/> Federal Bureau of Prisons <input type="checkbox"/> U.S. Marshals Service <input type="checkbox"/> U.S. Immigration and Customs Enforcement <input type="checkbox"/> Bureau of Indian Affairs <input type="checkbox"/> U.S. Military branch <input type="checkbox"/> State or Territorial correctional agency <input type="checkbox"/> County correctional or detention agency <input type="checkbox"/> Judicial district correctional or detention facility <input type="checkbox"/> City or municipal correctional or detention facility (e.g. police lockup or city jail) <input type="checkbox"/> Private corrections or detention provider <input type="checkbox"/> Other - please name or describe: <a href="#">Click or tap here to enter text.</a> <input checked="" type="checkbox"/> N/A	
Number of staff currently employed by the facility who may have contact with residents:	182	
Number of staff hired by the facility during the past 12 months who may have contact with residents:	92	
Number of contracts in the past 12 months for services with contractors who may have contact with residents:	7	
Number of individual contractors who have contact with residents, currently authorized to enter the facility:	17	
Number of volunteers who have contact with residents, currently authorized to enter the facility:	20	

## Physical Plant

<p><b>Number of buildings:</b></p> <p>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.</p>	10
<p><b>Number of resident housing units:</b></p> <p>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.</p>	11
<p><b>Number of single resident cells, rooms, or other enclosures:</b></p>	198
<p><b>Number of multiple occupancy cells, rooms, or other enclosures:</b></p>	0
<p><b>Number of open bay/dorm housing units:</b></p>	11
<p><b>Number of segregation or isolation cells or rooms (for example, administrative, disciplinary, protective custody, etc.):</b></p>	18
<p><b>Does the facility have a video monitoring system, electronic surveillance system, or other monitoring technology (e.g. cameras, etc.)?</b></p>	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
<p><b>Has the facility installed or updated a video monitoring system, electronic surveillance system, or other monitoring technology in the past 12 months?</b></p>	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
<b>Medical and Mental Health Services and Forensic Medical Exams</b>	
<p><b>Are medical services provided on-site?</b></p>	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
<p><b>Are mental health services provided on-site?</b></p>	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No

<b>Where are sexual assault forensic medical exams provided? Select all that apply.</b>	<input type="checkbox"/> On-site <input checked="" type="checkbox"/> Local hospital/clinic <input type="checkbox"/> Rape Crisis Center <input type="checkbox"/> Other (please name or describe: <a href="#">Click or tap here to enter text.</a> )	
<b>Investigations</b>		
<b>Criminal Investigations</b>		
<b>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:</b>	<b>2</b>	
<b>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.</b>	<input type="checkbox"/> Facility investigators <input checked="" type="checkbox"/> Agency investigators <input type="checkbox"/> An external investigative entity	
<b>Select all external entities responsible for CRIMINAL INVESTIGATIONS: Select all that apply (N/A if no external entities are responsible for criminal investigations)</b>	<input type="checkbox"/> Local police department <input type="checkbox"/> Local sheriff's department <input type="checkbox"/> State police <input type="checkbox"/> A U.S. Department of Justice component <input type="checkbox"/> Other (please name or describe: <a href="#">Click or tap here to enter text.</a> ) <input checked="" type="checkbox"/> N/A	
<b>Administrative Investigations</b>		
<b>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?</b>	<b>2</b>	
<b>When the facility receives allegations of sexual abuse or sexual harassment (whether staff-on-resident or resident-on-resident), ADMINISTRATIVE INVESTIGATIONS are conducted by: <i>Select all that apply</i></b>	<input type="checkbox"/> Facility investigators <input checked="" type="checkbox"/> Agency investigators <input type="checkbox"/> An external investigative entity	
<b>Select all external entities responsible for ADMINISTRATIVE INVESTIGATIONS: Select all that apply (N/A if no external entities are responsible for administrative investigations)</b>	<input type="checkbox"/> Local police department <input type="checkbox"/> Local sheriff's department <input type="checkbox"/> State police <input type="checkbox"/> A U.S. Department of Justice component <input type="checkbox"/> Other (please name or describe: <a href="#">Click or tap here to enter text.</a> ) <input checked="" type="checkbox"/> 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.*

### Introduction

The Prison Rape Elimination Act (PREA) onsite audit of Oakley Youth Development Center (OYDC) was conducted October 24-25, 2019. The parent agency for OYDC is the Mississippi Department of Human Services (MDHS), Division of Youth Services (DYS). OYDC is located at 2375 Oakley Road, Raymond, Mississippi 39154. The audit was conducted by Robert B. Latham from Birmingham, Alabama, who is a U. S. Department of Justice Certified PREA auditor for juvenile facilities. The auditor conducted the audit as a single auditor with no additional support staff. The facility contacted the auditor regarding the audit and a contract was agreed upon September 9, 2019. There are no known existing conflicts of interest or barriers to completing the audit. This is the first PREA compliance audit for OYDC.

The mission of DYS and OYDC is to provide leadership for change for youth, family units, and communities. The agency operates by creating legitimate alternative pathways to adulthood through equal access to services that are least intrusive, culturally sensitive, and consistent with the highest professional standards.

### Audit Methodology Pre-Onsite Audit Phase

Prior to being onsite, the PREA Coordinator and the auditor had discussions concerning access to the facility and staff, the audit process, logistics for the onsite phase of the audit, and goals and expectations. The PREA Coordinator was receptive to the audit process. The auditor explained the role of the auditor and the expectations during each stage of the PREA audit.

### Notice of Audit Posting and Timeline

The audit notice was posted September 12, 2019. The notices were in English and Spanish. The audit notice was posted using a large font and easy-to-read language on colorful paper. The audit notices were placed throughout the facility, in places visible to visitors, residents and staff, including the front entrance, education, dining hall, intake, visiting areas, housing units, and recreational spaces. The auditor verified placement through emailed pictures of the posted audit notices, observations during the onsite review and interviews with staff and residents. The audit notices included a statement regarding confidentiality of resident and staff correspondence with the auditor. No correspondence was received during any phase of the audit.

### Pre-Audit Questionnaire (PAQ) and Supporting Documentation

The PAQ was received October 11, 2019 by email. The PAQ was completed on September 27, 2019 and revised January 21, 2020. Limited supporting documentation and policies and procedures were received on a flash drive October 22, 2019. Using the Auditor Compliance Tool and Checklist of Documentation, the auditor provided the facility with an issues log November 6, 2019.

### Requests of Facility Lists

OYDC provided the following information for interview selections and document sampling:

Complete Resident Roster	An up-to-date roster was provided upon arrival to the facility.
Youthful inmates/detainees	N/A (Oakley Youth Development Center does not accept youthful inmates/detainees.)
Residents with physical disabilities	None were identified.
Residents with cognitive disabilities	None were identified.
Residents who are Limited English Proficient	None were identified.
Lesbian, Gay, and Bisexual Residents	None were identified.
Transgender or Intersex Residents	None were identified.
Residents in segregated housing	N/A (Oakley Youth Development Center does not have segregated housing.)
Residents in isolation	None were identified or observed.
Residents who reported sexual abuse	None were identified.
Residents who reported sexual victimization during risk screening	One (1) resident identified previous sexual victimization during the interview process.
Complete Staff Roster	The staff roster and schedule were provided upon arrival to the facility.
Specialized Staff	Specialized staff were identified on the roster.
All contractors who have contact with the residents	The facility has seventeen (17) individual contractors.
All volunteers who have contact with the residents	The facility has twenty (20) volunteers.
All grievances/allegations made in the 12 months preceding the audit	Six (6) grievances total reported to Program Integrity; Three (3) grievance concerning allegations of sexual harassment
All allegations of sexual abuse and sexual harassment reported for investigation in the 12 months preceding the audit	6
Detailed list of number of sexual abuse and sexual harassment allegations in the 12 months preceding the audit	6
All hotline calls made in the 12 months preceding the audit	6 (All allegations are reported to the Child Abuse Hotline.)

### External Contacts

The following external contacts were made:

Just Detention International	Just Detention International reviewed their database for records and information and reported no information for the preceding 12 months.
Community Based Organizations (CBOs)	<ol style="list-style-type: none"> <li>1. Children's Safe Center</li> <li>2. Mississippi Children's Advocacy Center</li> <li>3. Mississippi Coalition Against Sexual Assault (MSCASA)</li> </ol>
The Mississippi Department of Child Protection Services Hotline	The auditor contacted the Mississippi Department of Child Protection Services Hotline at 800-222-8000.

**Research****Who must report child abuse and neglect?**

M.S.A. 43-21-353 - Any attorney, physician, dentist, intern, resident, nurse, psychologist, social worker, child protection specialist, child care giver, minister, law enforcement officer, public or private school employee or any other person having reasonable cause to suspect that a child is a neglected child or an abused child, shall cause an oral report to be made immediately by telephone or otherwise and followed as soon thereafter as possible by a report in writing to the Department of Human Services.

**Onsite Audit Phase****Entrance briefing**

An entrance briefing was held with the Facility Administrator, PREA Coordinator, Security Administrator, Campus Investigator, Branch Director I, Director of Mental Health, Intake Officer, and the Principal. Introductions were made, the agenda for the two days was discussed followed by the facility tour. The auditor was accompanied by the PREA Coordinator and Security Administrator during the tour.

**Site review**

The auditor had access to, and observed, all areas of the facility. The auditor was provided a diagram of the physical plant during the pre-onsite phase of the audit and was thus familiar with the layout of the facility. In addition to the living units, the auditor reviewed intake, visitation areas, recreation areas, school and classrooms, kitchen and dining room, dayrooms, and staff offices. One the first day of the onsite audit the population of the facility was fifty-five (55). juveniles.

**Processes and areas observed**

The auditor observed the intake and risk screening to better understand the process. Grievance boxes are accessible to the residents. Grievance forms are available. Writing utensils are available upon request. The grievance boxes are checked daily.

**Specific area observations**

Cameras were located throughout the facility. The auditor observed the toilet and shower areas are out of view of the cameras. Wherever residents were present, the auditor observed officers actively supervising the residents. Classrooms were observed to be compliant with the 1:8 ratio requirements. Staff supervision and the video surveillance system mitigate blind spots. The auditor noticed a need for additional PREA related signage. This need was addressed during corrective action. The facility created posters with vital information about reporting and support services available to the residents. The posters are posted in English and Spanish.

**Exit briefing**

An exit briefing was held with the Facility Administrator and the PREA Coordinator. The auditor discussed the onsite audit. The auditor discussed each standard, actions needed to meet compliance, and the importance of institutionalizing PREA compliant practices. The documentation provided by the facility, prior to the onsite phase of the audit, was limited. The auditor requested the PREA Coordinator review the PAQ for accuracy and the auditor developed a detailed issues log.

**Interviews Logistics****Location and Privacy**



Interviews were held in a conference room that provided privacy and was centrally located to minimize disruption of daily activities and programming.

### Selection Process

Specialized staff were selected based on their respective duties in the facility. Twelve (12) Juvenile Care Workers (JCW's), randomly selected from both shifts, were interviewed using the random staff interview protocol. Sixteen (16) residents, randomly selected from each housing unit, were interviewed using the random resident interview questionnaire. The resident population was fifty-five (55) on the first day of the audit. There was one (1) resident interviewed who disclosed prior sexual victimization during risk screening.

Interview Protocols	Number of Interviews
<b>Administration and Agency Leadership</b>	
Agency Head Designee (Division Director)	1
Superintendent	1
PREA Coordinator	1
PREA Compliance Manager	N/A
<b>Specialized Staff</b>	
Medical Staff	1
Mental Health Staff	1
Mental Health Staff (Contract)	1
Non-Medical Staff Involved in Cross-Gender Strip Searches or Visual Body Cavity Searches (if applicable)	N/A
Administrative (Human Resources) Staff	1
Agency Contract Administrator	N/A
Intermediate or Higher-level Facility Staff (unannounced rounds)	1
SAFE and SANE	1
Investigative Staff	1
Staff who Perform Screening for Risk of Victimization and Abusiveness	1
Staff who Supervise Residents in Isolation (no isolation)	N/A
Staff on the Incident Review Team	1
Designated Staff Member Charged with Monitoring Retaliation	1
Security First Responders	1
Non-Security Staff First Responders	1
Intake Staff	1
<b>Random Sample of Staff</b>	
Day Shift 6:00am to 6:00pm	5
Night Shift 6:00pm to 6:00am	7
Total Random Sample of Staff	12
<b>Volunteers Contractors who have Contact with Residents</b>	
Volunteers	2
Contractors	2
<b>Residents</b>	
Random Sample of Residents from all Housing Units	16
<b>Targeted Residents</b>	
Residents who Reported a Sexual Abuse	None identified
Residents with Cognitive Disabilities	None identified
Residents with Physical Disabilities	None identified

Limited English Proficient Residents	None identified
Gay, Lesbian, and Bisexual Residents	None identified
Transgendered and Intersex Residents	None identified
Residents in Isolation	None identified
Residents who Disclosed Prior Sexual Victimization During Risk Screening	1
<b>Interview Totals</b>	
Total Number of Staff Interviews	31
Total Number of Resident Interviews	16
Total Number of Interviews	47

#### Interviewed Residents Length of Time at Facility

Days or Months	Number of Residents
1 Day to 31 Days	4
32 Days to 6 Months	12
7 Months to 12 Months	0
13 Months Plus	0
<b>Total</b>	16

#### Records Review

Name of Record	Total Records Reviewed
Personnel Records/Documentation	163
Volunteers and Contractors Files/Documentation	24 volunteer documents
Training Files/Documentation/Records	164
Resident Records/ Documentation	16
Medical/Mental Health Records and Documentation for Victims	N/A
Grievance Forms (Sexual Abuse and Sexual Harassment)	3
All Incident Reports (Sexual Abuse and Sexual Harassment)	6
Investigation Records (Sexual Abuse and Sexual Harassment)	6

#### Investigative Files

Youth-on-Youth Sexual Victimization	Substantiated	Unsubstantiated	Unfounded
Nonconsensual Sexual Acts	0	0	0
Abusive Sexual Contact	4	0	1
Sexual Harassment	0	0	0
Staff-on-Youth Sexual Abuse	Substantiated	Unsubstantiated	Unfounded
Staff Sexual Misconduct	0	0	0
Staff Sexual Harassment	0	1	0

## 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.*

### Characteristics Related to PREA and Sexual Safety

Introduction	
Parent Agency	Mississippi Department of Human Services
Other Significant Relationship Information	Division of Youth Services
Facility Name	Oakley Youth Development Center
Facility Address	2375 Oakley Road, Raymond, Mississippi 39154
Age of Facility	1925 (renovated in 1999)
Total Facility Rated Capacity	112
Resident Population Size and Makeup	
Average daily population in the last 12 months	50
Actual population on day 1 of the onsite portion of the audit	55
Population Gender	Male and Female
Population Ethnicity	Multiethnic
Length of Stay	4-6 months
Staff Size and Makeup	
Total Staff Size	202
Number of Security Staff	95
Types of Supervision Practiced:	Direct Supervision
Number of Volunteers who may have contact with residents	24
Number of Contractors who may have contact with residents	unknown
Number of Interns who may have contact with residents	unknown
Number and Type of Housing Units	
Number of single-occupancy cells	198; 52 in use
Number of open-bay dorms	11; 9 in use
Number of segregation/isolation units	18 Assessment/Management Units
Number of medical units	1
Number of closed units	3
Type of Supervision (direct or indirect)	Direct
Video Monitoring	246 cameras

### Facility Operations

#### Physical Plant Description

Oakley Youth Development Center (OYDC) is located at 2375 Oakley Road, Raymond, Mississippi 39154. The facility has a 112-bed capacity for male and female youth. The facility was renovated in 1999. The facility has eleven (11) housing units. Nine (9) housing units are in use. Each cell has a toilet and sink. Showers are conducted individually behind a shower curtain. In addition to the living units, there are gymnasiums, outdoor recreation areas, an auditorium, dining hall and kitchen, educational

and vocational facilities, library, barber shop, medical and dental clinic, training facilities, a security/guard building, sally port, and an administrative building.

### **Services Available**

Under the agency of Mississippi Department of Human Services (MDHS), the Division of Youth Services (DYS) provides institutional care to delinquent juveniles committed to DYS custody through Oakley Youth Development Center (OYDC). OYDC provides psycho-educational services to all youth housed at OYDC and is an accredited nonpublic school (Williams School) approved by the Mississippi Department of Education that serves both males and females. The psycho-educational program offered at OYDC begins with standardized admission, intake screening, and orientation assessment. Each youth receives a complete physical and a full-scale psychological assessment which includes: IQ testing, personality profile, drug and alcohol abuse risk questionnaire, suicide risk assessment, sexual risk and victimization assessment, achievement testing, and a trauma risk assessment. Diagnostic testing, youth evaluation, and record review allow staff to gather medical, dental, recreational, educational, vocational, and psychological data which allows for the facility to place each youth into an appropriate housing unit and to develop a comprehensive service plan for the youth involving treatment programs, counseling, recreation, and education.

OYDC provides students with on-campus medical, dental, and psychiatric care. Youth receive hands-on care from campus nurses, contracted dentists, dental hygienists, and contracted physicians. Youth also receive telehealth services and are transported to all off-campus medical appointments.

Youth participate daily in recreational activities run by the OYDC Recreation Department. Activities include, but are not limited to: basketball, baseball, kickball, soccer, golf, video games, movies, bike riding, swimming, track and field, arts and crafts, board games, card games, pool, foosball, and air hockey. The recreation department also supports individuals seeking certification to become a Certified Therapeutic Recreation Specialist (CTRS) under the supervision of the Director of Recreation Services and a site CTRS supervisor per the guidelines set forth by the National Council for Therapeutic Recreation Certification (NCTRC). CTRS interns develop personalized physical fitness plans for youth that qualify and/or would benefit from a one-on-one program.

OYDC utilizes Positive Behavioral Intervention Supports (PBIS) to encourage positive behavior change. Students are able to earn points on their daily point sheet by engaging in positive expectations including daily routine activities (i.e. maintaining a clean room, participating in school activities, participating in counseling, etc.). Youth are able to earn preferred items from the "Student Store" and participation in special event campus activities (i.e. movie nights, talent shows, sports tournaments, etc.). In addition to student point sheets, the PBIS program utilizes a level system in which youth are able to graduate to another level in which more increased activities and rewards are able to be earned. Youth are also able to earn and apply for the opportunity to participate in Community Workforce in which they are able to earn time off and other rewards. Community Workforce duties are individually assessed and assigned per the interest of the student.

Williams School provides students in grades 5-12 with educational supports in the classroom, on campus, and on the units when necessary. Services provided include: computer labs that provide remedial, job interest assessments, and cognitive development, an Interactive Video Network which allows students to interact with each other in GED and gifted classes, Library/Media Services, character education training to develop responsible citizenship skills, G.E.D. preparation and testing for eligible students, A.C.T. preparation and testing for students who have graduated or earned a G.E.D., vocational training that includes classes in welding, carpentry, small engine repair, brick masonry and basic business computer, Jobs for Mississippi Graduates (JMG), and Special Education supports. All youth at OYDC receive Individual and group therapy that emphasizes Reality Therapy, social skills

development, anger management, sex education, drug and alcohol awareness. character education, sexual offender counseling, psycho-correctional skills, and any other individualized therapies needed to support the youth. Additionally, OYDC works with Division of Youth Services (DYS) Community Counselors to work with youth, their families, and communities. The supports continue as a part of the youth's transition from OYDC to the community.

## 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:** 1

**List of Standards Exceeded:** Standard 115.354 Third-party reporting

### Standards Met

**Number of Standards Met:** 42

### 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.*

**The following evidence was analyzed in making the compliance determination:**

**Documents:**

1. OYDC Policy III.8, Sexual Harassment
2. OYDC Policy XIII.24 LGBTQI2-S
3. OYDC Policy XV.7, PREA
4. Mississippi State Employee Handbook
5. OYDC Pre-Audit Questionnaire responses

**Document (Corrective Action):**

1. Organizational Chart (updated November 26, 2019)

**Interview:**

1. Interview with the PREA Coordinator

**Site Review Observations:**

1. Observations during on-site review of physical plant

**Findings (By Provision):**

**115.311 (a)**

PAQ: The agency has a written policy mandating zero tolerance toward all forms of sexual abuse and sexual harassment in facilities it operates directly or under contract. The facility has a policy outlining how it will implement the agency's approach to preventing, detecting, and responding to sexual abuse and sexual harassment. The policy includes definitions of prohibited behaviors regarding sexual abuse and sexual harassment. The policy includes sanctions for those found to have participated in prohibited behaviors. The policy includes a description of agency strategies and responses to reduce and prevent sexual abuse and sexual harassment of residents.

It is the policy of the Mississippi Department of Human Services (MDHS), Division of Youth Services (DYS), and Oakley Youth Development Center (OYDC) that it maintains a zero-tolerance policy against the sexual abuse and harassment of youth and custodial misconduct in accordance with the standards set forth in the Prison Rape Elimination Act of 2003 (PREA). Any sexual contact, whether youth-on-youth or staff-on-youth, and whether consensual or forced, is strictly prohibited.

Policy establishes the responsibilities, policies, and procedures to implement a zero-tolerance policy for prohibiting, preventing, detecting, responding to and investigating the sexual abuse and harassment of youth under DYS and/or OYDC supervision and care.

**115.311 (b)**

PAQ: The agency employs or designates an upper-level, agency-wide PREA Coordinator. The PREA Coordinator has sufficient time and authority to develop, implement, and oversee agency efforts to comply with the PREA standards at the facility. The position of the PREA Coordinator is in the agency's organizational structure.



Policy outlines the roles and responsibilities of the PREA Coordinator. MDHS DYS employs an upper-level, agency-wide PREA coordinator. The PREA Coordinator confirmed she has sufficient time and authority to develop, implement, and oversee agency efforts to comply with the PREA standards at Oakley Youth Development Center. Based on the review of the Pre-audit Questionnaire, the PREA Coordinator reports directly to the Facility Administrator.

The auditor reviewed the agency organizational chart for verification the position of the PREA Coordinator is included.

**115.311 (c)**

The Mississippi Department of Human Services, Division of Youth Services operates one facility, the Oakley Youth Development Center. There is no PREA Compliance Manager.

**Corrective Action**

**115.311 (b)**

The organizational chart was updated November 26, 2019 to identify the position of the PREA Coordinator in the agency's organizational structure.

Based upon review and analysis of the available evidence, the auditor has determined the agency and facility are fully compliant with this standard regarding zero-tolerance toward sexual abuse and sexual harassment and designation of a PREA Coordinator. Corrective action has been completed.

## **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.) ☐ 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.*

### The following evidence was analyzed in making the compliance determination:

#### Document:

1. OYDC Pre-Audit Questionnaire responses

#### Findings (By Provision):

The Mississippi Department of Human Services, Division of Youth services does not contract with private agencies or other entities for the confinement of residents. This was verified through the Pre-Audit Questionnaire responses and interviews with agency staff.

#### Corrective Action

Based upon the review and analysis of the available evidence, the auditor confirmed the agency and facility is fully compliant with this standard regarding contracting with other entities for the confinement of residents. No corrective action is required.

## 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 facility have a documented staffing plan that provides for adequate levels of staffing and, where applicable, video monitoring, to protect residents against sexual abuse?  
☒ Yes ☐ No
- In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: Generally accepted juvenile detention and correctional/secure residential practices? ☒ Yes ☐ No
- In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: Any judicial findings of inadequacy? ☒ Yes ☐ No

- In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: Any findings of inadequacy from Federal investigative agencies? ☒ Yes ☐ No
- In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: Any findings of inadequacy from internal or external oversight bodies? ☒ Yes ☐ No
- In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: All components of the facility's physical plant (including "blind-spots" or areas where staff or residents may be isolated)? ☒ Yes ☐ No
- In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: The composition of the resident population? ☒ Yes ☐ No
- In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: The number and placement of supervisory staff? ☒ Yes ☐ No
- In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: Institution programs occurring on a particular shift? ☒ Yes ☐ No
- In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: Any applicable State or local laws, regulations, or standards? ☒ Yes ☐ No
- In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration the prevalence of substantiated and unsubstantiated incidents of sexual abuse? ☒ Yes ☐ No
- In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: 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 if the facility is not a secure juvenile facility per the PREA standards definition of "secure".)  
☒ 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 if the facility is not a secure juvenile facility per the PREA standards definition of “secure”.) ☒ 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 if the facility is not a secure juvenile facility per the PREA standards definition of “secure”.) ☒ Yes ☐ No ☐ NA
- Does the facility ensure only security staff are included when calculating these ratios? (N/A if the facility is not a secure juvenile facility per the PREA standards definition of “secure”.) ☒ 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 Coordinator, 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 Coordinator, 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 Coordinator, 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 Coordinator, 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.*

### The following evidence was analyzed in making the compliance determination:

#### Documents:

1. OYDC Policy XV.7, PREA
2. OYDC Pre-Audit Questionnaire responses
3. Daily Schedule and Population Reports
4. Logbook Entries - Unannounced Rounds

#### Documents (Corrective Action):

1. Staffing Plan – Developed March 10, 2020
2. 2020 Annual Facility Staffing Assessment – April 29, 2020
3. Unannounced Supervisory Visits – Developed December 3, 2019

#### Interviews:

1. Interview with the Facility Administrator
2. Interview with the PREA Coordinator
3. Interview with Intermediate or Higher-Level Facility Staff

#### Site Review Observations:

1. Observations during on-site review of physical plant

### Findings (By Provision):

#### 115.313 (a)

PAQ: Since the 2017 PREA audit:

1. The average daily number of residents: 50
2. The average daily number of residents on which the staffing plan was predicated: 50

Policy states the Facility Administrator will assist in the development and documentation of the facility staffing plan and will make his/her best effort to comply with the staffing plan. The plan will provide for adequate levels of staffing and, where applicable, video monitoring to protect youth against sexual abuse.

The Facility Administrator and PREA Coordinator stated that when assessing adequate staffing levels and the need for video monitoring, the facility staffing plan would consider: generally accepted juvenile detention and correctional/secure residential practices; any judicial findings of inadequacy; any findings of inadequacy from Federal investigative agencies; any findings of inadequacy from internal or external oversight bodies; all components of the facility's physical plant (including "blind spots" or areas where staff or residents may be isolated); the composition of the resident population; the number and placement of supervisory staff; institution programs occurring on a particular shift; any applicable state or local laws, regulations, or standards; the prevalence of substantiated and unsubstantiated incidents of sexual abuse; and any other relevant factors. The Facility Administrator stated he checks for compliance with the staffing plan by reviewing daily logs and monthly reports.

The facility developed a PREA compliant staffing plan. The auditor reviewed the staffing plan and determined it to be inclusive of the standard requirements.

**115.313 (b)**

PAQ: Each time the staffing plan is not complied with, the facility documents and justifies all deviations from the staffing plan.

Policy states OYDC 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 Administrator stated the facility has been able to meet the requirements of the staffing plan with no deviations. He stated the facility would document all instances of non-compliance with the staffing plan and the documentation would include explanations for non-compliance.

**115.313 (c)**

PAQ: The facility is obligated by law, regulation, or judicial consent decree to maintain staffing ratios of a minimum of 1:8 during resident waking hours and 1:16 during resident sleeping hours. The facility does not maintain staff ratios of a minimum of 1:8 during resident waking hours. The facility maintains staff ratios of a minimum of 1:16 during resident sleeping hours.

In the past 12 months:

1. The number of times the facility deviated from the staffing ratios of 1:8 security staff during resident waking hours is Zero (0).
2. The number of times the facility deviated from the staffing ratios of 1:16 security staff during resident sleeping hours: Zero (0)

Policy states OYDC shall maintain staff ratios of a minimum of 1:8 during youth waking hours and 1:16 during youth sleeping hours, except during limited and discrete exigent circumstances, which shall be fully documented. Only direct care and security staff shall be included in these ratios.

The Facility Administrator stated the agency is obligated by law to maintain staffing ratios of 1:8 during waking hours and 1:16 during sleeping hours. He stated he ensures the facility maintains appropriate staffing ratios by reviewing daily logs, quality assurance reports and monthly reports.

During the facility tour the auditor observed classrooms and living units were in compliance with the staffing ratios. The auditor reviewed Daily Schedule and Population Reports for the 1<sup>st</sup>, 10<sup>th</sup>, and 20<sup>th</sup> of each month from January 1, 2019 to October 1, 2019 for both shifts. The reports demonstrated compliance with the staffing ratios.

**115.313 (d)**

PAQ: At least once every year the agency or facility, in collaboration with the PREA Coordinator, reviews the staffing plan to see whether adjustments are needed to:

1. The staffing plan;
2. Prevailing staffing patterns;
3. The deployment of monitoring technology; or
4. The allocation of agency or facility resources to commit to the staffing plan to ensure compliance with the staffing plan.

Policy states whenever necessary, but no less frequently than once each year, the PREA Coordinator shall meet with the Facility Administrator to assess, determine, and document whether adjustments are needed to: the staffing plan established pursuant to paragraph (a) of this standard; prevailing staffing patterns; OYDC's deployment of video monitoring systems and other monitoring technologies; and the resources OYDC has available to commit to ensure adherence to the staffing plan. OYDC will document the review utilizing the Annual Facility Staffing Assessment.

The auditor reviewed the Annual Facility Staffing Assessment for verification. The assessment considers all aspects of the standard requirements.

#### **115.313 (e)**

PAQ: The facility requires that intermediate-level or higher-level staff conduct unannounced rounds to identify and deter staff sexual abuse and sexual harassment. The facility documents unannounced rounds. The unannounced rounds cover all shifts. The facility prohibits staff from alerting other staff of the conduct of such rounds.

Policy states the facility shall implement a practice of having intermediate and higher-level staff conduct and document unannounced rounds to identify and deter sexual abuse and harassment. These shall be implemented on day shifts as well as night shifts. There must be a prohibition on alerting others of the rounds occurring and practices in place that disallow staff from alerting other staff of the rounds unless there is a legitimate operational need to do so.

The Security Administrator confirmed she has conducted unannounced rounds and the unannounced rounds are documented in the unit logbook and supervisor logbook. She stated she prevents staff from alerting other staff that she is conducting unannounced rounds by not informing staff the rounds are occurring and alternating entering the living units from either the front or back entrance.

During the onsite tour of the facility the Security Administrator explained how unannounced rounds are conducted. Logbook entries were being used to document the rounds on both shifts. The auditor reviewed logbooks with documentation of unannounced rounds.

#### **Corrective Action**

Based upon review and analysis of the available evidence, the auditor has determined the agency and facility is fully compliant with this standard regarding supervision and monitoring. Corrective action has been completed.

**115.313 (a)** To comply with the standard provision, the facility developed, implemented, and documented 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, the facility takes into consideration all aspects of the standard requirements.



To assist with the development of a PREA compliant staffing plan the auditor provided the facility the “Developing and Implementing A PREA-Compliant Staffing Plan” resource developed by the Moss Group, Inc. on November 6, 2019. The resource was developed to assist facilities with the development and implementation of PREA compliant staffing plans, The Moss Group, Inc., under subcontract with the National PREA Resource Center, developed the *Staffing Plan White Paper*. The paper identifies and explains the applicable PREA Standards and requirements, along with other influencing factors that impact a facility’s development, documentation and implementation of a PREA-compliant facility staffing plan.

The facility developed a PREA compliant staffing plan. The staffing plan was completed March 10, 2020. The auditor reviewed the staffing plan for verification. The staffing plan is inclusive of all of the standard requirements.

**115.313 (d)**

The Annual Facility Staffing Assessment was completed April 29, 2020 and emailed to the auditor for verification. The assessment considers all aspects of the standard requirements.

**115.313 (e)**

Policy was updated to be inclusive of the standard requirements. To improve documentation of unannounced rounds, the facility developed a form, “Unannounced Supervisory Visits”, that better demonstrates all requirements of the standard provisions. The form was emailed to the auditor for review December 3, 2019. The Facility Administrator confirmed the form has been implemented. The facility has demonstrated the updated form has been institutionalized for conducting unannounced rounds. The facility emailed examples for verification on a monthly basis, December 2019 through April 2020.

## **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 have policies 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 have 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.*

### The following evidence was analyzed in making the compliance determination:

#### Documents:

1. OYDC Policy XV.7, PREA
2. OYDC Policy VII.14, Youth Searches
3. OYDC Policy XIII.24, LGBTQI2-S
4. OYDC Pre-Audit Questionnaire responses
5. Training Curriculum / Videos
6. Juvenile Care Worker Basic Course: Security and Emergency Procedures
7. Search Procedures
8. Staff Training Records – Searches

#### Documents (Corrective Action):

1. Youth Cross-Gender Search Form
2. Cross-gender Announcement Reminder Signs - posted December 5, 2019
3. Staff Training Records (Opposite Gender Announcements) - December 3, 2019 and December 5, 2019

#### Interviews:

1. Interview with the PREA Coordinator
2. Interviews with a Random Sample of Staff
3. Interviews with a Random Sample of Residents
4. Interviews with Transgendered and Intersex Residents – N/A

#### Site Review Observations:

1. Observations during on-site review of physical plant

#### Findings (By Provision):

##### 115.315 (a)

##### PAQ:

The facility does not conduct cross-gender strip or cross-gender visual body cavity searches of residents.

In the past 12 months:

1. The number of cross-gender strip or cross-gender visual body cavity searches of residents:  
Zero (0)

2. The number of cross-gender strip or cross-gender visual body cavity searches of residents that did not involve exigent circumstances or were performed by non-medical staff: Zero (0)

Policy states employees/staff members shall not conduct cross-gender strip searches or cross-gender visual body cavity searches.

#### **115.315 (b)**

PAQ: The facility does not permit cross-gender pat-down searches of residents, absent exigent circumstances.

In the past 12 months:

1. The number of cross-gender pat-down searches of residents: Zero (0)
2. The number of cross-gender pat-down searches of residents that did not involve exigent circumstance(s): Zero (0)

Policy states the facility shall not conduct cross-gender pat-down searches of youth, except in exigent circumstances and must be approved by a Shift Supervisor.

Policy review and interviews with staff and residents confirmed cross-gender pat-down searches are restricted.

#### **115.315 (c)**

PAQ: Facility policy requires that all cross-gender strip searches, cross-gender visual body cavity searches, and cross-gender pat-down searches be documented and justified.

Policy states cross-Gender pat-down searches must be justified and documented in the Unit Logbook and on a Youth Cross-Gender Search Form when they occur.

#### **115.315 (d)**

PAQ:

1. The facility has implemented policies and procedures that enable residents to shower, perform bodily functions, and change clothing without non-medical 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 (this includes viewing via video camera).
2. Policies and procedures require staff of the opposite gender to announce their presence when entering a resident housing unit or area where residents are likely to be showering, performing bodily functions, or changing clothing.

It is OYDC's policy that the facility shall implement procedures that enable youth to shower, perform bodily functions, and change clothing without nonmedical staff of the opposite gender viewing their breasts, buttocks, or genitals, except in exigent circumstances or when such viewing is incidental to routine room and/or unit checks. Such procedures shall require staff of the opposite gender to announce their presence when entering a youth housing unit.

Residents interviewed stated they are never naked in full view of staff of the opposite gender. Staff and resident interviews revealed male staff conduct showers for male residents and female staff conduct showers for female residents. Interviews with staff and residents did not demonstrate policies and procedures require staff of the opposite gender to announce their presence when entering a resident housing unit. This was addressed by corrective action.

#### **115.315 (e)**

PAQ: The facility has a policy prohibiting staff from searching or physically examining a transgender or intersex resident for the sole purpose of determining the resident's genital status. Zero (0) such searches occurred in the past 12 months.

Policy states at no time shall any search be conducted solely for the purpose of determining a youth's biological sex or gender. Any questions regarding a youth's gender or sex shall be referred to a Gender Classification Specialist. If an indication of need arises, a Gender Classification Specialist shall conduct a screening interview in a private and respectful manner. The Gender Classification Specialist will only ask questions related to sexual orientation, gender identity, or gender expression for the purpose of making intake, housing, and classification assignments. If necessary, the youth will be referred to the clinic for screening.

Staff interviewed confirmed they are aware of the policy prohibiting them from searching or physically examining a transgender or intersex resident for the purpose of determining the resident's genital status. There were no transgender or intersex residents confined at the facility during the onsite phase of the audit.

#### **115.315 (f)**

PAQ: The percent of all security staff who received training on conducting cross-gender pat-down searches and searches of transgender and intersex residents in a professional and respectful manner, consistent with security needs: 100%

Policy requires staff training 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. Employees receive the training during orientation, and annually thereafter.

Staff interviews, staff training records, and training curricula demonstrate the training is occurring as required by the standard.

#### **Corrective Action**

Based upon review and analysis of the available evidence, the auditor has determined the agency and facility is fully compliant with this standard regarding limits to cross-gender viewing and searches. Corrective action has been completed.

#### **115.315 (d)**

Policies and procedures did not require staff of the opposite gender to announce their presence when entering a resident housing unit. The facility implemented this policy, posted signs at the entrance of each living unit reminding staff to announce their presence, and provided training to staff. The Facility Administrator emailed the auditor the final draft for the opposite gender announcement signs November 27, 2019. Staff were trained on the requirement to announce their presence when entering a resident housing unit of the opposite gender on December 3, 2019 December 5, 2019. Pictures of the posted opposite gender announcement signs and training logs were emailed to the auditor December 6, 2019 for verification. The facility is now compliant with this provision.

### **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.*

#### The following evidence was analyzed in making the compliance determination:

##### Documents:

1. OYDC Policy XV.7, PREA
2. OYDC Pre-Audit Questionnaire responses
3. "I Speak" Chart (Language Identification)
4. MOU with the Division of Economic Assistance Language Lab
5. Contract with the De L'eppe Deaf Center for Sign language Interpreting Services
6. Training Curriculum / Videos

## 7. Staff Training Records

### **Documents (Corrective Action):**

1. Propio Over-the-phone Interpreting – implemented March 2, 2020
2. PREA Posters (English and Spanish) – final update February 25, 2020
3. Student Handbook – final update April 15, 2020

### **Interviews:**

1. Interview with the PREA Coordinator
2. Interview with the Agency Head designee (Division Director)
3. Interviews with Residents with Disabilities and Limited English Proficient Residents - N/A
4. Interviews with a Random Sample of Staff

### **Site Review Observations:**

1. Observations during on-site review of physical plant

### **Findings (By Provision):**

#### **115.316 (a)**

PAQ: The agency has established procedures to provide disabled residents 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.

Policy states 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.

The 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 Division Director confirmed the agency has established procedures to provide residents with disabilities and residents who are limited English proficient 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. The facility has a MOU with the Division of Economic Assistance Language Lab for residents who do not speak English or who are limited English proficient. Additionally, the facility uses Propio over-the-phone interpreting services. The facility has a contract with the De L'eppe Deaf Center for sign language interpreting services. The sign language interpreting services are available 24/7. OYDC is in the process of providing PREA education materials available in Braille. Staff training on PREA compliant practices for residents with disabilities is included in PREA training. Training records were reviewed for verification.

#### **115.316 (b)**



PAQ: The agency has established procedures to provide residents with limited English proficiency 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.

Policy states 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.

The auditor observed the "I Speak" Language Identification Chart. The facility has a MOU with the Division of Economic Assistance Language Lab and Propio over-the-phone interpreting services for residents who do not speak English or who are limited English proficient. The facility has a contract with the De L'eppe Deaf Center for sign language interpreting services. The sign language interpreting services are available 24/7. OYDC is in the process of providing PREA education materials available in Braille. No residents were identified as having a disability or being limited English proficient during the on-site audit. Staff training on PREA compliant practices for residents with disabilities is included in PREA training. Training records were reviewed for verification.

#### **115.316 (c)**

PAQ: Agency policy prohibits use of 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.

1. The agency or facility documents the limited circumstances in individual cases where resident interpreters, readers, or other types of resident assistants are used.
2. In the past 12 months, the number of instances where resident interpreters, readers, or other types of resident assistants have been used and it was not the case that an extended delay in obtaining another interpreter could compromise the resident's safety, the performance of first-response duties under § 115.364, or the investigation of the resident's allegations: Zero (0)

Policy states 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, or the investigation of the resident's allegations.

Staff interviewed confirmed the agency does not allow the use of resident interpreters, resident readers, or other types of resident assistants to assist disabled residents or residents with limited English proficiency when making an allegation of sexual abuse or sexual harassment. Staff interviewed had no knowledge of resident interpreters, resident readers, or other types of resident assistants being used in relation to allegations of sexual abuse or sexual harassment.

#### **Corrective Action**

Based upon review and analysis of the available evidence, the auditor has determined the agency and facility is fully compliant with this standard regarding residents with disabilities and residents who are limited English proficient. Corrective action has been completed.

PREA Posters have been developed and are available in English and Spanish. OYDC is in the process of providing PREA education materials available in Braille. This has been delayed due to Covid-19.



## 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 who may have contact with residents? ☒ Yes ☐ No
- Does the agency consider any incidents of sexual harassment in determining whether 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 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? ☒ 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)

- 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.*

### The following evidence was analyzed in making the compliance determination:

#### Documents:

1. OYDC Policy III.2 DYS Employment
2. OYDC Policy XIV.2 MDHS Division of Youth Services Employment
3. I.5 Employee Handbook Chapter 7 (Termination for falsifying application/background)
4. OYDC Pre-Audit Questionnaire responses
5. Spreadsheet – Employee Criminal Records Checks and Child Abuse and Neglect Registry Checks
6. Background Check Form

#### Document (Corrective Action):

1. Prison Rape Elimination Act (PREA) Employment/ Appraisal Questionnaire

#### Interview:

1. Interview with the Administrative (Human Resources) Staff

#### Site Review Observations:

1. Observations during on-site review of physical plant

#### Findings (By Provision):

##### 115.317 (a)

PAQ: Agency policy prohibits hiring or promoting anyone who may have contact with residents, and prohibits enlisting 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.

Departmental policy prohibits the hiring or promotion of an employee or contractor who may have contact with youth who: has engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility, or other institution; 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 has been civilly or administratively adjudicated to have engaged in these activities.

The interview with the human resources staff and documentation review revealed these three questions about prior misconduct were not previously considered in hiring or promoting anyone who may have contact with residents, and were not considered in enlisting the services of any contractor who may have contact with residents. The agency created a form titled the "Prison Rape Elimination Act (PREA) Employment/ Appraisal Questionnaire" and emailed the form to the auditor November 12, 2019. One hundred sixty-three (163) completed forms for existing staff were emailed to the auditor December 2, 2019.

#### **115.317 (b)**

PAQ: Agency policy requires the consideration of 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.

Policy states OYDC shall consider any incidents of sexual harassment in deciding whether to hire or promote any employee or contractor.

The human resources staff reported consideration would be given to 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.

#### **115.317 (c)**

PAQ: Agency policy requires that before it hires any new employees who may have contact with residents, it (a) conducts criminal background record checks, (b) consults any child abuse registry maintained by the State or locality in which the employee would work; and (c) consistent with Federal, State, and local law, 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

During the past 12 months:

1. The number of persons hired who may have contact with residents who have had criminal background record checks: 92
2. The percent of persons hired who may have contact with residents who have had criminal background record checks: 100%

Policy states all prospective applicants considered for employment must sign a release of information form or consent to electronic fingerprinting, in order for the agency to conduct a Criminal Records Check. The agency consults any child abuse registry maintained by the State or locality in which the

employee would work. The agency will make its best efforts to contact all prior institutional employers in regard to substantiated allegations of sexual abuse or any resignation during a period of sexual abuse investigation.

The Human Resources staff stated the facility performs criminal record background checks or considers pertinent civil or administrative adjudications for all newly hired employees who may have contact with residents and all employees, who may have contact with residents, who are being considered for promotions. The same is required for any contractor who may have contact with residents as well. The Human Resources staff stated before hiring new employees or contractors who may have contact with residents, the facility consults any child abuse registry maintained by the State or locality in which a potential employee/contractor would work.

The auditor reviewed documentation of criminal background records checks and child abuse registry checks for employees for verification.

**115.317 (d)**

PAQ: Agency policy requires that a criminal background records check be completed, and applicable child abuse registries consulted before enlisting the services of any contractor who may have contact with residents.

During the past 12 months:

1. The number of contracts for services where criminal background record checks were conducted on all staff covered in the contract who might have contact with residents: 7
2. The percent of contracts for services where criminal background record checks were conducted on all staff covered in the contract who might have contact with residents: 100%

The human resources staff stated the facility performs criminal record background checks or considers pertinent civil or administrative adjudications for any contractor who may have contact with residents.

The auditor reviewed documentation of criminal background records checks and child abuse registry checks for verification.

**115.317 (e)**

PAQ: Agency policy requires that either criminal background records checks be conducted at least every five years of current employees and contractors who may have contact with residents or that a system is in place for otherwise capturing such information for current employees.

Policy states the MDHS Personnel Department shall conduct criminal background records checks at least every five years of current employees and contractors who may have contact with youth.

The auditor observed the background checks are current.

**115.317 (f)** Before hiring a new employee or contractor, MDHS Personnel Division or designee shall ask potential employees and contractors about previous misconduct described in provision (a).

Policy states the agency shall also ask all applicants and employees who may have contact with youth directly about previous misconduct 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.

The Human Resources staff confirmed these questions about previous misconduct were not previously asked and the facility did not impose upon employees a continuing affirmative duty to disclose any such previous misconduct. The agency created a form called the "Prison Rape Elimination Act (PREA) Employment/ Appraisal Questionnaire" and emailed the form to the auditor November 12, 2019. One hundred sixty-three (163) completed forms for existing staff were emailed to the auditor December 2, 2019.

**115.317 (g)**

PAQ: Agency policy states that material omissions regarding such misconduct, or the provision of materially false information, shall be grounds for termination.

Before hiring a new employee or contractor, MDHS Personnel Division or designee shall apprise potential employees and contractors that false information or material omissions regarding such misconduct shall be grounds for termination and that they have a continuing duty to disclose such conduct.

**115.317 (h)**

Policy states 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.

The human resources staff reported this information would be handled by the MDHS legal department.

**Corrective Action**

Based upon review and analysis of the available evidence, the auditor has determined the agency and facility is fully compliant with this standard regarding hiring and promotion decisions. Corrective action has been completed.

**115.317 (a)** The agency created a form called the "Prison Rape Elimination Act (PREA) Employment/ Appraisal Questionnaire" and emailed the form to the auditor November 12, 2019. One hundred sixty-three (163) completed forms for existing staff were emailed to the auditor December 2, 2019. For compliance, the agency must show this standard provision has become institutionalized for staff promotions.

**115.317 (f)** The agency shall 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. The agency created a form called the "Prison Rape Elimination Act (PREA) Employment/ Appraisal Questionnaire" and emailed the form to the auditor November 12, 2019. One hundred sixty-three (163) completed forms for existing employees were emailed to the auditor December 2, 2019.

## **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.*

### The following evidence was analyzed in making the compliance determination:

#### Documents:

1. OYDC Policy XV.7, PREA
2. OYDC Pre-Audit Questionnaire responses

#### Interview:

1. Interview with the Agency Head designee (Division Director)
2. Interview with the Facility Administrator

#### Site Review Observations:

1. Observations during on-site review of physical plant



### **Findings (By Provision):**

**115.318 (a)** The agency or facility has not acquired a new facility or made a substantial expansion or modification to existing facilities since August 20, 2012.

Policy states when designing or acquiring any new facility and in planning any substantial expansion or modification of existing facilities, the agency shall consider the effect of the design, acquisition, expansion, or modification upon the agency's ability to protect youth from sexual abuse.

The Division Director stated renovations were completed in 2014. Rooms were updated with toilets and sinks. Showers were made more private. The Division Director and Facility Administrator confirmed when designing, acquiring, or planning substantial modifications to facilities, the agency considers the effects of such changes on its ability to protect residents from sexual abuse.

### **115.318 (b)**

PAQ: The agency or facility has installed or updated a video monitoring system, electronic surveillance system, or other monitoring technology since August 20, 2012. The Division Director stated cameras with sound and the ability to rotate were added and video retention was increased to 90 days. The Division Director and Facility Administrator stated the agency uses the new monitoring technology to enhance the protection of residents from incidents of sexual abuse agency considers the effect of such changes on its ability to protect residents from sexual abuse.

Policy states when installing or updating a video monitoring system, electronic surveillance system, or other monitoring technology, the agency shall consider how such technology may enhance the agency's ability to protect youth from sexual abuse.

The auditor observed the video monitoring system and location of cameras during the facility tour. Oakley Youth Development Center has two video surveillance systems. Insight camera systems is the main system and Bosch camera systems is the backup. The systems allow for up to 90 days of video retention. Some of the capabilities of the systems include choosing what type of recording you want for each camera. This includes record off, record always, motion only recording, and scheduled recording. A user can set up different views. For example, if a user wants to just see just the living units, a view can be created for that. The system can be viewed live or recorded. A user has the ability to hear sound on most of the cameras. There is the ability to take a snapshot from any of the cameras and save it to a computer. There is a total of 246 cameras.

### **Corrective Action**

Based upon review and analysis of the available evidence, the auditor has determined the agency and facility is fully compliant with this standard regarding upgrades to facilities and technology. No corrective action is required.



## 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 evidentiary 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? (N/A if the agency *always* makes a victim advocate from a rape crisis center available to victims.) ☐ Yes ☐ No ☒ NA
- 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 agency 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? (N/A if agency *always* makes a victim advocate from a rape crisis center available to victims.) ☐ 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.*

### The following evidence was analyzed in making the compliance determination:

#### Documents:

1. OYDC Policy XV.7, PREA
2. OYDC Policy VII.2 Incident Reporting with Attachments
3. OYDC Policy VII.3 Institutional Investigations with Attachments
4. OYDC Policy VII.5 Abuse and Neglect Reporting with Attachments
5. OYDC Policy XI.13 Access to Health/Mental Health Care
6. OYDC Policy XI.25 Medical Consultation Hospitalization, Forms XI.25 A&B
7. OYDC Policy XI.26 (Section 8) Emergency Medical Response and Services with Attachments XI.26A and XI.8A
8. OYDC Policy XI.27 Emergency Medical Referral
9. MDHS Division of Program Integrity - Internal Investigations
10. MOU with the University of Mississippi Medical Center (UMMC)
11. OYDC Pre-Audit Questionnaire responses

#### Documents (Corrective Action):

1. Mississippi Coalition Against Sexual Assault (MCASA) – Finalized February 8, 2020

#### Interviews:

1. Interviews with a Random Sample of Staff
2. Interview with SAFE/SANE (UMMC)
3. Interview with PREA Coordinator
4. Residents who Reported a Sexual Abuse – N/A

#### Site Review Observations:

1. Observations during on-site review of physical plant

#### Findings (By Provision):

##### 115.321 (a)

PAQ: MDHS Program Integrity investigators are responsible for conducting administrative or criminal sexual abuse investigations (including resident-on-resident sexual abuse or staff sexual misconduct).

When conducting a sexual abuse investigation, the investigators follow a uniform evidence protocol. The Auditor reviewed the National Protocol for Sexual Assault Medical Forensic Examinations, Adults/Adolescents Second Edition developed in April 2013. Staff interviewed confirmed they know and understand the agency's protocol for obtaining usable physical evidence if a resident alleges sexual abuse. Staff were knowledgeable that Program Integrity is responsible for conducting sexual abuse investigations.

##### 115.321 (b)

PAQ: The uniform evidence protocol is developmentally appropriate for youth and, as appropriate, is adapted from or otherwise based on the most recent edition of the U.S. Department of Justice's Office on Violence Against Women publication, "National Protocol for Sexual Assault Medical Forensic Examinations, Adults/Adolescents Second Edition developed in April 2013. The Auditor reviewed the National Protocol for Sexual Assault Medical Forensic Examinations, Adults/Adolescents Second Edition developed in April 2013.

**115.321 (c)**

PAQ: The facility offers all residents who experience sexual abuse access to forensic medical examinations, without financial cost, where evidentiarily or medically appropriate at the University of Mississippi Medical Center (UMMC) pediatric emergency department.

During the past 12 months:

1. The number of forensic medical exams conducted was zero (0).
2. The number of exams performed by SANEs/SAFEs was zero (0).
3. The number of exams performed by a qualified medical practitioner was zero (0).

An interview with a representative from the pediatric emergency department confirmed a trained and certified sexual assault nurse examiner (SANE) is available on all shifts. Oakley YDC has a MOU with UMMC. The MOU with UMMC and the interview with a representative from the pediatric emergency department corroborate that all resident victims of sexual abuse have access to forensic medical examinations.

**115.321 (d)**

PAQ: The facility attempts to make a victim advocate from a rape crisis center available to the victim, in person or by other means. These efforts are documented.

The Mississippi Coalition Against Sexual Assault (MCASA) website states most hospitals provide an advocate for sexual assault survivors to provide support during forensic medical examinations. A victim may request a victim advocate from the local rape crisis center if one is not sent automatically. The agency signed a MOU with the Mississippi Coalition Against Sexual Assault (MCASA) for victim advocacy services February 8, 2020. No staff members were identified as being qualified victim advocates. The auditor reviewed the MOU for verification.

The PREA Coordinator confirmed the policy/practice for providing residents with access to their attorneys or other legal representation includes access to attorneys from the Southern Poverty Law Center. They would be allowed confidential meetings in the security conference room, phone calls, and letters. She did not indicate any circumstances where juveniles are limited access to attorneys or legal representation. There were no residents who reported a sexual abuse confined at the facility during the onsite phase of the audit.

**115.321 (e)**

PAQ: If requested by the victim, a victim advocate, or qualified agency staff member, or qualified community-based organization staff member accompanies and supports the victim through the forensic medical examination process and investigatory interviews and provides emotional support, crisis intervention, information, and referrals.

This standard provision was corroborated by the interview with the PREA Coordinator. No residents who reported a sexual abuse were confined during the onsite audit phase.

**115.321 (f)**

PAQ: The agency/facility is responsible for investigating all allegations of sexual abuse. Department of Program Integrity investigators with the Mississippi Department of Human Services conduct administrative and criminal investigations.

This standard provision was corroborated through interviews and the PAQ responses.

**115.321 (g)**

There is no State entity outside of the agency that is responsible for investigating allegations of sexual abuse in juvenile facilities; and no Department of Justice component that is responsible for investigating allegations of sexual abuse in juvenile facilities.

**115.321 (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. Oakley YDC does not use staff members as victim advocates. The agency has a MOU with the Mississippi Coalition Against Sexual Assault (MCASA) for victim advocacy services.

**Corrective Action**

Based upon review and analysis of the available evidence, the auditor has determined the agency and facility is fully compliant with this standard regarding zero-tolerance toward sexual abuse and sexual harassment and designation of a PREA coordinator. Corrective action is complete.

**115.321 (d)** The agency signed a MOU with the Mississippi Coalition Against Sexual Assault (MCASA) for victim advocacy services February 8, 2020.

## **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 the policy 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.*

### The following evidence was analyzed in making the compliance determination:

#### Documents:

1. OYDC Policy III.9 Sexual Harassment
2. OYDC Policy VII.2 Incident Reporting
3. OYDC Policy VII.3 Institutional Investigations
4. OYDC Policy VII.6 Abusive Institutional Practices
5. OYDC Policy XV.7 PREA
6. MDHS Division of Program Integrity - Internal Investigations
7. OYDC Pre-Audit Questionnaire responses
8. Investigative Reports

#### Interview:

1. Interview with the Division Director
2. Interview with Investigative Staff

**Site Review Observations:**

1. Observations during on-site review of physical plant

**Findings (By Provision):**

**115.322 (a)**

The facility ensures that an administrative or criminal investigation is completed for all allegations of sexual abuse and sexual harassment.

In the past 12 months:

1. The number of allegations of sexual abuse and sexual harassment that were received is six (6).
2. The number of allegations resulting in an administrative investigation is six (6).
3. The number of allegations referred for criminal investigation is zero (0).

Policy states all allegations of sexual abuse and sexual harassment will be fully investigated in accordance with the MDHS DYS Institutional Investigations policy.

The Division Director confirmed the agency ensures that an administrative or criminal investigation is completed for all allegations of sexual abuse or sexual harassment. The Division Director described how an administrative or criminal investigation is completed for allegations of sexual abuse or harassment. All incident reports are referred to the Division of Program Integrity and the Child Protective Services (CPS) Abuse Hotline is called. The reported allegation is sent to the Program Integrity supervisor, the Attorney General and then returned to the facility-based Program Integrity investigators for investigation.

Referring to allegations received in the past 12 months, six (6) administrative investigations were completed. Three (3) administrative investigations were pending completion during the onsite audit phase. The auditor reviewed the six (6) complete investigation files.

**115.322 (b)**

PAQ: The agency has 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 publishes the policy on its website. The agency shall document all referrals.

The investigator confirmed this policy. Policy states all allegations of sexual abuse and sexual harassment will be fully investigated in accordance with the MDHS DYS Institutional Investigations policy requirement. The agency's policy regarding the referral of allegations of sexual abuse or sexual harassment for a criminal investigation is published on the agency website at <https://www.mdhs.ms.gov/youth-services/>.

**115.322 (c)**

Division of Program Integrity investigators conduct administrative and criminal investigations. This was corroborated through interviews and the PAQ responses.

**115.322 (d)**

The MDHS Division of Program Integrity is responsible for conducting administrative or criminal investigations of sexual abuse and sexual harassment in accordance with the MDHS DYS Institutional Investigations policy.

**115.322 (e)**

No Department of Justice component is responsible for conducting administrative or criminal investigations of sexual abuse or sexual harassment at OYDC.

**Corrective Action**

Based upon review and analysis of the available evidence, the auditor has determined the agency and facility is fully compliant with this standard regarding zero-tolerance toward sexual abuse and sexual harassment and designation of a PREA coordinator. No corrective action is required.



## 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.*

#### The following evidence was analyzed in making the compliance determination:

**Documents:**

1. OYDC Policy XV.7, PREA
2. OYDC Policy IV.1 Staff Training
3. Staff Training Curriculum / Video
4. Staff PREA Acknowledgment Form
5. OYDC Pre-Audit Questionnaire responses

**Interviews:**

1. Interviews with a Random Sample of Staff

**Site Review Observations:**

1. Observations during on-site review of physical plant

**Findings (By Provision):****115.331 (a)**

PAQ: The agency trains all employees who may have contact with residents on the eleven (11) required topics.

Policy states all staff are trained prior to working with youth, all employees, contract employees, and volunteers, with direct or incidental contact with youth must sign the Staff PREA Acknowledgement Form (XV.7.B) or the Volunteer/Contractor PREA Acknowledgement Form (XV.7.B) and receive documented PREA awareness training covering: the prohibition of sexual contact with youth; youth-on-youth sexual contact awareness, and procedures for identifying, responding to, resolving, and reporting youth sexual contact. Refresher training will occur every 2 years after initial PREA training.

Staff are trained by video and in person presentations. The auditor reviewed the videos and determined they are inclusive of the training topics. Staff interviews corroborated staff are trained on the required training topics. The auditor reviewed Staff PREA Acknowledgement Forms for 2018 and 2019.

**115.331 (b)**

PAQ: The training is tailored to the unique needs and attributes and gender of the residents at the facility. OYDC houses both male and female residents and is the only state operated juvenile confinement facility in the state of Mississippi.

**115.331 (c)**

PAQ: The number of staff currently employed by the facility, who may have contact with residents, who were trained or retrained on PREA requirements: 182

The percent of staff currently employed by the facility, who may have contact with residents, who were trained or retrained on PREA requirements: 100%

Between trainings, the agency provides employees who may have contact with residents with refresher information about current policies regarding sexual abuse and sexual harassment. Refresher training is provided on a as needed basis, requested by Program Integrity, supervisors, staff, and/or medical personnel. The auditor reviewed Staff PREA Acknowledgement Forms for 2018 and 2019.

**115.331 (d)**

PAQ: The agency documents that employees who may have contact with residents understand the training they have received through employee signature or electronic verification.

Policy states Employee training shall be documented to denote employee understanding of material and verified through employee signature using the PREA Staff Acknowledgement Form.

'The auditor reviewed Staff PREA Acknowledgement Forms for 2018 and 2019. Staff sign that they have received and understand the training.

#### **Corrective Action**

Based upon review and analysis of the available evidence, the auditor has determined the agency and facility is fully compliant with this standard regarding employee Training. No corrective action is required.

### **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.*

**The following evidence was analyzed in making the compliance determination:**

**Documents:**

1. OYDC Policy XV.7, PREA
2. OYDC Policy IV.1 Staff Training
3. Staff Training Curriculum / Video
4. Volunteer/Contractor PREA Acknowledgment Form
5. OYDC Pre-Audit Questionnaire responses

**Interviews:**

1. Interviews with Volunteers and Contractors who have Contact with Residents

**Site Review Observations:**

1. Observations during on-site review of physical plant

**Findings (By Provision):**

**115.332 (a)**

**PAQ:**

All volunteers and contractors who have contact with residents have been trained on their responsibilities under the agency's policies and procedures regarding sexual abuse and sexual harassment prevention, detection, and response policies and procedures.

1. The number of volunteers and contractors, who have contact with residents, who have been trained in agency's policies and procedures regarding sexual abuse and sexual harassment prevention, detection, and response: thirty-seven (37)
2. The percent of volunteers and contractors, who have contact with residents, who have been trained in agency's policies and procedures regarding sexual abuse and sexual harassment prevention, detection, and response: 100%

Policy states contractors and volunteers shall receive training to include, but not be limited to the prevention, detection, response, and reporting of allegations of youth sexual abuse, sexual harassment, and custodial sexual misconduct. Such training shall encompass all required areas the contractor or volunteer may need to know to ensure compliance with PREA standards requirements.

Volunteer and contracted staff are trained by video. The auditor reviewed the videos and determined they are inclusive of the training topics. Volunteer and Contractor interviews corroborated they are trained in their responsibilities regarding sexual abuse and sexual harassment prevention, detection and response, per agency policy and procedure. The auditor reviewed Volunteer/Contractor PREA Acknowledgement Forms for 2018 and 2019.

**115.332 (b)**

PAQ: 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.

Policy states 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 youth, but all volunteers and contractors who have contact with youth shall be notified of the agency's zero-tolerance policy regarding sexual abuse and sexual harassment and informed how to report such incidents.

Volunteer and contracted staff are trained by video. The auditor reviewed the videos and determined they are inclusive of the training topics. The auditor reviewed Volunteer/Contractor PREA Acknowledgement Forms for 2018 and 2019. A contracted mental health staff confirmed receiving the same training topics as other facility medical and mental health staff.

**115.332 (c)**

PAQ: The agency maintains documentation confirming that volunteers and contractors understand the training they have received.

Policy states all staff working with youth, all employees, contract employees, and volunteers, with direct or incidental contact with youth must sign the Staff PREA Acknowledgement Form (XV.7.B) or the Volunteer/Contractor PREA Acknowledgement Form (XV.7.B) and receive documented PREA awareness training conveying: the prohibition of sexual contact with youth; youth-on-youth sexual contact awareness, and procedures for identifying, responding to, resolving, and reporting youth sexual contact.

Interviews with volunteers and contractors who have contact with residents confirmed they have received training in their responsibilities regarding sexual abuse and sexual harassment prevention, detection and response, per agency policy and procedure. They stated training consist of watching a video. They also they have been notified of the agency's zero-tolerance policy on sexual abuse and sexual harassment, as well as informed about how to report such incidents. The auditor reviewed a sample of Volunteer/Contractor PREA Acknowledgement forms.

**Corrective Action**

Based upon the review and analysis of the available evidence, the auditor has determined the agency and facility is fully compliant with this standard regarding volunteer and contractor training. No corrective action is required.

## **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 the comprehensive education referenced in 115.333(b)?  
☒ 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.*

### The following evidence was analyzed in making the compliance determination:

#### Documents:

1. OYDC Policy XV.7, PREA
2. OYDC Policy: XIII.1, Admission
3. OYDC Pre-Audit Questionnaire responses
4. "I Speak" Chart (Language Identification)
5. MOU with the Division of Economic Assistance Language Lab
6. Contract with the De L'eppe Deaf Center for Sign language Interpreting Services
7. Student Handbook
8. Juvenile Orientation Notice of Understanding – discontinued December 3, 2019
9. PREA Posters

#### Documents (Corrective Action):

1. Propio Over-the-phone Interpreting – implemented March 2, 2020
2. Youth Orientation Acknowledgement Form – updated December 3, 2019
3. PREA Posters (English and Spanish) – final update February 25, 2020
4. Student Handbook – final update April 15, 2020

#### Interviews:

1. Interview with Intake staff
2. Interviews with a Random Sample of Residents

#### Site Review Observations:

1. Observations during on-site review of physical plant

#### Findings (By Provision):

#### 115.333 (a)



PAQ: Residents receive information at time of intake about the zero-tolerance policy and how to report incidents or suspicions of sexual abuse or sexual harassment. This information is provided in an age appropriate fashion. Of residents admitted during the past 12 months: The number who were given this information at intake: 113. The percent who were given this information at intake:100%

Policy states all youth shall be given verbal and written, understandable information explaining the OYDC's zero tolerance PREA policy including how to report sexual abuse and harassment during intake.

Intake staff confirmed she provides residents with information about the agency's zero-tolerance policy and how to report incidents or suspicions of sexual abuse and sexual harassment. The residents watch a video, they are given PREA handouts and a juvenile handbook. The residents sign the Youth Orientation Acknowledgement Form. This form was updated and put into practice December 3, 2019. The updated form is fully inclusive of the PREA educational information required during the first 72 hours of confinement.

The auditor reviewed a sample of intake records of residents entering the facility in the past 12 months and throughout the corrective action period. The residents signed the Juvenile Orientation Notice of Understanding (updated to Youth Orientation Acknowledgement Form) confirming they completed the orientation process and understand all information that has been given to them.

The auditor reviewed the PREA handouts and juvenile handbook to ensure that relevant information is covered, and material are presented in age appropriate fashion.

#### **115.333 (b)**

PAQ: Of residents admitted during the past 12 months:

1. The number who received such education within 10 days of intake: 113
2. The percent who were given this information within 10 days of intake: 100%

Policy states all youth shall receive a comprehensive educational orientation by an OYDC Counselor on the OYDC's zero tolerance PREA policy and how to report sexual abuse and harassment within 72 hours of their arrival at OYDC.

The intake staff stated the agency ensure that residents are educated 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. The residents watch a video, they are given PREA handouts and a juvenile handbook.

In general, 24 to 48 hours from the date of intake residents are made aware of these rights. A random sample of sixteen (16) residents interviewed confirmed they were told about their right to not be sexually abused or sexually harassed, how to report sexual abuse and sexual harassment, and their right not to be punished for reporting sexual abuse or sexual harassment. Residents interviewed confirmed they were given information about the rules against sexual abuse and sexual harassment. All residents interviewed reported they received PREA education within 2 days of intake.

The auditor reviewed a sample of intake records of residents entering the facility in the past 12 months and throughout the corrective action period. The residents signed the Juvenile Orientation Notice of Understanding (updated to Youth Orientation Acknowledgement Form) confirming they completed the orientation process and understand all information that has been given to them.

The auditor reviewed relevant education materials to ensure that relevant information is covered, and material is presented in age appropriate fashion.

**115.333 (c)**

PAQ: All residents were educated within 10 days of intake.

Policy states all youth shall receive a comprehensive PREA education.

The Intake Staff confirmed all residents are educated on the facility's zero-tolerance policy on sexual abuse and sexual harassment regardless if they are transferred from other facilities.

The auditor reviewed a sample of intake records of residents entering the facility in the past 12 months and throughout the corrective action period.

**115.333 (d)**

PAQ: 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.

Policy states 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.

The agency has a MOU with the Division of Economic Assistance Language Lab for language interpreting and a contract with the De L'eppe Deaf Center for sign language interpreting services. Propio Over-the-phone Interpreting was implemented March 2, 2020. OYDC is in the process of providing PREA education materials available in Braille.

**115.333 (e)**

PAQ: The agency maintains documentation of resident participation in PREA education sessions.

Policy states that upon completion of a youth's PREA orientation, the youth shall sign the Youth Orientation Acknowledgement Form. If the youth refuses to sign, the witness shall indicate by writing "Refused to Sign" and affix his/her signature. The completed Youth Orientation Acknowledgement Form shall be maintained into the youth's records.

The auditor reviewed a sample of intake records of residents entering the facility in the past 12 months and throughout the corrective action period. The residents signed the Juvenile Orientation Notice of Understanding (updated to Youth Orientation Acknowledgement Form) confirming they completed the orientation process and understand all information that has been given to them.

**115.333 (f)**

PAQ: The agency ensures that key information about the agency's PREA policies is continuously and readily available or visible through posters, resident handbooks, or other written formats.

The auditor reviewed education and informational materials (posters, resident handbook, etc.) in compliance with the standard. The facility had a limited number of posters with the sexual abuse hotline number. OYDC developed a new PREA poster that is inclusive of ways to report, contact information for outside support services, and the sexual abuse hotline. The poster is available in English and Spanish. The final draft was emailed to the auditor February 25, 2020 for review and pictures of the posted posters were emailed March 13, 2020 for verification.

During the tour, the auditor made observations of the need for additional signage. This was addressed through corrective action.

### **Corrective Action**

Based upon review and analysis of the available evidence, the auditor has determined the agency and facility is fully compliant with this standard regarding resident education. Corrective action has been completed.

**115.333 (d)** OYDC developed a new PREA poster that is inclusive of ways to report, contact information for outside support services, and the sexual abuse hotline. The poster is available in English and Spanish. The final draft was emailed to the auditor February 25, 2020 for review and pictures of the posted posters were emailed March 13, 2020 for verification. Propio Over-the-phone Interpreting was implemented March 2, 2020. OYDC is in the process of providing PREA education materials available in Braille.

**115.333 (f)** Additional signage was needed to ensure that key information about the agency's PREA policies is continuously and readily available. OYDC created PREA posters in both English and Spanish. The final draft was emailed to the auditor February 25, 2020 for review and pictures of the posted posters were emailed March 13, 2020 for verification.

## **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.*

#### The following evidence was analyzed in making the compliance determination:

##### Documents:

1. OYDC Policy XV.7 PREA
2. OYDC Policy IV.1 Staff Training
3. OYDC Pre-Audit Questionnaire responses

**Documents (Corrective Action):**

1. National Institute of Corrections (NIC) - completed December 19, 2019
2. Staff Acknowledgment of PREA - completed January 20, 2020

**Interview:**

1. Interview with Investigative Staff

**Site Review Observations:**

1. Observations during on-site review of physical plant

**Findings (By Provision):****115.334 (a)**

PAQ: Agency policy requires that investigators are trained in conducting sexual abuse investigations in confinement settings.

Program Integrity investigators completed this training during corrective action through online training provided by the National Institute of Corrections (NIC) on December 19, 2019 and agency-provided training on January 20, 2020. The auditor reviewed NIC certificates and Staff Acknowledgment of PREA (standard 115.331) for investigative staff for verification.

**115.334 (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.

Policy states investigators and other OYDC employees with PREA related responsibilities shall receive additional training related to their roles to include, but not limited to: interviewing sexual abuse victims, proper use of Miranda and Garrity warnings, conducting sexual abuse investigations and the collection of evidence in a confinement setting, and the criteria and evidence required to substantiate a case for administrative action or prosecutorial referral.

The auditor reviewed NIC certificates and Staff Acknowledgments of PREA (standard 115.331) for investigative staff for verification.

**115.334 (c)**

PAQ: The agency will maintain documentation showing that investigators have completed the required training. The number of investigators the agency currently employs is two (2). The number of investigators currently employed who have completed the required training is two (2).

The auditor reviewed NIC certificates and Staff Acknowledgments of PREA (standard 115.331) for investigative staff for verification.

**115.334 (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 MDHS Division of Program Integrity investigators are required to complete the required specialized training for compliance with the standard.

### **Corrective Action**

Based upon the review and analysis of the available evidence, the auditor has determined the agency and facility is fully compliant with this standard regarding specialized training for investigations. Corrective action has been completed.

### **115.334 (a) & 115.334 (b)**

The MDHS Division of Program Integrity investigators are required to complete the training requirements of standard §115.331 and the required specialized training for compliance with the standard. Program Integrity investigators completed this training through online training provided by the National Institute of Corrections (NIC) on December 19, 2019 and agency-provided training on January 20, 2020. The auditor reviewed NIC certificates and Staff Acknowledgments of PREA (standard 115.331) for verification.

## **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? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners who work regularly in its facilities.)  
☒ Yes   ☐ No   ☐ NA
- 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? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners who work regularly in its facilities.) ☒ Yes   ☐ No   ☐ NA
- 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? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners who work regularly in its facilities.) ☒ Yes   ☐ No   ☐ NA
- 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? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners who work regularly in its facilities.)  
☒ Yes   ☐ No   ☐ NA

#### **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 or the agency does not employ medical staff.)

☒ 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? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners who work regularly in its facilities.) ☒ Yes ☐ No ☐ NA

#### 115.335 (d)

- Do medical and mental health care practitioners employed by the agency also receive training mandated for employees by §115.331? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners who work regularly in its facilities.)  
☒ Yes ☐ No ☐ NA
- Do medical and mental health care practitioners contracted by or volunteering for the agency also receive training mandated for contractors and volunteers by §115.332? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners contracted by or volunteering for the agency.) ☒ 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.*

#### The following evidence was analyzed in making the compliance determination:

##### Documents:

1. OYDC Policy XV.7, PREA
2. OYDC Policy IV.1 Staff Training
3. Staff PREA Acknowledgment Forms
4. Contractor PREA Acknowledgment Forms
5. OYDC Pre-Audit Questionnaire responses

##### Documents (Corrective Action):

1. NIC Specialized Training: PREA Medical and Mental Care Standards



2. NIC Certificates – completed December 20, 2019

**Interviews:**

1. Interviews with Medical and Mental Health Staff

**Site Review Observations:**

1. Observations during on-site review of physical plant

**Findings (By Provision):****115.335 (a)**

PAQ: The agency has a policy related to the training of medical and mental health practitioners who work regularly in its facilities.

1. The number of all medical and mental health care practitioners who work regularly at this facility who received the training: twenty-five (25)
2. The percent of all medical and mental health care practitioners who work regularly at this facility who received the training required by agency policy: 100%

Policy states medical and mental health employees, shall receive additional training to include, but not limited to: How to detect and assess signs of sexual abuse and harassment, how to preserve physical evidence of sexual abuse, how to respond effectively and professionally to victims of sexual abuse and harassment, how and to whom to report allegations or suspicions of sexual abuse and harassment, recognizing the special medical and mental health needs of all youth, and factors to consider in a youth's risk of sexual victimization.

Interviews with medical and mental health staff confirmed they had not received any specialized training regarding sexual abuse and sexual harassment. This training was completed online through the NIC on December 20, 2019. Certificates of completion were emailed to the auditor for verification.

**115.335 (b)**

PAQ: OYDC does not employ medical staff that conduct forensic exams. Forensic medical examinations are performed offsite.

Medical staff confirmed they do not conduct forensic examinations.

**115.335 (c)**

PAQ: The agency maintains documentation showing that medical and mental health practitioners have completed the required training.

Policy states training shall be documented to denote employee understanding of material and verified through employee signature.

The agency maintains NIC certificates that medical and mental health practitioners have received the training referenced in this standard from the National Institute of Corrections.

**115.335 (d)**

Policy states 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 youth



The auditor reviewed Staff PREA Acknowledgment forms and Contractor PREA Acknowledgment forms for medical and mental health care practitioners to ensure they received the training for employees and contracted medical and mental health staff in the referenced standards. A contracted mental health staff confirmed receiving the same training topics as other facility medical and mental health staff.

**Corrective Action**

Based upon the review and analysis of the available evidence, the auditor has determined the agency and facility is fully compliant with this standard regarding specialized training for medical and mental health care. Corrective action has been completed.

**115.335 (a)**

Specialized training was completed online through the NIC on December 29, 2019. Certificates of completion were emailed to the auditor for verification.

## 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: (1) Prior sexual victimization or abusiveness? ☒ Yes ☐ No
- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: (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? ☒ Yes ☐ No
- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: (3) Current charges and offense history? ☒ Yes ☐ No
- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: (4) Age? ☒ Yes ☐ No
- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: (5) Level of emotional and cognitive development? ☒ Yes ☐ No
- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: (6) Physical size and stature? ☒ Yes ☐ No
- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: (7) Mental illness or mental disabilities? ☒ Yes ☐ No

- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: (8) Intellectual or developmental disabilities? ☒ Yes ☐ No
- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: (9) Physical disabilities? ☒ Yes ☐ No
- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: (10) The residents' own perception of vulnerability? ☒ Yes ☐ No
- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: (11) 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.*

**The following evidence was analyzed in making the compliance determination:**

**Documents:**

1. OYDC Policy XV.7 PREA
2. OYDC Policy XIII.1 Admission, Intake, and Orientation
3. OYDC Policy XIII.3 Youth Screening and Assessment
4. OYDC Pre-Audit Questionnaire responses
5. Vulnerability-Sexual Risk Assessment

**Documents (Corrective Action):**

1. Vulnerability-Sexual Risk Assessment – updated November 25, 2019

**Interviews:**

1. Interview with Staff Responsible for Risk Screening
2. Interviews with a Random Sample of Residents
3. Interview with the PREA Coordinator

**Site Review Observations:**

1. Observations during on-site review of physical plant

**Findings (By Provision):**

**115.341 (a)**

PAQ: The agency has a policy that requires screening (upon admission to a facility or transfer to another facility) for risk of sexual abuse victimization or sexual abusiveness toward other residents. The policy requires that residents be screened for risk of sexual victimization or risk of sexually abusing other residents within 72 hours of their intake.

In the past 12 months:

1. The number of residents entering the facility (either through intake or transfer) whose length of stay in the facility was for 72 hours or more who were screened for risk of sexual victimization or risk of sexually abusing other residents within 72 hours of their entry into the facility: 113
2. The percent of residents entering the facility (either through intake or transfer) whose length of stay in the facility was for 72 hours or more who were screened for risk of sexual victimization or risk of sexually abusing other residents within 72 hours of their entry into the facility: 100%

The policy requires that a resident's risk level be reassessed periodically throughout their confinement.

Policy states all youth, at initial intake, shall be screened within 72 hours utilizing the Vulnerability-Sexual Risk Assessment, for potential risk of sexual vulnerability and potential risk of sexual aggression. A youth's risk level shall be reassessed when warranted due to a referral, request, incident of sexual abuse, or receipt of additional information that bears on the youth's risk of sexual victimization or abusiveness. A youth's risk level shall be reassessed every 6 months to ensure that the information on the youth's risk assessment is accurate and up to date.

The auditor reviewed records for residents admitted to the facility within the past 12 months for evidence of appropriate screening within 72 hours. The screening instrument was not inclusive of the instrument requirements. The screening instrument was updated as part of corrective action.

The staff responsible for risk screening confirmed she screens residents upon admission to the facility or transfer from another facility for risk of sexual abuse victimization or sexual abusiveness toward other residents. She screens residents for risk of sexual victimization or risk of sexually abusing other residents within 72 hours of their intake. This information is ascertained through conversations with resident during intake, medical and mental health records, and a resident's social history.

All sixteen (16) residents interviewed entered the facility within the past twelve months. They confirmed they were asked questions like the following examples at intake:

- Have you have ever been sexually abused?
- Do you have any disabilities?
- Do you think you might be in danger of sexual abuse at the facility?

Residents were not asked if they identify with being gay, bisexual, or transgender. These questions were added to the risk screening tool as part of corrective action.

#### **115.341 (b)**

PAQ: Risk assessment is conducted using an objective screening instrument. Such assessments shall be conducted using an objective screening instrument.

OYDC conducts risk assessments using the Vulnerability-Sexual Risk Assessment.

#### **115.341 (c)**

The auditor reviewed the screening instrument and discovered it did not consider 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. The screening instrument was updated to include this information on November 25, 2019 and staff were trained on using the form December 3, 2019. The revised Vulnerability-Sexual Risk Assessments were emailed to the auditor for verification from December 10, 2019, through March 15, 2020.

During the onsite audit, the staff responsible for risk screening confirmed the initial risk screening considers all aspects of the standard, with the exception of the aforementioned omissions.

#### **115.341 (d)**

Policy states a Counselor or Qualified Mental Health Professional (QMHP) shall complete the Vulnerability-Sexual Risk Assessment. This will include an interview with the youth and review of prior known information and documentation from the youth's file in order to determine the youth's potential risk of sexual vulnerability and/or sexually aggressive behavior.

#### **115.341 (e)**

Policy states there will be appropriate controls on the dissemination of screening information so as to ensure each youth's sensitive information is not exploited.

The PREA Coordinator stated the agency outlines who should have access to a resident's risk assessment within the facility in order to protect sensitive information from exploitation. These individuals include administrative staff, mental health staff, Program Integrity, and the PREA Coordinator. The staff responsible for risk screening concurred that administrative staff and mental health staff have access to a resident's risk assessment.

### **Corrective Action**

Based upon review and analysis of the available evidence, the auditor has determined the agency and facility is fully compliant with this standard regarding obtaining information from residents. Corrective action has been completed.

**115.341 (a)**

Revised policy requires that a resident's risk level be reassessed periodically throughout their confinement.

**115.341 (c)**

The auditor reviewed the screening instrument and discovered it did not consider 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. The screening instrument was updated to include this information on November 25, 2019 and staff were trained on using the form December 3, 2019. The revised Vulnerability-Sexual Risk Assessments were emailed to the auditor for verification from December 10, 2019 through March 15, 2020.

## **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? (N/A if the facility *never* places residents in isolation for any reason.) ☒ Yes ☐ No ☐ NA

- During any period of isolation, does the agency always refrain from denying residents daily large-muscle exercise? (N/A if the facility *never* places residents in isolation for any reason.) ☒ Yes ☐ No ☐ NA
- During any period of isolation, does the agency always refrain from denying residents any legally required educational programming or special education services? (N/A if the facility *never* places residents in isolation for any reason.) ☒ Yes ☐ No ☐ NA
- Do residents in isolation receive daily visits from a medical or mental health care clinician? (N/A if the facility *never* places residents in isolation for any reason.) ☒ Yes ☐ No ☐ NA
- Do residents in isolation also have access to other programs and work opportunities to the extent possible? (N/A if the facility *never* places residents in isolation for any reason.) ☒ Yes ☐ No ☐ NA

#### 115.342 (c)

- Does the agency always refrain from placing lesbian, gay, and bisexual (LGB) 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 (LGBTI) 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 provision (b) of this section, does the facility clearly document: The basis for the facility's concern for the resident's safety? (N/A if the facility *never* places residents in isolation for any reason.) ☒ Yes ☐ No ☐ NA
- If a resident is isolated pursuant to provision (b) of this section, does the facility clearly document: The reason why no alternative means of separation can be arranged? (N/A if the facility *never* places residents in isolation for any reason.) ☒ 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? (N/A if the facility *never* places residents in isolation for any reason.)  
☒ 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.*

**The following evidence was analyzed in making the compliance determination:**

**Documents:**

1. OYDC Policy XV.7 PREA
2. OYDC Policy XIII.3 Youth Screening and Assessment
3. OYDC Policy XIII.4 Treatment Teams
4. OYDC Policy XIII.5 Service Plans
5. OYDC Policy XIII.24 LGBTQI2-S
6. OYDC Pre-Audit Questionnaire responses

**Documents (Corrective Action):**

1. Vulnerability-Sexual Risk Assessment – updated November 25, 2019

**Interviews:**

1. Interview with the PREA coordinator
2. Interview with Staff Responsible for Risk Screening
3. Interview with the Facility Administrator
4. Interview with Staff who Supervise Residents in Isolation – N/A
5. Interviews with Medical and Mental Health Staff
6. Interviews with Transgendered/Intersex/Gay/Lesbian/Bisexual Residents – N/A

**Site Review Observations:**

1. Observations during on-site review of physical plant

**Findings (By Provision):**

**115.342 (a)**

PAQ: The agency/facility uses information from the risk screening required by §115.341 to inform housing, bed, work, education, and program assignments with the goal of keeping all residents safe and free from sexual abuse.

Policy states if the Vulnerability-Sexual Risk Assessment, interview, or prior known information reflects that the youth is at high risk to be victimized or screens as sexually aggressive, the counselor and/or QMHP will recommend further review by a QMHP prior to assigning permanent housing.

The PREA Coordinator and Staff Responsible for Risk Screening explained how the facility uses information from risk screening during intake (per 115.341) to keep residents safe and free from sexual abuse and sexual harassment. They stated programming and placement would be considered based on risk level.

**115.342 (b)**

PAQ: The facility has a policy that residents at risk of sexual victimization may only be placed in isolation as a last resort if less restrictive measures are inadequate to keep them and other residents safe, and only until an alternative means of keeping all residents safe can be arranged. The facility policy requires that residents at risk of sexual victimization who are placed in isolation have access to legally required educational programming, special education services, and daily large-muscle exercise. In the past 12 months:

1. The number of residents at risk of sexual victimization who were placed in isolation: 0
2. The number of residents at risk of sexual victimization who were placed in isolation who have been denied daily access to large muscle exercise, and/or legally required education, or special education services: 0
3. The average period of time residents at risk of sexual victimization who were held in isolation to protect them from sexual victimization: N/A

The Facility Administrator confirmed residents are only isolated from others 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. However, he stated the facility does not use isolation for these reasons. There were no residents in isolation for risk of sexual victimization who allege to have suffered sexual abuse during the onsite audit phase.

#### **115.342 (c)**

PAQ: The facility prohibits placing lesbian, gay, bisexual, transgender, or intersex residents in particular housing, bed, or other assignments solely on the basis of such identification or status. The facility prohibits considering lesbian, gay, bisexual, transgender, or intersex identification or status as an indicator of likelihood of being sexually abusive.

Policy states OYDC shall not place LGBTQI2-S youth in a dedicated facility, unit, or dorm solely on the basis of such identification or status.

Policy states LGBTQI2-S youth may not be placed in segregated housing against their will due to the sole purpose of their sexual orientation and the mere identification of a youth as LGBTQI2-S is insufficient to warrant an assumption of enhanced risk that the youth will be sexually abusive.

The PREA Coordinator confirmed the facility does not have a special housing unit for LGBTQI2-S residents. There were no juveniles who identified as LGBTQI2-S who were confined at the facility during the onsite phase of the audit.

#### **115.342 (d)**

PAQ: The agency or facility makes housing and program assignments for transgender or intersex residents in the facility on a case-by-case basis.

Policy states, in deciding whether to assign a transgender, intersex, and/or 2-Spirit youth to a housing unit for male or female youth, and in making other housing and programming assignments, the Gender Classification Committee shall consider on a case-by-case basis whether a placement would ensure the Youth's health and safety, and whether the placement would present management or security problems.

The PREA Coordinator confirmed the facility determines housing and program assignments for transgender or intersex residents on a case-by-case basis. She confirmed the agency considers whether the placement would present management or security problems. There were no juveniles who identified as LGBTQI2-S who were confined at the facility during the onsite phase of the audit.

#### **115.342 (e)**

PAQ: 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 states the policy and procedure for and record of placements for Transgender, Intersex, and/or 2-Spirit Youth shall be reassessed at least twice each year to review any threats to safety experienced by the youth. The Gender Classification Committee will record and keep these findings for permanent review and referrals for future training.

The PREA Coordinator confirmed placement and programming assignments for each transgender or intersex resident are reassessed at least every six months to review any threats to safety experienced by the resident.

**115.342 (f)**

PAQ: A transgender or intersex resident's own views with respect to his or her own safety shall be given serious consideration.

Policy states a transgender or intersex youth's own views with respect to his or her own safety shall be given serious consideration.

The PREA Coordinator confirmed the agency considers whether the placement will ensure the resident's health and safety. The Staff Responsible for Risk Screening confirmed transgender or intersex residents' views of their safety are given serious consideration in placement and programming assignments.

There were no juveniles who identified as transgender or intersex who were confined at the facility during the onsite phase of the audit.

**115.342 (g)**

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

Policy states transgender, intersex, and Two-Spirit youth shall be given the opportunity to shower separately from other youth.

The Staff Responsible for Risk Screening confirmed transgender and intersex residents are given the opportunity to shower separately from other residents. She added that all residents shower separately. There were no juveniles who identified as transgender or intersex who were confined at the facility during the onsite phase of the audit.

During the tour, the auditor observed living units allow for transgender and intersex residents to shower separately from other residents.

**115.342 (h)**

PAQ: From a review of case files of residents at risk of sexual victimization who were held in isolation in the past 12 months, the number of case files that include BOTH:

1. A statement of the basis for facility's concern for the resident's safety, and
2. The reason or reasons why alternative means of separation cannot be arranged: N/A

The facility does not use isolation for residents at risk of sexual victimization.

**115.342 (i)**

PAQ: If a resident at risk of sexual victimization is held in isolation, the facility affords each such resident a review every 30 days to determine whether there is a continuing need for separation from the general population.

The facility does not use isolation for residents at risk of sexual victimization.

There were no residents in isolation (for risk of sexual victimization/who allege to have suffered sexual abuse) during the onsite phase of the audit.

**Corrective Action**

Based upon the review and analysis of the available evidence, the auditor has determined the agency and facility is fully compliant with this standard regarding use of screening information. No corrective action is required.

## 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? (N/A if the facility *never* houses residents detained solely for civil immigration purposes.) ☐ Yes ☐ No ☒ NA

#### 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.*

### The following evidence was analyzed in making the compliance determination:

#### Documents:

1. OYDC Policy VII.2 Incident Reporting
2. OYDC Policy XV.7 PREA
3. OYDC Pre-Audit Questionnaire responses

#### Documents (Corrective Action):

1. Student Handbook – updated April 14, 2020

#### Interview:

1. Interview with the PREA Coordinator
2. Interviews with a random sample of staff
3. Interviews with a random sample of residents
4. Interviews with residents who reported a sexual abuse – N/A

#### Site Review Observations:

1. Observations during on-site review of physical plant

### Findings (By Provision):

#### 115.351 (a)

PAQ: The agency has established procedures allowing for multiple internal ways for residents to report privately to agency officials about: Sexual abuse or 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 states youth may report sexual abuse or harassment verbally, in writing, through a third party, or anonymously. They may file a grievance, call the MDHS Child Abuse Hotline (1-800-222-8000) and/or

the MSCASA hotline (1-800-656-4673), deposit a complaint in the grievance box (a secured receptacle, located in each unit), tell the PREA Coordinator, contact Program Integrity via use of a pre-addressed Program Integrity envelope, or they may tell any staff, contractor, or volunteer, and expect the information to be reported immediately and thoroughly investigated.

Reporting information is included in orientation materials, the student handbook and PREA posters.

Interviews with a random sample of staff revealed residents can privately report sexual abuse or sexual harassment, retaliation by other residents or staff for reporting sexual abuse and sexual harassment, or staff neglect or violation of responsibilities that may have contributed to an incident of sexual abuse or sexual harassment by calling the child abuse hotline or submitting a grievance.

Interviews with a random sample of residents confirmed they are knowledgeable of different ways to report any sexual abuse or sexual harassment that happened to them or someone else. Responses included telling staff, writing a grievance, or calling the hotline.

During the tour, the staff described the grievance process and pointed out the posters with the child abuse hotline number. Posters were not in all of the housing units. The facility substantially increased signage as part of corrective action.

**115.351 (b)**

PAQ: The agency provides 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. OYDC does not detain residents solely for civil immigration purposes.

Policy states youth may report sexual abuse by calling the Mississippi Coalition Against Sexual Assault (MSCASA) Hotline at 1-800-656-4673.

The PREA Coordinator confirmed residents can call the Mississippi Coalition Against Sexual Assault (MSCASA) Hotline. Calling the hotline enables receipt and immediate transmission of resident reports of sexual abuse and sexual harassment to agency officials, which allow the resident to remain anonymous upon request.

Interviews with a random sample of residents confirmed a majority of the residents could identify someone who does not work at the facility that they could report to about sexual abuse or sexual harassment. Resident interviews revealed they were not knowledgeable of their right to make anonymous reports.

During the tour, the auditor observed some posters with the child abuse hotline number. Posters were not in all of the housing units. The facility increased signage as part of corrective action. The new posters include contact information for MSCASA.

**115.351 (c)**

PAQ: The agency has a policy mandating that staff accept reports of sexual abuse and sexual harassment made verbally, in writing, anonymously, and from third parties. Staff are required to document verbal reports immediately, but no longer than the end of their shift.

Policy states according to the Mississippi Code of 1972, § 43-21-353, all OYDC employees/staff who receive any information, including verbal, written, third-party reports, and anonymous complaints, concerning youth sexual abuse, sexual harassment, and custodial sexual misconduct; retaliation

against youth or staff who report such an incident; or any staff neglect or violation of responsibilities that may have contributed to an incident or violation, shall immediately report the incident through their chain of command.

The auditor reviewed investigation files with allegations that were reported verbally. The verbal reports made to staff were documented with Incident Reports.

Interviews with a random sample of staff confirmed when a resident alleges sexual abuse or sexual harassment, can he/she do so verbally, in writing, anonymously and through third parties. Verbal reports are documented immediately using an Incident Report form.

Interviews with a random sample of resident confirmed they are knowledgeable they c make reports of sexual abuse or sexual harassment either in person or in writing. They confirmed someone else (for example, a friend or relative) could make the report them. They were less sure that they could do so without out giving their name.

#### **115.351 (d)**

PAQ: The facility provides residents with access to tools to make written reports of sexual abuse or 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.

The PREA Coordinator confirmed that the facility provides residents with pencils and paper to help them make written reports of sexual abuse or 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. There were no residents who reported a sexual abuse that were confined at the facility during the onsite phase of the audit.

#### **115.351 (e)**

PAQ: The agency has established procedures for staff to privately report sexual abuse and sexual harassment of residents.

Staff can report through the Mississippi Department of Child Protection Services Hotline at 800-222-8000 or 601-432-4570. Staff are informed of these procedures in the staff handbook.

Interviews with a random sample of staff revealed staff are knowledgeable they can privately report sexual abuse and sexual harassment of residents to the Mississippi Department of Child Protection Services Hotline at 800-222-8000 or 601-432-4570.

#### **Corrective Action**

Based upon review and analysis of the available evidence, the auditor has determined the agency and facility is fully compliant with this standard regarding resident reporting. Corrective action is complete.

**115.351 (b) and (c)** Resident interviews revealed they were not knowledgeable of their right to make anonymous reports. Refresher training was provided to the residents concerning their right to make anonymous reports and outside services available for resident victims of sexual abuse. This information was also added to the orientation materials and is included in the newly developed posters.



## 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

#### 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.*

#### The following evidence was analyzed in making the compliance determination:

##### Documents:

1. OYDC Policy, XV.2, Youth Grievance
2. OYDC Policy XV.7 PREA
3. OYDC Pre-Audit Questionnaire responses

##### Documents (Corrective Action):

1. Student Handbook – updated April 14, 2020

##### Interviews:

Interviews with Residents who Reported a Sexual Abuse - N/A

##### Site Review Observations:

Observations during on-site review of physical plant

**Findings:**

**115.352 (a)**

PAQ: The agency has an administrative procedure for dealing with resident grievances regarding sexual abuse.

Policy states the facility will use OYDC Policy, XV.2, Youth Grievance, as an administrative procedure to address youth grievances regarding sexual abuse and sexual harassment.

**115.352 (b)**

PAQ: Agency policy or procedure allows a resident to submit a grievance regarding an allegation of sexual abuse at any time regardless of when the incident is alleged to have occurred. Agency policy does not require a resident to use an informal grievance process, or otherwise to attempt to resolve with staff, an alleged incident of sexual abuse.

Policy states OYDC will not impose a time limit on when a youth may submit a grievance regarding an allegation of sexual abuse.

The auditor reviewed the student handbook and verified relevant information is provided.

**115.352 (c)**

PAQ: The agency's policy and procedure allow a resident to submit a grievance alleging sexual abuse without submitting it to the staff member who is the subject of the complaint.

Policy states OYDC shall ensure that a youth who alleges sexual abuse may submit a grievance without submitting it to a staff member who is the subject of the complaint, and such grievance is not referred to a staff member who is the subject of the complaint.

The auditor reviewed the student handbook and verified relevant information is provided.

**115.352 (d)**

PAQ: The agency has policy and procedures that require that a decision on the merits of any grievance or portion of a grievance alleging sexual abuse be made within 90 days of the filing of the grievance.

In the past 12 months:

1. The number of grievances that were filed that alleged sexual abuse: Three (3)
2. The number of grievances alleging sexual abuse that reached final decision within 90 days after being filed: Three (3)
3. The number of grievances alleging sexual abuse that involved extensions because final decision was not reached within 90 days: Zero (0)

Policy states MDHS 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. Computation of the 90-day time period shall not include time consumed by youth in preparing any administrative appeal. MDHS 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. MDHS shall notify the youth in writing of any such extension and provide a date by which a decision will be made. At any level of the administrative process, including the final level, if the youth does not receive a response within the time allotted for reply, including any properly noticed extension, the youth may consider the absence of a response to be a denial at that level.

The auditor reviewed resident grievances alleging sexual abuse and final decisions included in investigation reports.

**115.352 (e)**

PAQ: Agency policy and procedure permits third parties, including fellow residents, staff members, family members, attorneys, and outside advocates, to assist residents in filing requests for administrative remedies relating to allegations of sexual abuse, and to file such requests on behalf of residents. Agency policy and procedure require that if the resident declines to have third-party assistance in filing a grievance alleging sexual abuse, the agency documents the resident's decision to decline.

Policy states third parties, including fellow youth, staff members, family members, attorneys, and outside advocates, shall be permitted to assist youth in filing requests for administrative remedies relating to allegations of sexual abuse, and shall also be permitted to file such requests on behalf of youth. The Third-Party Reporting for Alleged Sexual Abuse Sexual Assault and Sexual Harassment form (XV.7.E) is posted to the MDHS, DYS website, along with corresponding contact information.

If a third party, other than a parent or legal guardian, files such a request on behalf of a youth, OYDC 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. If the youth declines to have the request processed on his or her behalf, OYDC shall document the youth's decision.

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

During the audit reporting period there was no documentation of third-party reports or declination of third-party assistance.

**115.352 (f)**

PAQ: The agency has a policy and established procedures for filing an emergency grievance alleging that a resident is subject to a substantial risk of imminent sexual abuse. Agency policy and procedures for emergency grievances alleging substantial risk of imminent sexual abuse require an initial response within 48 hours. The number of emergency grievances alleging substantial risk of imminent sexual abuse that were filed in the past 12 months: Zero (0)

Policy states after receiving an emergency grievance alleging a youth is subject to a substantial risk of imminent sexual abuse, OYDC 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 5 calendar days. The initial response and final agency decision shall document the agency's determination whether the youth is in substantial risk of imminent sexual abuse and the action taken in response to the emergency grievance.

**115.352 (g)**

PAQ: The agency has a written policy that limits its ability to discipline a resident for filing a grievance alleging sexual abuse to occasions where the agency demonstrates that the resident filed the grievance in bad faith.

In the past 12 months, the number of resident grievances alleging sexual abuse that resulted in disciplinary action by the agency against the resident for having filed the grievance in bad faith: Zero (0)

Policy states OYDC may discipline a youth for filing a grievance related to alleged sexual abuse only where the agency demonstrates that the youth filed the grievance in bad faith.

#### **Corrective Action**

Based upon the review and analysis of the available evidence, the auditor has determined the agency and facility is fully compliant with this standard regarding exhaustion of administrative remedies. No corrective action is required.

### **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**

##### **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 assessable 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? (N/A if the facility *never* has persons detained solely for civil immigration purposes.) ☐ Yes ☐ No ☒ NA
- 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 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 following evidence was analyzed in making the compliance determination:

#### Documents:

1. OYDC Policy XV.7 PREA
2. OYDC Policy XV.3 Youth Visitation
3. OYDC Policy XV.4 Youth Access to Mail
4. OYDC Policy XV.5 Youth Phone Usage
5. OYDC Pre-Audit Questionnaire responses

#### Documents (Corrective Action):

1. Mississippi Coalition Against Sexual Assault (MCASA) – Finalized February 8, 2020

#### Interviews:

1. Interview with the PREA Compliance Manager
2. Interview with the Facility Administrator
3. Interviews with a Random Sample of Residents
4. Interviews with Residents who Reported a Sexual Abuse - N/A

#### Site Review Observations:

Observations during on-site review of physical plant

#### Findings (By Provision):

### 115.353 (a)



PAQ: The facility provides residents access to outside victim advocates for emotional support services related to sexual abuse by:

1. Giving residents (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.
2. Enabling reasonable communication between residents and these organizations, in as confidential a manner as possible.

Policy states ODYC shall provide youth 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. OYDC shall enable reasonable communication between youth and these organizations and agencies, in as confidential a manner as possible.

Residents acknowledged there are services available outside of this facility for dealing with sexual abuse if they ever need it. They confirmed they would be able to talk with people from outside services when needed and the call would be private.

#### **115.353 (b)**

PAQ: The facility informs residents, prior to giving them access to outside support services, the extent to which such communications will be monitored. The facility informs residents, prior to giving them access to outside support services, of the mandatory reporting rules governing privacy, confidentiality, and/or privilege that apply to disclosures of sexual abuse made to outside victim advocates, including any limits to confidentiality under relevant Federal, State, or local law.

Policy states OYDC shall inform youth, 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.

Interviews with residents confirmed they were knowledgeable of mandatory reporting rules when having conversations with people from outside services.

#### **115.353 (c)**

PAQ: The agency or facility maintains memoranda of understanding (MOUs) or other agreements with community service providers that are able to provide residents with emotional support services related to sexual abuse. The agency or facility maintains copies of those agreements.

Policy states MDHS shall maintain or attempt to enter into memoranda of understanding or other agreements with community service providers that are able to provide youth 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.

OYDC has a MOU with the Mississippi Coalition Against Sexual Assault (MCASA) for emotional support services related to sexual abuse. The MOU was finalized February 8, 2020 as part of corrective action.

#### **115.353 (d)**

PAQ: The facility provides residents with reasonable and confidential access to their attorneys or other legal representation. The facility provides residents with reasonable access to parents or legal guardians.



Policy states OYDC shall provide youth with reasonable and confidential access to their attorneys or other legal representation and reasonable access to parents or legal guardians.

The Facility Administrator and PREA Compliance Manager confirmed the facility would provide residents with reasonable and confidential access to their attorneys or other legal representation and reasonable access to parents or legal guardians. Residents confirmed the facility allows them to see or talk with their lawyer or another lawyer and they are allowed to talk with that person privately. Residents also confirmed the facility allows them to see or talk with their parents or someone else such as a legal guardian.

#### **Corrective Action**

Based upon review and analysis of the available evidence, the auditor has determined the agency and facility is fully compliant with this standard regarding third-party reporting. Corrective action has been completed.

#### **115.353 (c)**

OYDC has a MOU with the Mississippi Coalition Against Sexual Assault (MCASA) for emotional support services related to sexual abuse. The MOU was finalized February 8, 2020 as part of corrective action.

### **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.*

**The following evidence was analyzed in making the compliance determination:**

**Documents:**

1. OYDC Policy XV.7 PREA
2. OYDC Pre-Audit Questionnaire responses

**Documents (Corrective Action):**

1. Third Party Reporting for Alleged Sexual Abuse, Sexual Assault, and Sexual Harassment Form developed November 26, 2019/ finalized April 30, 2020
2. Website Publication (Third-party Reporting) - April 30, 2020

**Site Review Observations:**

1. Observations during on-site review of physical plant

**Findings (By Provision):**

**115.354 (a)**

PAQ: The agency or facility provides a method to receive third-party reports of resident sexual abuse or sexual harassment.

**Corrective Action**

Based upon review and analysis of the available evidence, the auditor has determined the agency and facility exceeds this standard regarding third-party reporting. The agency provides numerous avenues for third-party reports of resident sexual abuse or sexual harassment. Corrective action has been completed.

**115.354 (a)**

The website publication reads as follows:

If you suspect sexual abuse has happened at Oakley Youth Development Center (OYDC), you have several options for reporting. You may call the OYDC PREA Coordinator at (601) 857-7708; or you may call the MDHS Child Abuse Hotline at 1-800-222-8000. If you prefer, you may call and report to the Hinds County Sheriff or Raymond Police Department. You may also report using the Third-Party Reporting for Alleged Sexual Abuse Sexual Assault and Sexual Harassment Form.

You may email this form to the OYDC PREA Coordinator at [Yulana.Littles@mdhs.ms.gov](mailto:Yulana.Littles@mdhs.ms.gov) and MDHS Program Integrity at [Samantha.Lewis@mdhs.ms.gov](mailto:Samantha.Lewis@mdhs.ms.gov). Addresses to mail the form via the Postal Service are listed below. Please have any information or evidence available for the investigator who will be assigned to handle the case. All reports are taken seriously and investigated as outlined in PREA and OYDC policies and procedures.

Mail to:

MDHS

and

OYDC

Attn: Program Integrity

Attn: PREA Coordinator

200 South Lamar Street

2375 Oakley Road

Jackson, MS 39201

Raymond, MS 39154

The auditor reviewed the publicly available third-party reporting information for verification at <https://www.mdhs.ms.gov/wp-content/uploads/2020/05/DOC050720-05072020141327.pdf>.

## 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 an 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? ☒ Yes ☐ No
- 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.*

#### The following evidence was analyzed in making the compliance determination:

##### Documents:

1. OYDC Policy XV.7 PREA
2. OYDC Policy VII.2 Incident Reporting
3. OYDC Policy VII.5 Abuse and Neglect Reporting
4. OYDC Policy VII.6, Abusive Institutional Practices
5. Mississippi Code of 1972, § 43-21-353
6. OYDC Pre-Audit Questionnaire responses

##### Interviews:

1. Interview with the PREA Coordinator
2. Interview with the Facility Administrator
3. Interviews with a Random Sample of Staff
4. Interviews with Medical and Mental Health Staff

**Site Review Observations:**

Observations during on-site review of physical plant

**Findings (By Provision):****115.361 (a)**

PAQ: The agency requires all staff to report immediately and according to agency policy:

1. 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.
2. Any retaliation against residents or staff who reported such an incident.
3. Any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation.

Policy states according to the Mississippi Code of 1972, § 43-21-353, all OYDC employees/staff who receive any information, including verbal, written, third-party reports, and anonymous complaints, concerning youth sexual abuse, sexual harassment, and custodial sexual misconduct; retaliation against youth or staff who report such an incident; or any staff neglect or violation of responsibilities that may have contributed to an incident or violation, shall immediately report the incident through their chain of command. In addition, in accordance with the Mississippi Code of 1972, § 43-21-353, any contractor, volunteer, and/or visitor that receives any information concerning sexual abuse of a youth must report this information to the appropriate authorities and/or abuse hotlines.

Staff confirmed the agency requires all staff to report any knowledge, suspicion, or information regarding an incident of sexual abuse or sexual harassment that occurred in a facility; 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. They stated they would report to their supervisor.

**115.361 (b)**

PAQ: The agency requires all staff to comply with any applicable mandatory child abuse reporting laws.

Policy states according to the Mississippi Code of 1972, § 43-21-353, all OYDC employees/staff shall immediately report an incident through their chain of command. Additionally, any contractor, volunteer, and/or visitor that receives any information concerning sexual abuse of a youth must report this information to the appropriate authorities and/or abuse hotlines.

Staff confirmed PREA training includes how to comply with relevant laws related to mandatory reporting of sexual abuse.

**115.361 (c)**

PAQ: Apart from reporting to designated supervisors or officials and designated State or local service agencies, agency policy prohibits staff from revealing any information related to a sexual abuse report to anyone other than to the extent necessary to make treatment, investigation, and other security and management decisions.

Policy states an employee/staff shall not reveal any information related to the incident to anyone other than to the extent necessary to make treatment, investigation, and management decisions. Initial interviews of potential sexual abuse victims should be limited to only that information necessary to protect the victim from immediate harm until an Investigator arrives for a more detailed interview.

Staff confirmed the agency requires all staff to report any knowledge, suspicion, or information regarding an incident of sexual abuse or sexual harassment that occurred in a facility; 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. They stated they would report to their supervisor.

**115.361 (d)**

Medical and mental health practitioners are required to report sexual abuse to MDHS. They are mandated to follow Duty to Report laws. Medical and mental health practitioners are required to inform residents at the initiation of services of their duty to report and the limitations of confidentiality.

Policy states Medical and Mental Health Practitioners shall ensure all youth are informed prior to the initiation of services of the limits of their confidentiality.

Interviews with medical and mental health staff confirmed they disclose the limitations of confidentiality and their duty to report at the initiation of services to a resident. They confirmed they are required by law to report any knowledge, suspicion, or information regarding an incident of sexual abuse or sexual harassment upon learning of it. They both reported they have not directly become aware of such incidents.

**115.361 (e)**

Policy states the Facility Administrator or 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. 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. If a juvenile court retains jurisdiction over the alleged victim, the Facility Administrator 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.

The PREA Coordinator confirmed when the facility receives an allegation of sexual abuse the allegation is reported to MDHS and the victim's legal guardians as appropriate. This notification would usually occur immediately. The Facility Administrator confirmed when the facility receives an allegation of sexual abuse the allegation is reported to MDHS and the victim's legal guardians as appropriate. This notification would occur immediately upon the allegation being received. If a juvenile court retains jurisdiction over the alleged victim, the Facility Administrator shall report the allegation to the juvenile's attorney. All allegations of sexual abuse and sexual harassment are reported to MDHS Program Integrity investigators.

**115.361 (f)**

Policy states any allegations of sexual harassment or sexual abuse involving a youth shall in addition be reported to MDHS.

The Facility Administrator confirmed all allegations of sexual abuse and sexual harassment (including those from third-party and anonymous sources) are reported directly to Program Integrity investigators.

**Corrective Action**

Based upon the review and analysis of the available evidence, the auditor has determined the agency and facility is fully compliant with this standard regarding staff and agency reporting duties. No corrective action is required.

## 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.*

### The following evidence was analyzed in making the compliance determination:

#### Documents:

1. OYDC Policy XV.7 PREA
2. OYDC Pre-Audit Questionnaire responses

#### Interviews:

1. Interview with the Agency Head Designee (Division Director)
2. Interview with the Facility Administrator
3. Interviews with a Random Sample of Staff

#### Site Review Observations:

Observations during on-site review of physical plant

#### Findings:



PAQ: When the agency or facility learns that a resident is subject to a substantial risk of imminent sexual abuse, it takes immediate action to protect the resident (i.e., it takes some action to assess and implement appropriate protective measures without unreasonable delay).

In the past 12 months:

1. The number of times the agency or facility determined that a resident was subject to substantial risk of imminent sexual abuse: Zero (0)

Policy states after receiving an emergency grievance alleging a youth is subject to a substantial risk of imminent sexual abuse, OYDC 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.

The Division Director confirmed that immediate actions will be taken to protect a resident who is subject to a substantial risk of imminent sexual abuse. Protective measures would include removing a juvenile from potential harm.

The Facility Administrator confirmed when he learns that a resident is subject to a substantial risk of imminent sexual abuse, the facility would take immediate protective actions such as removing a juvenile from potential harm and housing changes from potential perpetrators. He confirmed staff should respond immediately to protect residents at substantial risk of imminent sexual abuse.

#### **Corrective Action**

Based upon the review and analysis of the available evidence, the auditor has determined the agency and facility is fully compliant with this standard regarding agency protection duties. No corrective action is required.

### **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.*

### The following evidence was analyzed in making the compliance determination:

#### Documents:

1. OYDC Policy XV.7, PREA
2. OYDC Pre-Audit Questionnaire responses

#### Document: (Corrective Action):

1. Reporting to Other Confinement Facilities – developed and implemented November 26, 2019

#### Interview:

1. Interview with the Agency Head designee (Division Director)
2. Interview with the Facility Administrator

#### Site Review Observations:

1. Observations during on-site review of physical plant

#### Findings (By Provision):

##### 115.363 (a)

PAQ: The agency has a policy requiring that, upon receiving an allegation that a resident was sexually abused while confined at another facility, the head of the facility must notify the head of the facility or appropriate office of the agency or facility where sexual abuse is alleged to have occurred. The agency's policy also requires that the head of the facility notify the appropriate investigative agency. In the past 12 months, the number of allegations the facility received that a resident was abused while confined at another facility: Zero (0)

Policy states the Facility Administrator, upon receiving an allegation that a youth was sexually abused while confined in another facility, shall notify the head of the other facility of the alleged abuse, and shall ensure that the allegation investigation is done in accordance with PREA Standards.

**115.363 (b)**

PAQ: Agency policy requires that the facility head provides such notification as soon as possible, but no later than 72 hours after receiving the allegation.

Policy states the Facility Administrator, upon receiving an allegation that a youth was sexually abused while confined in another facility, shall notify the head of the other facility of the alleged abuse as soon as possible, but no later than 72 hours from receiving the allegation.

**115.363 (c)**

PAQ: The agency or facility documents that it has provided such notification within 72 hours of receiving the allegation.

Policy requires the Reporting to Other Confinement Facilities form is used for documenting such notifications.

The Reporting to Other Confinement Facilities form was developed and implemented as part of corrective action. The auditor reviewed the form and determined it is fully inclusive of the standard requirements.

**115.363 (d)**

PAQ: Agency/facility policy requires that allegations received from other facilities/agencies are investigated in accordance with the PREA standards. The facility head or agency office that receives such notification shall ensure that the allegation is investigated in accordance with these standards. In the past 12 months, the number of allegations of sexual abuse the facility received from other facilities: Zero (0)

The Division Director and the Facility Administrator stated if the facility receives an allegation from another facility or agency that an incident of sexual abuse or sexual harassment occurred at OYDC, Program Integrity would be the point of contact. There are no examples of another facility or agency reporting such allegations.

**Corrective Action**

Based upon the review and analysis of the available evidence, the auditor has determined the agency and facility is fully compliant with this standard regarding reporting to other confinement facilities. Corrective action has been completed.

**115.363 (c)**

To better document notifications, according to the standard requirements, the facility developed the Reporting to Other Confinement Facilities form November 26, 2019. The auditor reviewed the form and determined it is fully inclusive of the standard requirements.

**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.*

#### The following evidence was analyzed in making the compliance determination:

##### Documents:

1. OYDC Policy XV.7, PREA
2. OYDC Pre-Audit Questionnaire responses

### 3. Investigation Reports

#### **Documents (Corrective Action):**

#### **Documents (Corrective Action):**

1. First Responder Refresher Training Records – December 6, 2019
2. First Responder Guidelines for Sexual Abuse Allegations – November 26, 2019
3. First Responder Checklist – November 26, 2019

#### **Interviews:**

1. Interviews with Security Staff and Non-security Staff First Responders
2. Interviews with a Random Sample of Staff

#### **Site Review Observations:**

1. Observations during on-site review of physical plant

#### **Findings (By Provision):**

##### **115.364 (a)**

PAQ: The agency has a first responder policy for allegations of sexual abuse. The agency policy requires that, upon learning of an allegation that a resident was sexually abused, the first security 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.

In the past 12 months, the number of allegations that a resident was sexually abused: Five (5)  
Of these allegations, the number of times the first security staff member to respond to the report separated the alleged victim and abuser: Five (5)

In the past 12 months, the number of allegations where staff were notified within a time period that still allowed for the collection of physical evidence: Zero (0)

Interviews with security staff and non-security staff first responders revealed the staff needed refresher training on their first responder duties. The facility provided refresher training December 3, 2019 and December 5, 2019. Sign-in sheets were emailed to the auditor December 6, 2019 for verification. Refresher training is required for all staff. Additionally, the facility developed two instructional documents for first responders: First Responder Guidelines for Sexual Abuse Allegations and a First Responder Checklist. The forms were emailed to the auditor November 26, 2019.

No residents who reported a sexual abuse were confined at the facility during the onsite phase of the audit.

##### **115.364 (b)**

PAQ: Agency policy requires that if the first staff responder is not a security staff member, that responder shall be required to:

1. Request that the alleged victim not take any actions that could destroy physical evidence.
2. Notify security staff.

Of the allegations that a resident was sexually abused made in the past 12 months, the number of times a non-security staff member was the first responder: Zero (0)

Policy states if the first responder staff is not security staff, the responder should request that the alleged victim not take any actions that would destroy evidence and notify a security staff.

Interviews with security staff and non-security staff first responders and a random sample of staff revealed the staff needed refresher training on their first responder duties. The facility provided refresher training December 3, 2019 and December 5, 2019. Sign-in sheets were emailed to the auditor December 6, 2019 for verification. Additionally, the facility developed two instructional documents for first responders: First Responder Guidelines for Sexual Abuse Allegations and a First Responder Checklist. The forms were emailed to the auditor November 26, 2019.

### **Corrective Action**

Based upon the review and analysis of the available evidence, the auditor has determined the agency and facility is fully compliant with this standard regarding staff first responder duties. Corrective action has been completed.

### **115.364 (a) and (b)**

The facility provided first responder refresher training December 3, 2019 and December 5, 2019. Sign-in sheets were emailed to the auditor December 6, 2019 for verification. Additionally, the facility developed two instructional documents for first responders: First Responder Guidelines for Sexual Abuse Allegations and a First Responder Checklist. The forms were emailed to the auditor November 26, 2019.

## **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.*

### **The following evidence was analyzed in making the compliance determination:**

#### **Documents:**

1. OYDC Policy XV.7 PREA
2. OYDC Pre-Audit Questionnaire responses

#### **Documents (Corrective Action):**

1. Sexual Abuse Coordinated Team Response – developed March 10, 2020

#### **Interview:**

1. Interview with the Facility Administrator

#### **Site Review Observations:**

1. Observations during on-site review of physical plant

#### **Findings (By Provision):**

PAQ: The facility has developed 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 Sexual Abuse Coordinated Team Response was developed as part of corrective action.

The Facility Administrator described how first responders would contact medical and mental health staff, Program Integrity Investigators would begin an investigation, and the facility leadership would work in concert with facility staff in a coordinated fashion.

#### **Corrective Action**

Based upon the review and analysis of the available evidence, the auditor has determined the agency and facility is fully compliant with this standard regarding a coordinated response. Corrective has been completed.

The facility did not have a written institutional plan. The OYDC PREA Coordinator developed 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 Sexual Abuse Coordinated Team Response was emailed to the auditor for verification on March 10, 2020. The document is inclusive of staff responsibilities and coordinated actions that are taken when responding to an incident of sexual abuse.



## 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.*

### The following evidence was analyzed in making the compliance determination:

#### Documents:

- OYDC Policy XV.7 PREA
- OYDC Pre-Audit Questionnaire responses

#### Interview:

- Interview with the Division Director

#### Site Review Observations:

- Observations during on-site review of physical plant

### Findings (By Provision):



**115.366 (a)**

PAQ: The agency, facility, or any other governmental entity responsible for collective bargaining on the agency's behalf has not entered into or renewed any collective bargaining agreement or other agreement since August 20, 2012.

The Division Director confirmed OYDC does not participate in collective bargaining agreements.

**115.366 (b)** OYDC does not participate in collective bargaining agreements.

**Corrective Action**

Based upon the review and analysis of the available evidence, the auditor has determined the agency and facility is fully compliant with this standard regarding preservation of the ability to protect residents from contact with abusers. OYDC does not participate in collective bargaining agreements.

No corrective action is required.

**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, 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 who fear retaliation for reporting sexual abuse or sexual harassment or for cooperating with investigations,? ☒ 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.*

### The following evidence was analyzed in making the compliance determination:

#### Documents:

1. OYDC Policy XV.7 PREA
2. OYDC Pre-Audit Questionnaire responses

#### Documents (Corrective Action):

1. Protection Against Retaliation – updated November 25, 2019

#### Interviews:

1. Interview with the Agency Head Designee (Division Director)
2. Interview with the Facility Administrator
3. Interview with the Designated Staff Member Charged with Monitoring Retaliation (PREA Compliance Manager)
4. Interview with Residents in Isolation (for risk of sexual victimization/who allege to have suffered sexual abuse) - N/A
5. Interview with Residents who Reported a Sexual Abuse – N/A

#### Site Review Observations:

Observations during on-site review of physical plant

#### Findings (By Provision):

##### 115.367 (a)

PAQ: The agency has 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.

The Agency designates staff member(s) or charges department(s) with monitoring for possible retaliation.

The department of the staff member(s): MDHS Division of Program Integrity

Policy states the Facility Administrator and PREA Coordinator shall ensure youth and staff who report sexual abuse, sexual harassment, or cooperate with a sexual abuse investigation are protected from retaliation by other youth or staff.

##### 115.367 (b)

Policy states MDHS and OYDC shall employ multiple protection measures, such as housing changes or transfers for youth victims or abusers, removal of alleged staff or youth abusers from contact with

victims, and emotional support services for youth and/or staff who fear retaliation for reporting sexual abuse or sexual harassment or for cooperating with investigations.

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 Division Director stated the facility would protect residents and staff from retaliation for sexual abuse or sexual harassment allegations. He stated staff relocation or administrative leave would be used. The Facility Administrator stated the facility would make housing changes and place staff on no-contact status. The Designated Staff Member Charged with Monitoring Retaliation stated the role he plays in preventing retaliation against residents and staff who report sexual abuse or sexual harassment, or against those who cooperate with sexual abuse or sexual harassment investigations is protecting victims, removing alleged abusers, removing staff from the location, and making sure youth are provided mental health services. He stated the different measures he would take to protect residents and staff from retaliation would be initiating an investigation, maintaining an open line of communication, reviewing video surveillance, making housing changes, and ensuring staff receive refresher training as needed. He confirmed he would initiate contact with residents who have reported sexual abuse.

**115.367 (c)**

PAQ: The agency and/or facility monitors the conduct or treatment of residents or staff who reported sexual abuse and of residents who were reported to have suffered sexual abuse to see if there are any changes that may suggest possible retaliation by residents or staff.

The length of time that the agency and/or facility monitors the conduct or treatment: 90 days

The agency/facility acts promptly to remedy any such retaliation.

The agency/facility continues such monitoring beyond 90 days if the initial monitoring indicates a continuing need.

The number of times an incident of retaliation occurred in the past 12 months: Zero (0)

Policy requires Program Integrity will be chiefly responsible for Retaliation Monitoring by monitoring the conduct and treatment of the youth(s) and/or staff for at least 90 days after an incident is reported.

That time will be extended in 30-day increments if there is a continuing need.

The Facility Administrator stated measures he would take when he suspects retaliation includes making housing changes and placing staff on no-contact status. The Designated Staff Member Charged with Monitoring Retaliation stated the things he looks for to detect possible retaliation includes disciplinary reports, housing changes, staff performance, staff attendance records, etc. He monitors resident disciplinary reports, housing changes, negative performance reviews or reassignments of staff, and periodic status checks. He stated he would monitor the conduct and treatment of residents and staff who report the sexual abuse of a resident or were reported to have suffered sexual abuse for 90 days. If there is concern that potential retaliation might occur, the maximum length of time that the facility would monitor conduct and treatment would be until retaliation ends.

**115.367 (d)**

Policy states the monitoring of youth shall consider any disciplinary reports, housing or program changes, and shall include periodic status checks.

The Designated Staff Member Charged with Monitoring Retaliation stated the things he looks for to detect possible retaliation includes disciplinary reports, housing changes, staff performance, staff

attendance records, etc. He monitors resident disciplinary reports, housing changes, negative performance reviews or reassignments of staff, and periodic status checks.

**115.367 (e)**

Policy states 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 Division Director stated if an individual who cooperates with an investigation expresses fear of retaliation, the agency takes measures to protect that individual against retaliation including staff no-contact status, shift changes, housing unit changes, and separating youth for protection. The Facility Administrator stated the different measures he would take to protect residents and staff from retaliation would include housing changes and staff no-contact status. He stated measures he would take when he suspects retaliation also would include housing changes and staff no-contact status.

**115.367 (f)**

Policy states the facility's obligation to monitor may terminate if the facility determines the allegation is unfounded.

**Corrective Action**

Based upon the review and analysis of the available evidence, the auditor has determined the facility is fully compliant with this standard regarding agency protection against retaliation. Corrective action has been completed.

During the audit reporting period, the facility did not monitor for retaliation according to the standard requirements. To achieve compliance with this standard, the facility developed a form for documenting periodic status checks, the Protections Against Retaliation form. The form was emailed to the auditor November 26, 2019 for review. To demonstrate retaliation monitoring, periodic status checks, and use of the form has been institutionalized, the facility created two scenarios with staff reporting retaliation. The facility conducted the retaliation monitoring for 90 days and provided the auditor with Protections Against Retaliation forms verifying periodic status checks were conducted on a weekly basis.

## **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**

*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 following evidence was analyzed in making the compliance determination:**

#### **Documents:**

1. OYDC Policy XV.7 PREA
2. OYDC Pre-Audit Questionnaire responses

#### **Interview:**

1. Interview with the Facility Administrator

#### **Site Review Observations:**

1. Observations during on-site review of physical plant

#### **Findings (By Provision):**

Any 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.

PAQ: The facility has a policy that residents who allege to have suffered sexual abuse may only be placed in isolation as a last resort if less restrictive measures are inadequate to keep them and other residents safe, and only until an alternative means of keeping all residents safe can be arranged.

The facility policy requires that residents who are placed in isolation because they allege to have suffered sexual abuse have access to legally required educational programming, special education services, and daily large-muscle exercise.

In the past 12 months:

1. The number of residents who allege to have suffered sexual abuse who were placed in isolation: Zero (0)

If a resident who alleges to have suffered sexual abuse is held in isolation, the facility affords each such resident a review every 30 days to determine whether there is a continuing need for separation from the general population.

The Facility Administrator confirmed OYDC does not use segregated housing to protect a resident who is alleged to have suffered sexual abuse.

#### **Corrective Action**

Based upon the review and analysis of the available evidence, the auditor has determined the agency and facility is fully compliant with this standard regarding post-allegation protective custody. No corrective action is required.

## 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 agency 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.*

### The following evidence was analyzed in making the compliance determination:

#### Documents:

1. OYDC Policy XV.7 PREA
2. OYDC Policy VII.2 Incident Reporting
3. OYDC Policy VII.5 Abuse and Neglect Reporting
4. OYDC Pre-Audit Questionnaire responses

#### Interviews:

1. Interview with the Facility Administrator
2. Interview with the PREA Coordinator
3. Interview with Investigative Staff

#### Site Review Observations:

1. Observations during on-site review of physical plant

#### Findings (By Provision):

##### 115.371 (a)

PAQ: The agency/facility has a policy related to criminal and administrative agency investigations.

Policy states Program Integrity Investigators are responsible for conducting a prompt, thorough and objective investigation, whether administrative or criminal.

The Program Integrity Investigator stated initiation of an investigation is immediate. He confirmed anonymous and third-party investigations are investigated in the same manner as all investigations.

**115.371 (b)**

Policy states investigators and other OYDC employees with PREA related responsibilities shall receive additional training related to their roles to include, but not limited to: interviewing sexual abuse victims, proper use of Miranda and Garrity warnings, conducting sexual abuse investigations and the collection of evidence in a confinement setting, and the criteria and evidence required to substantiate a case for administrative action or prosecutorial referral. Training shall be documented and verified through employee signature and forwarded to the Training Director for retention.

The Program Integrity Investigator confirmed he was in the process of receiving training specific to conducting sexual abuse and sexual harassment investigations in confinement settings through online NIC training. The training topics 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 or prosecution referral.

This training was completed as part of corrective action. The auditor reviewed training records and certificates for verification.

**115.371 (c)**

Policy states when applicable, investigators may gather and preserve direct and circumstantial evidence, including any available physical and DNA evidence in collaboration with local law enforcement 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 Program Integrity Investigator confirmed the first steps in initiating an investigation is assigning a case to an investigator, identify all parties involved, and ensuring staff are on no contact status if they are the subject of an allegation. The investigation processes includes an allegation being assigned to an investigator. Then the process continues with interviews, evidence collection, reviewing incident reports, etc. Direct and circumstantial evidence investigators would be responsible for gathering in an investigation of an incident of sexual abuse include monitoring data, interviews, collection of evidence and reviewing and collecting video footage.

**115.371 (d)**

PAQ: The agency does not terminate an investigation solely because the source of the allegation recants the allegation.

Policy states Program Integrity nor OYDC shall terminate an investigation solely because the source of the allegation recants the allegation.

The Program Integrity Investigator confirmed an investigation does not terminate if the source of the allegation recants the allegation.

**115.371 (e)**

Policy states when the quality of evidence appears to support criminal prosecution, Program Integrity shall conduct compelled interviews only after consulting with prosecutors as to whether compelled interviews may be an obstacle for subsequent criminal prosecution.

The Program Integrity Investigator confirmed when he discovers evidence that a prosecutable crime may have taken place, he contacts the Facility Administrator and the MDHS legal department before conducting compelled interviews.

**115.371 (f)**

Policy states 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 youth or staff. Program Integrity shall not require a youth 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 Program Integrity Investigator confirmed he judges the credibility of an alleged victim, suspect, or witness based on evidence. He stated under no circumstance, does he require a resident who alleges sexual abuse to submit to a polygraph examination or truth telling device as a condition for proceeding with an investigation.

**115.371 (g)**

Policy states administrative investigations shall include an effort to determine whether staff actions or failures to act contributed to the abuse,

The Program Integrity Investigator confirmed the efforts he makes during an administrative investigation to determine whether staff actions or failures to act contributed to the sexual abuse include discussing the allegation with the Facility Administrator. All investigations are documented.

**115.371 (h)**

Policy states 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 Program Integrity Investigator confirmed criminal investigations are documented. He stated everything is included in the report, including a thorough description of physical evidence, testimonial and documentary evidence, as well as attached copies of documentary evidence.

**115.371 (i)**

PAQ: Substantiated allegations of conduct that appear to be criminal are referred for prosecution. The number of substantiated allegations of conduct that appear to be criminal that were referred for prosecution since the last PREA audit: Zero (0)

The Program Integrity Investigator confirmed cases are referred for prosecution only when there are substantiated allegations of conduct that appears to be criminal. Allegations are referred based on the evidence.

**115.371 (j)**

PAQ: The agency retains all written reports pertaining to the administrative or criminal investigation of alleged sexual abuse or sexual harassment for as long as the alleged abuser is incarcerated or employed by the agency, plus five years.

Policy states the agency shall retain all written reports 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 youth and applicable law requires a shorter period of retention.

**115.371 (k)**

Policy states 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 Program Integrity Investigator confirmed an investigation continues when a staff member alleged to have committed sexual abuse or sexual harassment terminates employment prior to a completed investigation into his/her conduct.

**115.371 (l)**

Any State entity or Department of Justice component that conducts such investigations shall do so pursuant to the above requirements.

**115.371 (m) N/A**

MDHS Program Integrity investigators conduct administrative and criminal investigations into allegations of sexual abuse and sexual harassment.

**Corrective Action**

Based upon the review and analysis of the available evidence, the auditor has determined the agency and facility is fully compliant with this standard regarding criminal and administrative agency investigations. Corrective action has been completed.

**115.371 (b)**

The MDHS Division of Program Integrity investigators are required to complete the training requirements of standard §115.331 and the required specialized training for compliance with the standard. Program Integrity investigators completed this training through online training provided by the National Institute of Corrections (NIC) on December 19, 2019 and agency-provided training on January 20, 2020. The auditor reviewed NIC certificates and Staff Acknowledgments of PREA (standard 115.331) for verification.

## 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.*

### The following evidence was analyzed in making the compliance determination:

#### Documents:

1. OYDC Policy XV.7 PREA
2. OYDC Pre-Audit Questionnaire responses

#### Interview:

1. Interview with Investigative Staff

#### Site Review Observations:

1. Observations during on-site review of physical plant

#### Findings (By Provision):

PAQ: The agency imposes a standard of a preponderance of the evidence or a lower standard of proof when determining whether allegations of sexual abuse or sexual harassment are substantiated.

Policy states the standard of proof in all investigations of sexual abuse and harassment is a preponderance of the evidence.

The Program Integrity investigator confirmed 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 auditor's review of Investigation Reports corroborates the interview results.

#### Corrective Action

Based upon the review and analysis of the available evidence, the auditor has determined the agency and facility is fully compliant with this standard regarding an evidentiary standard for administrative investigations. Program Integrity imposes no standard higher than a preponderance of the evidence in determining whether allegations of sexual abuse or sexual harassment are substantiated.

No corrective action is required.

## 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 the agency's 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.*

#### The following evidence was analyzed in making the compliance determination:

##### Documents:

1. OYDC Policy XV.7 PREA
2. OYDC Pre-Audit Questionnaire responses

##### Document (Corrective Action):

1. Youth Notification of Investigative Outcome Form – developed and implemented December 12, 2019

##### Interviews:

1. Interview with the Facility Administrator
2. Interview with Investigative Staff

##### Site Review Observations:

1. Observations during on-site review of physical plant

##### Findings (By Provision):

#### 115.373 (a)

PAQ: The agency has a policy requiring that any resident who makes an allegation that he or she suffered sexual abuse in an agency facility is informed, verbally or in writing, as to whether the allegation has been determined to be substantiated, unsubstantiated, or unfounded following an investigation by the agency.

In the past 12 months:

1. The number of criminal and/or administrative investigations of alleged resident sexual abuse that were completed by the agency/facility: Five (5)



2. Of the investigations that were completed of alleged sexual abuse, the number of residents who were notified, verbally or in writing, of the results of the investigation: Five (5)

Policy states that following the Program Integrity investigation into a youth's allegation that he or she suffered sexual abuse, the Program Integrity shall inform the youth as to whether the allegation has been determined to be substantiated, unsubstantiated, or unfounded.

The interviews with interview with the Facility Administrator and Program Integrity investigator indicated the facility notifies a resident who makes an allegation of sexual abuse, that the allegation has been determined to be substantiated, unsubstantiated, or unfounded following an investigation.

#### **115.373 (b)**

PAQ: No outside entities conduct investigations of alleged resident sexual abuse in the facility.

In the past 12 months:

The number of investigations of alleged resident sexual abuse in the facility that were completed by an outside agency: Zero (0)

#### **115.373 (c)**

PAQ: Following a resident's allegation that a staff member has committed sexual abuse against the resident, the agency/facility subsequently informs the resident (unless the agency/facility 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.

There has not been a substantiated or unsubstantiated complaint (i.e., not unfounded) of sexual abuse committed by a staff member against a resident in the past 12 months.

Policy states following a youth's allegation that a staff member has committed sexual abuse against the youth, MDHS shall subsequently inform the youth (unless the agency has determined that the allegation is unfounded) whenever: the staff member is no longer posted within the youth's unit; the staff member is no longer employed at the facility; MDHS learns that the staff member has been indicted on a charge related to sexual abuse within the facility; or MDHS learns that the staff member has been convicted on a charge related to sexual abuse within the facility.

There were no residents who reported a sexual abuse confined at the facility during the onsite phase of the audit.

#### **115.373 (d)**

PAQ: Following a resident's allegation that he or she has been sexually abused by another resident in an agency facility, the agency subsequently informs 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 states that following a youth's allegation that he or she has been sexually abused by another youth, MDHS shall subsequently inform the alleged victim whenever: MDHS learns that the alleged



abuser has been indicted on a charge related to sexual abuse within the facility; or MDHS learns that the alleged abuser has been convicted on a charge related to sexual abuse within the facility. All such notifications or attempted notifications shall be documented. MDHS's obligation to report under this policy shall terminate if the youth is released from the agency's custody.

There were no residents who reported a sexual abuse confined at the facility during the onsite phase of the audit.

**115.373 (e)**

PAQ: The agency has a policy that all notifications to residents described under this standard are documented.

In the past 12 months:

1. The number of notifications to residents that were made pursuant to this standard: Five (5)
2. The number of those notifications that were documented: Five (5)

Policy states all such notifications or attempted notifications shall be documented.

Previously Program Integrity investigators verbally notified youth of the outcome of sexual abuse allegations. These notifications were documented in investigative reports. To improve documenting the notifications, the facility developed the Youth Notification of Investigative Outcome form December 12, 2019. The auditor reviewed the form and determined it is fully inclusive of the standard requirements.

**115.373 (f)**

Policy states MDHS's obligation to report under this policy shall terminate if the youth is released from the agency's custody.

**Corrective Action**

Based upon the review and analysis of the available evidence, the auditor has determined the agency and facility is fully compliant with this standard regarding reporting to residents. Corrective action has been completed.

**115.373 (e)**

To improve documenting notifications or attempted notifications for allegations of youth-on youth sexual abuse and staff sexual misconduct the facility has developed a form. The facility developed the Youth Notification of Investigative Outcome form December 12, 2019. The auditor reviewed the form and determined it is fully inclusive of the standard requirements. The new form requires a youth's signature to validate they have been informed of the outcome and standard requirements of provisions (c) and (d).

## 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 staff 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 who 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.*

**The following evidence was analyzed in making the compliance determination:**

**Documents:**

1. OYDC Policy XV.7, PREA
2. OYDC Pre-Audit Questionnaire responses

**Interview:**

1. Interview with the PREA coordinator

**Site Review Observations:**

1. Observations during on-site review of physical plant

**Findings (By Provision):**

**115.376 (a)**

PAQ: Staff is subject to disciplinary sanctions up to and including termination for violating agency sexual abuse or sexual harassment policies.

Policy states staff shall be subject to disciplinary sanctions up to and including termination for violating agency sexual abuse or sexual harassment policies.

**115.376 (b)**

In the past 12 months:

1. The number of staff from the facility that have violated agency sexual abuse or sexual harassment policies: Zero (0)
2. The number of those staff from the facility that have been terminated (or resigned prior to termination) for violating agency sexual abuse or sexual harassment policies: Zero (0)

Policy states termination shall be the presumptive disciplinary sanction for staff who have engaged in sexual abuse.

**115.376 (c)**

PAQ: Disciplinary sanctions for violations of agency policies relating to sexual abuse or sexual harassment (other than actually engaging in sexual abuse) are 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.

In the past 12 months, the number of staff from the facility that have been disciplined, short of termination, for violation of agency sexual abuse or sexual harassment policies: Zero (0)

Policy states disciplinary sanctions for violations of MDHS and/or OYDC policies relating to sexual abuse or sexual harassment (other than actually engaging in sexual abuse) 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.

**115.376 (d)**

PAQ: 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, are reported to law enforcement agencies, unless the activity was clearly not criminal, and to any relevant licensing bodies. In the past 12 months, the number of staff from the facility that have been reported to law enforcement or licensing boards following their termination (or resignation prior to termination) for violating agency sexual abuse or sexual harassment policies: Zero (0)

Policy states all terminations for violations of MDHS and/or OYDC 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.

#### **Corrective Action**

Based upon the review and analysis of the available evidence, the auditor has determined the agency and facility is fully compliant with this standard regarding disciplinary sanctions for staff. No corrective action is required.

### **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.*

### The following evidence was analyzed in making the compliance determination:

#### Documents:

1. OYDC Policy XV.7, PREA
2. OYDC Pre-Audit Questionnaire responses

#### Interview:

1. Interview with the Facility Administrator

#### Site Review Observations:

1. Observations during on-site review of physical plant

#### Findings (By Provision):

##### 115.377 (a)

PAQ: Agency policy requires that any contractor or volunteer who engages in sexual abuse be reported to law enforcement agencies, unless the activity was clearly not criminal, and to relevant licensing bodies. Agency policy requires that any contractor or volunteer who engages in sexual abuse be prohibited from contact with residents. In the past 12 months, no contractors or volunteers have been reported to law enforcement agencies and relevant licensing bodies for engaging in sexual abuse of residents.

Policy states any contractor or volunteer who engages in sexual abuse shall be prohibited from contact with youth and shall be reported to law enforcement agencies, unless the activity was clearly not criminal, and to relevant licensing bodies.

##### 115.377 (b)

PAQ: The facility takes appropriate remedial measures and considers 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.

This standard provision was corroborated by the Facility Administrator. He stated the facility would take remedial measures and prohibit further contact with residents in the case of any violation of agency sexual abuse or sexual harassment policies by a contractor or volunteer. An example of the remedial measures the facility could enforce includes no-contact status with the youth pending investigation.

#### Corrective Action

Based upon the review and analysis of the available evidence, the auditor has determined the agency and facility is fully compliant with this standard regarding corrective actions for contractors and volunteers. No corrective action is required.

## 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)

- If the agency prohibits all sexual activity between residents, 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.*

#### The following evidence was analyzed in making the compliance determination:

##### Documents:

1. OYDC Policy VII.9 Due Process Hearings
2. OYDC Policy XV.7, PREA
3. OYDC Pre-Audit Questionnaire responses
4. Incident Reports
5. Investigation Reports

##### Interviews:

1. Interview with the Facility Administrator
2. Interviews with Medical and Mental Health Staff

**Site Review Observations:**

1. Observations during on-site review of physical plant

**Findings (By Provision):****115.378 (a)**

PAQ: Residents are 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. Residents are subject to disciplinary sanctions only pursuant to a formal disciplinary process following a criminal finding of guilt for resident-on-resident sexual abuse.

In the past 12 months:

1. The number of administrative findings of resident-on-resident sexual abuse that have occurred at the facility: Four (4)
2. The number of criminal findings of guilt for resident-on-resident sexual abuse that have occurred at the facility: Zero (0)

Policy states after review by the Facility Administrator and/or Division Director, an occurrence of sexual assault between youth and another youth will be referred to the Disciplinary Hearing Officer and processed according OYDC policy: VII.9, Due Process Hearings. In addition, youth may be subject to criminal disciplinary action.

It is the policy of the Mississippi Department of Human Service, Division of Youth Services (DYS), to maintain a safe and secure environment and that, in all cases where youth are alleged to have committed a major, or a pattern of minor violations, a due process hearing shall occur. All Incident Reports are reviewed by the Disciplinary Hearing Officer (DHO) and Disciplinary Hearing Committee (DHC) that makes a determination based on the objective observations of the situation, that a Due Process Hearing should be held.

**115.378 (b)**

PAQ: In the event a disciplinary sanction for resident-on resident sexual abuse results in the isolation of a resident, the facility policy requires that residents in isolation have daily access to large muscle exercise, legally required educational programming, and special education services. In the event a disciplinary sanction for resident-on resident sexual abuse results in the isolation of a resident, residents in isolation receive daily visits from a medical or mental health care clinician. In the event a disciplinary sanction for resident-on resident sexual abuse results in the isolation of a resident, residents in isolation have access to other programs and work opportunities to the extent possible.

In the past 12 months:

1. The number of residents placed in isolation as a disciplinary sanction for resident-on resident sexual abuse: Zero (0)
2. The number of residents placed in isolation as a disciplinary sanction for resident-on resident sexual abuse, who were denied daily access to large muscle exercise, and/or legally required educational programming, or special education services: N/A
3. The number of residents placed in isolation as a disciplinary sanction for resident-on resident sexual abuse, who were denied access to other programs and work opportunities: N/A

Policy states disciplinary sanctions shall be commensurate with the nature and circumstances of the abuse committed, the youth's disciplinary history, and the sanctions imposed for comparable offenses by other youth with similar histories. In the event a disciplinary sanction results in the isolation of a youth, the youth shall receive a minimum of one hour of daily large-muscle exercise, and access to any legally required educational programming or special education services. Youth in isolation shall receive



daily visits from a medical or mental health care clinician. Youth shall also have access to other programs and work opportunities to the extent possible.

OYDC does not use isolation as a disciplinary sanction. The Facility Administrator stated disciplinary sanctions residents are subject to following an administrative or criminal finding the resident engaged in resident-on-resident sexual abuse could include added time. He confirmed the sanctions are proportionate to the nature and circumstances of the abuses committed, the residents' disciplinary histories, and the sanctions imposed for similar offenses by other residents with similar histories. Mental disability or mental illness is considered when determining sanctions and isolation is not used as a disciplinary sanction.

**115.378 (c)**

Policy states the disciplinary process shall consider whether a youth's mental disabilities or mental illness contributed to his or her behavior when determining what type of sanction, if any, should be imposed.

The Facility Administrator stated disciplinary sanctions residents are subject to following an administrative or criminal finding the resident engaged in resident-on-resident sexual abuse could include added time. The sanctions are proportionate to the nature and circumstances of the abuses committed, the residents' disciplinary histories, and the sanctions imposed for similar offenses by other residents with similar histories. Mental disability or mental illness considered when determining sanctions and isolation is not used as a disciplinary sanction.

**115.378 (d)**

PAQ: The facility offers therapy, counseling, or other interventions designed to address and correct the underlying reasons or motivations for abuse. If the facility offers therapy, counseling, or other interventions designed to address and correct the underlying reasons or motivations for abuse, the facility considers whether to require the offending resident to participate in such interventions as a condition of access to any rewards-based behavior management system or other behavior based incentives. Access to general programming or education is not conditional on participation in such interventions.

Mental Health Staff confirmed when the facility offers therapy, counseling, or other intervention services designed to address and correct the underlying reasons or motivations for sexual abuse, the facility considers whether to offer these services to an offending resident. A resident's participation is not required as a condition of access to any rewards-based behavior management system or programming or education.

**115.378 (e)**

PAQ: The agency disciplines residents for sexual contact with staff only upon finding that the staff member did not consent to such contact.

Policy states OYDC may discipline a youth for sexual contact with staff only upon a finding that the staff member did not consent to such contact.

**115.378 (f)**

PAQ: The agency prohibits disciplinary action for a report of sexual abuse made in good faith based upon a reasonable belief that the alleged conduct occurred, even if an investigation does not establish evidence sufficient to substantiate the allegation.

Policy states 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.

**115.378 (g)**

PAQ: The agency prohibits all sexual activity between residents. The agency deems such activity to constitute sexual abuse only if it determines that the activity is coerced.

Policy states OYDC prohibits all sexual activity between youth and may discipline youth for such activity. MDHS and/or OYDC may not, however, deem such activity to constitute sexual abuse if it is determined that the activity was not coerced.

**Corrective Action**

Based upon the review and analysis of the available evidence, the auditor has determined the agency and facility is fully compliant with this standard regarding interventions and disciplinary sanctions for residents. No corrective action is required.

## 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.*

### The following evidence was analyzed in making the compliance determination:

#### Documents:

1. OYDC Policy XV.7 PREA
2. OYDC Policy XI.26 Emergency Medical Response and Services
3. OYDC Pre-Audit Questionnaire responses

#### Interviews:

1. Interviews with Residents who Disclose Sexual Victimization at Risk Screening
2. Interview with Staff Responsible for Risk Screening
3. Interviews with Medical and Mental Health Staff

#### Site Review Observations:

1. Observations during on-site review of physical plant

#### Findings (By Provision):

##### 115.381 (a)

PAQ: All residents at this facility who have disclosed any prior sexual victimization during a screening pursuant to §115.341 are offered a follow-up meeting with a medical or mental health practitioner. The follow-up meeting was offered within 14 days of the intake screening. Medical and mental health staff maintain secondary materials (e.g., form, log) documenting compliance with the above required services. In the past 12 months, the percent of residents who disclosed prior victimization during screening who were offered a follow up meeting with a medical or mental health practitioner: 100%

Policy states a Counselor and/or QMHP shall meet with the youth and review their screening information. If the screening indicates that the youth has prior sexual victimization in their history, the Counselor and/or QMHP shall schedule a follow-up meeting with Mental Health Department within 14 days of the intake screening.

One (1) resident reported disclosing sexual victimization at risk screening. The resident confirmed when she told someone that she had been sexually abused, she was asked if she wanted to meet with a medical or mental health care practitioner. She stated she met with a Qualified Mental Health Professional (QMHP) the following day.

The staff responsible for risk screening confirmed if a screening indicates that a resident has experienced prior sexual victimization, whether in an institutional setting or in the community, they are offered a follow-up meeting with a medical and/or medical health practitioner within one week.

##### 115.381 (b)

PAQ: All residents who have previously perpetrated sexual abuse, as indicated during the screening pursuant to § 115.341, are offered a follow-up meeting with a mental health practitioner. The follow-up meeting was offered within 14 days of the intake screening. Mental health staff maintain secondary

materials (e.g., form, log) documenting compliance with the above required services. In the past 12 months, the percent of residents who previously perpetrated sexual abuse, as indicated during screening, who were offered a follow up meeting with a mental health practitioner: 100%

Policy states a Counselor and/or QMHP shall meet with the youth and review their screening information. If the screening indicates that the youth has prior sexual aggression in their history, the Counselor and/or QMHP shall schedule a follow-up meeting with Mental Health Department within 14 days of the intake screening.

The staff responsible for risk screening confirmed if a screening indicates that a resident previously perpetrated sexual abuse, they are offered a follow-up meeting with a mental health practitioner within one week.

**115.381 (c)**

PAQ: Information related to sexual victimization or abusiveness that occurred in an institutional setting is strictly limited to medical and mental health practitioners.

Policy states there will be appropriate controls on the dissemination of screening information so as to ensure each youth's sensitive information is not exploited.

**115.381 (d)**

PAQ: 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.

Policy states medical and mental health practitioners shall obtain informed consent from youth before reporting information about prior sexual victimization that did not occur in an institutional setting, unless the youth is under the age of 18.

Medical and mental health staff confirmed they obtain informed consent from residents before reporting about prior sexual victimization that did not occur in an institutional setting. They obtain informed consent regardless of age.

**Corrective Action**

Based upon the review and analysis of the available evidence, the auditor has determined the agency and facility is fully compliant with this standard regarding medical and mental health screenings; history of sexual abuse. No corrective action is required.

## **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.*

### The following evidence was analyzed in making the compliance determination:

#### Documents:

1. OYDC Policy XV.7 PREA
2. OYDC Policy XI.26 Emergency Medical Response and Services
3. OYDC Pre-Audit Questionnaire responses

**Interview:**

1. Interviews with Medical and Mental Health Staff
2. Interviews with Security Staff and Non-security Staff First Responders

**Site Review Observations:**

1. Observations during on-site review of physical plant

**Findings (By Provision):****115.382 (a)**

PAQ: Resident victims of sexual abuse receive timely, unimpeded access to emergency medical treatment and crisis intervention services. The nature and scope of such services are determined by medical and mental health practitioners according to their professional judgment. Medical and mental health staff maintain secondary materials (e.g., form, log) documenting the timeliness of emergency medical treatment and crisis intervention services that were provided; the appropriate response by non-health staff in the event health staff are not present at the time the incident is reported; and the provision of appropriate and timely information and services concerning contraception and sexually transmitted infection prophylaxis.

Medical and Mental Health Staff confirmed resident victims of sexual abuse receive timely and unimpeded access to emergency medical treatment and crisis intervention services. Responses indicated timely would be immediately, but not more than 24 hours. They all confirmed the nature and scope of these services determined according to your professional judgment and the medical staff stated doctor's orders would be followed as well. No residents who reported a sexual abuse were confined at the facility during the onsite phase of the audit.

**115.382 (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.

Interviews with security staff and non-security staff first responders revealed the staff needed refresher training on their first responder duties. The facility provided refresher training December 3, 2019 and December 5, 2019. Sign-in sheets were emailed to the auditor December 6, 2019 for verification.

**115.382 (c)**

PAQ: Resident victims of sexual abuse while incarcerated are 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. Medical and mental health staff maintain secondary materials documenting the timeliness of emergency medical treatment and crisis intervention services that were provided; the appropriate response by non-health staff in the event health staff are not present at the time the incident is reported; and the provision of appropriate and 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.

Medical staff confirmed victims of sexual abuse are offered timely information about access to emergency contraception and sexually transmitted infection prophylaxis. There were no residents who reported a sexual abuse confined at the facility during the onsite phase of the audit.

**115.382 (d)**

PAQ: Treatment services are provided to every victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident.

Policy states treatment services shall be provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with an investigation arising out of the incident.

#### **Corrective Action**

Based upon the review and analysis of the available evidence, the auditor has determined the agency and facility is fully compliant with this standard regarding access to emergency medical and mental health services. Corrective action has been completed.

#### **115.382 (b)**

Interviews with security staff and non-security staff first responders revealed the staff needed refresher training on their first responder duties. The facility provided refresher training December 3, 2019 and December 5, 2019. Sign-in sheets were emailed to the auditor December 6, 2019 for verification.

### **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. *Note: in "all-male" facilities, there may be residents who identify as transgender men who may have female genitalia. Auditors should be sure to know whether such individuals may be in the population and whether this provision may apply in specific circumstances.*) ☒ 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. *Note: in “all-male” facilities, there may be residents who identify as transgender men who may have female genitalia. Auditors should be sure to know whether such individuals may be in the population and whether this provision may apply in specific circumstances.*) ☒ 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.*

### The following evidence was analyzed in making the compliance determination:

#### Documents:

1. OYDC Policy XV.7 PREA
2. OYDC Pre-Audit Questionnaire responses

**Interviews:**

1. Interviews with Medical and Mental Health Staff
2. Interviews with Residents who Reported a Sexual Abuse – N/A

**Site Review Observations:**

Observations during on-site review of physical plant

**Findings (by provision):****115.383 (a)**

PAQ: The facility offers 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.

Policy states medical and mental health evaluations and treatment shall be offered to all youth who have been victimized by sexual abuse.

The auditor observed the facility has mental health and medical staff onsite.

**115.383 (b)**

The evaluation and treatment of 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.

The Medical and Mental Health Staff stated residents who have been victimized would be provided follow-up services. The Director of Medical Services stated the facility would follow treatment plans. The Director of Mental Health and Rehabilitation Services stated mental health services would be provided.

No resident victims of sexual abuse required emergency medical or mental health services within the twelve-month audit period.

**115.383 (c)**

The facility provides victims with medical and mental health services consistent with the community level of care.

The Medical and Mental Health Staff stated they consider medical and mental health services are consistent with the community level of care.

**115.383 (d)**

PAQ: Female victims of sexual abusive vaginal penetration while incarcerated are offered pregnancy tests.

Policy states youth victims of sexually abusive vaginal penetration while incarcerated shall be offered pregnancy tests.

**115.383 (e)**

PAQ: 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.

Policy states youth victims of sexual abuse while residing at OYDC 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 Director of Medical Services confirmed if pregnancy results from sexual abuse while incarcerated, victims receive timely and comprehensive information about, and timely access to, all lawful pregnancy-related medical services. These services would be provided immediately.

**115.383 (f)**

PAQ: Resident victims of sexual abuse while incarcerated are offered tests for sexually transmitted infections as medically appropriate.

Policy states youth victims of sexual abuse while incarcerated shall be offered tests for sexually transmitted infections as medically appropriate.

**115.383 (g)**

PAQ: Treatment services are 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 states treatment services shall be provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with an investigation arising out of the incident.

**115.383 (h)**

PAQ: The facility attempts to conduct a mental health evaluation of all known resident-on-resident abusers within 60 days of learning of such abuse history and offers treatment when deemed appropriate by mental health practitioners.

Policy states an attempt shall be made to conduct a mental health evaluation of known youth-on-youth abusers within 60 days of learning of such abuse history and offer treatment.

The Director of Mental Health and Rehabilitation Services confirmed a mental health evaluation of all known resident-on-resident abusers would be conducted and they would be offered treatment if appropriate.

**Corrective Action**

Based upon the review and analysis of the available evidence, the auditor has determined the agency and facility is fully compliant with this standard regarding ongoing medical and mental health care for sexual abuse victims and abusers. No corrective action is required.

## 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.*

### The following evidence was analyzed in making the compliance determination:

#### Documents:

1. OYDC Policy XV.7 PREA
2. OYDC Pre-Audit Questionnaire responses

#### Documents (Corrective Action):

1. Sexual Abuse Critical Incident Review – developed and implemented January 28, 2020

#### Interviews:

1. Interview with the Facility Administrator
2. Interview with the PREA Compliance Manager
3. Interview with an Incident Review Team Member

#### Site Review Observations:

Observations during on-site review of physical plant

#### Findings (by provision):

##### 115.386 (a)

PAQ: The facility conducts a sexual abuse incident review at the conclusion of every sexual abuse criminal or administrative investigation unless the allegation has been determined to be unfounded. In the past 12 months, the number of criminal and/or administrative investigations of alleged sexual abuse completed at the facility, excluding only “unfounded” incidents: Four (4)

Policy states within thirty (30) days of the conclusion of the Program Integrity investigation, the Facility Administrator shall convene a sexual abuse incident review team to review all substantiated and unsubstantiated PREA allegations.

The auditor reviewed four (4) completed administrative investigations of sexual abuse.

**115.386 (b)**

PAQ: The facility ordinarily conducts a sexual abuse incident review within 30 days of the conclusion of the criminal or administrative sexual abuse investigation.

In the past 12 months, the number of criminal and/or administrative investigations of alleged sexual abuse completed at the facility that were followed by a sexual abuse incident review within 30 days, excluding only “unfounded” incidents: Four (4)

The auditor reviewed completed administrative investigations of sexual abuse and an example of a Sexual Abuse Critical Incident Review.

**115.386 (c)**

PAQ: The sexual abuse incident review team includes upper-level management officials and allows for input from line supervisors, investigators, and medical or mental health practitioners.

Policy states the sexual abuse incident review team to review shall be composed of the Facility Administrator designee, medical representative, mental health representative, Program Integrity Investigator, Shift Supervisor present at time of the allegation, and the PREA Coordinator.

The Facility Administrator confirmed the facility has a sexual abuse incident review team.

The auditor reviewed an example of a Sexual Abuse Critical Incident Review.

**115.386 (d)**

PAQ: The facility prepares a report of its findings from sexual abuse incident reviews, including but not necessarily limited to determinations made pursuant to paragraphs (d)(1)-(d)(5) of this section, and any recommendations for improvement and submits such report to the facility head and PREA compliance manager.

The PREA Coordinator shall take detailed meeting minutes to include the agenda, participants, date, name and number of the investigation, type of investigation and findings, and all meeting content, utilizing OYDC form: XV.7.H, Sexual Abuse Critical Incident Review.

The team shall: consider whether the allegation or investigation indicates a need to change policy or practice to better prevent, detect, or respond to sexual abuse; consider whether the incident or allegation was motivated by race, ethnicity, gender identity; LGBTQI2-S identification, status, or perceived status or gang affiliation; or was motivated or otherwise caused by other group dynamics; examine the area in the facility where the incident allegedly occurred to assess whether physical barriers in the area may enable abuse; assess the adequacy of the staffing levels in that area during different shifts; and assess whether monitoring technology would be deployed or augmented to supplement supervision by staff; and prepare a report of its findings including, but not necessarily limited to, determinations made pursuant to the preceding paragraphs and any recommendations for improvement. Such report shall be submitted to the Director of Division of Youth Services, Facility Administrator, and PREA Coordinator in a timely manner.

The Facility Administrator confirmed the PREA Incident Review Team considers 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 was motivated or otherwise

caused by other group dynamics at the facility. The area in the facility where the incident allegedly occurred is examined to assess whether physical barriers in the area may enable abuse. Adequacy of staffing levels in the area are assessed for different shifts. He confirmed the PREA Incident Review Team assesses whether monitoring technology should be deployed or augmented to supplement supervision by staff.

The PREA Coordinator confirmed if the facility conducts a sexual abuse incident review, the facility prepares a report of its findings from the review, including any determinations and any recommendations for improvement. The PREA Compliance Manager is a member of the sexual abuse incident review team.

**115.386 (e)**

PAQ: The facility implements the recommendations for improvement or documents its reasons for not doing so.

Policy states the Facility Administrator/designee shall implement the recommendations for improvement or shall document the reasons for not doing so.

**Corrective Action**

Based upon the review and analysis of the available evidence, the auditor has determined the agency and facility is fully compliant with this standard regarding sexual abuse incident reviews. Corrective action has been completed.

**115.386 (d)**

To better demonstrate compliance with all aspects of the standard, the facility developed the Sexual Abuse Critical Incident Review Form on January 28, 2020. The form is inclusive of all of the standard requirements. The facility emailed the audit a completed example for verification the form has been implemented.

## 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.*

### The following evidence was analyzed in making the compliance determination:

#### Documents:

1. OYDC Policy XV.7 PREA
2. 2017 Survey of Sexual Victimization, State Juvenile Systems Summary Form
3. 2018 Survey of Sexual Victimization, State Juvenile Systems Summary Form
4. OYDC Pre-Audit Questionnaire responses

#### Site Review Observations:

Observations during on-site review of physical plant



**Findings (by provision):****115.387 (a)**

PAQ: The agency collects accurate, uniform data for every allegation of sexual abuse at facilities under its direct control using a standardized instrument and set of definitions. The standardized instrument includes, at a minimum, the data necessary to answer all questions from the most recent version of the Survey of Sexual Victimization conducted by the Department of Justice.

Policy states the PREA Coordinator 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. The PREA Coordinator shall aggregate the incident-based sexual abuse data at least annually.

The auditor reviewed the Incident Report Form and Survey of Sexual Victimization Substantiated Incident Form (Juvenile) for verification.

**115.387 (b)**

PAQ: The agency aggregates the incident-based sexual abuse data at least annually.

The auditor reviewed the aggregated data from 2017 and 2018.

**115.387 (c)**

PAQ: 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.

Policy states the (Special Incident Report) SIR process includes, at a minimum, the data necessary to answer all questions from the most recent version of the Survey of Sexual Victimization (SSV) conducted by the Department of Justice.

**115.387 (d)**

PAQ: The agency maintains, reviews, and collects data as needed from all available incident-based documents, including reports, investigation files, and sexual abuse incident reviews.

Policy states the PREA Coordinator shall maintain, review, and collect data as needed from all available incident-based documents, including reports, investigation files, and sexual abuse incident reviews.

**115.387 (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 data from private facilities complies with SSV reporting regarding content.

Oakley Youth Development Center is the sole Mississippi Department of Human Services juvenile confinement facility.

**115.387 (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.

Policy states the PREA Coordinator shall compile the records and data from the previous calendar year necessary to fill out the requested data in the DOJ's Survey of Sexual Victimization (SSV) should it be requested. This is to be provided to the Department of Justice no later than June 30.

OYDC completed the Survey of Sexual Victimization Summary Form for 2018.

The auditor reviewed the 2018 Survey of Sexual Victimization Summary Forms for verification.

#### **Corrective Action**

Based upon the review and analysis of the available evidence, the auditor has determined the agency and facility is fully compliant with this standard regarding data collection. No corrective action is required.

### **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.*

### The following evidence was analyzed in making the compliance determination:

#### Documents:

1. OYDC Policy XV.7 PREA
2. OYDC Pre-Audit Questionnaire responses

#### Documents (Corrective Action):

1. Vulnerability-Sexual Risk Assessment – updated November 25, 2019

#### Interviews:

1. Interview with the Agency Head Designee (Division Director)
2. Interview with the PREA Coordinator

#### Site Review Observations:

Observations during on-site review of physical plant

#### Findings (by provision):

##### 115.388 (a)

PAQ: The agency reviews 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, and training, including:

1. Identifying problem areas;
2. Taking corrective action on an ongoing basis; and
3. Preparing an annual report of its findings from its data review and any corrective actions for each facility, as well as the agency as a whole.

Policy states the PREA Coordinator shall review data collected to assess and improve the effectiveness of appropriate OYDC policies and procedures. The PREA Coordinator shall prepare a report for the

facility for the Director of Division of Youth Services and Facility Administrators identifying problem areas, suggesting corrective action, and providing comparison from the previous year's data and reports. This report shall be approved by the Director of Division of Youth Services and made readily available to the public through the MDHS-DYS website.

The Division Director confirmed the facility uses incident-based sexual abuse data to assess and improve sexual abuse prevention, detection, response policies, practices, and training to identify problem areas and take corrective action as needed. The PREA Coordinator confirmed the agency reviews data collected and aggregated in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, and training. The agency ensures that data collected is securely retained.

**115.388 (b)**

PAQ: The annual report includes a comparison of the current year's data and corrective actions with those from prior years. The annual report provides an assessment of the agency's progress in addressing sexual abuse.

Policy states the annual report provides a comparison from the previous year's corrective actions, data, and reports.

The auditor reviewed the 2019 annual report for verification.

**115.388 (c)**

PAQ: The agency makes its annual report readily available to the public at least annually through its website. The annual reports are approved by the agency head.

Policy states the report shall be approved by the Director of Division of Youth Services and made readily available to the public through the MDHS-DYS website.

The PREA Coordinator confirmed the Division Director approves annual reports.

The auditor observed the annual reports were published on the agency's website and approved by the Division Director at <https://www.mdhs.ms.gov/wp-content/uploads/2020/05/DOC050720-05072020141319.pdf>.

**115.388 (d)**

PAQ: When the agency redacts material from an annual report for publication the redactions are limited to specific materials where publication would present a clear and specific threat to the safety and security of the facility. The agency indicates the nature of material redacted.

Policy states MDHS and/or OYDC 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 PREA Coordinator stated all identifying information is redacted from the report.

The auditor observed no personal identifiers were included in the annual report.

**Corrective Action**

Based upon the review and analysis of the available evidence, the auditor has determined the agency and facility is fully compliant with this standard regarding data review for corrective action. Corrective action has been completed.

**115.388 (a) - (d)**

The facility completed the 2019 annual report April 29, 2020 and emailed it to the auditor for verification. The report was inclusive of the standard requirements and was published on the agency's website.

## 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.*

**The following evidence was analyzed in making the compliance determination:**

**Documents:**

1. OYDC Policy XV.7 PREA
2. OYDC Pre-Audit Questionnaire responses

**Interview:**

1. Interview with the PREA Coordinator

**Site Review Observations:**

Observations during on-site review of physical plant

**Findings (by provision):**

**115.389 (a)**

PAQ: The agency ensures that incident-based and aggregate data are securely retained.

Policy states data shall be retained securely.

The PREA Coordinator confirmed the agency reviews data collected and aggregated in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, and training. The agency ensures that data collected is securely retained.

**115.389 (b)**

PAQ: Agency policy requires that aggregated sexual abuse data from facilities under its direct control and private facilities with which it contracts be made readily available to the public, at least annually, through its website.

Oakley Youth Development Center is the sole Mississippi Department of Human Services juvenile confinement facility.

The auditor observed the annual report was published on the agency's website and approved by the Division Director.

<https://www.mdhs.ms.gov/wp-content/uploads/2020/05/DOC050720-05072020141319.pdf>

**115.389 (c)**

PAQ: Before making aggregated sexual abuse data publicly available, the agency removes all personal identifiers.

Policy states MDHS and/or OYDC may redact specific material from the reports when publication would present a clear and specific threat to the safety and security of a facility

The auditor observed the annual report was published on the agency's website. The auditor observed no personal identifiers.

**115.389 (d)**

PAQ: The agency maintains sexual abuse data sexual abuse data collected pursuant to §115.387 for at least 10 years after the date of initial collection, unless Federal, State, or local law requires otherwise.

Policy states data shall be retained securely for ten (10) years

The auditor reviewed historical sexual abuse data from 2017 and 2018 included in the 2019 annual report.

**Corrective Action**

Based upon the review and analysis of the available evidence, the auditor has determined the agency and facility is fully compliant with this standard regarding data storage, publication, and destruction. No corrective action is required.

## 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 residents? ☒ 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 following evidence was analyzed in making the compliance determination:

1. OYDC Pre-Audit Questionnaire responses
2. Interviews
3. Research
4. Policy Review
5. Document Review
6. Observations during onsite review of facility

This is the first PREA audit for Oakley Youth Development Center. The Mississippi Department of Human Services, Division of Youth Services is a single facility agency. There are no juvenile confinement facilities operated by a private organization on behalf of MDHS.

The auditor was given access to, and the ability to observe, all areas of the audited facility. The auditor was permitted to conduct private interviews with residents at the facility. The auditor sent an audit notice to the facility more than six weeks prior to the on-site audit. The audit notice contained contact information for the auditor. The residents were permitted to send confidential information or correspondence to the auditor in the same manner as if they were communicating with legal counsel. No confidential information or correspondence was received.

### Corrective Action

Based upon the review and analysis of the available evidence, the auditor has determined the agency and facility is fully compliant with this standard regarding frequency and scope of audits. No corrective action is required.

## 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. The review period is for prior audits completed during the past three years PRECEDING THIS AGENCY AUDIT. 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.*

### The following evidence was analyzed in making the compliance determination:

1. OYDC Pre-Audit Questionnaire responses
2. Interviews
3. Research
4. Policy Review
5. Document Review
6. Observations during onsite review of facility

This is the first PREA audit for Oakley Youth Development Center. Previously there has never been a final PREA audit report issued. This final report will be published at <https://www.mdhs.ms.gov/youth-services/>.

### Corrective Action

Based upon the review and analysis of the available evidence, the auditor has determined the agency and facility is fully compliant with this standard regarding frequency and scope of audits. No corrective action is required.

## 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.<sup>1</sup> Auditors are not permitted to submit audit reports that have been scanned.<sup>2</sup> See the PREA Auditor Handbook for a full discussion of audit report formatting requirements.

Robert B. Latham

May 11, 2020

**Auditor Signature**

**Date**

<sup>1</sup> See additional instructions here: <https://support.office.com/en-us/article/Save-or-convert-to-PDF-d85416c5-7d77-4fd6-a216-6f4bf7c7c110>.

<sup>2</sup> See *PREA Auditor Handbook*, Version 1.0, August 2017; Pages 68-69.