Prison Rape Elimination Act (PREA) Audit Report
Juvenile Facilities

☐ **Interim** ☒ **Final**

Date of Report 08-12-2018

Auditor Information

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Company Name: PREA America LLC	
Mailing Address: P. O. Box 1473	**City, State, Zip:** Raton, NM 87740
Telephone: 405-945-1951	**Date of Facility Visit:** December 14 & 15, 2017

Agency Information

Name of Agency Rehabilitation Administration/Juvenile Rehabilitation		**Governing Authority or Parent Agency** *(If Applicable)* Washington State Department of Social and Health Services	
Physical Address: 14th & Jefferson Street		**City, State, Zip:** Olympia, Washington 98504	
Mailing Address: P. O. Box 45131		**City, State, Zip:** Olympia, Washington 98504	
Telephone: 360-902-8088		**Is Agency accredited by any organization?** ☐ Yes ☒ No	
The Agency Is:	☐ Military	☐ Private for Profit	☐ Private not for Profit
☐ Municipal	☐ County	☒ State	☐ Federal

Agency mission: To transform lives by creating pathways to self-sufficiency through effective rehabilitation services and meaningful partnerships.

Agency Website with PREA Information: https://www.dshs.wa.gov/ra/juvenile-rehabilitation

Agency Chief Executive Officer

Name: Marybeth Queral	**Title:** Assistant Secretary, RA
Email: QueraMB@dshs.wa.gov	**Telephone:** 360-902-7957

Agency-Wide PREA Coordinator

Name: Eric Crawford	**Title:** PREA Program Administrator

Email: CrawfEM@dshs.wa.gov	**Telephone:** 360-902-0230
PREA Coordinator Reports to: Debbie Lyne	**Number of Compliance Managers who report to the PREA Coordinator** 11

Facility Information

Name of Facility: Naselle Youth Camp				
Physical Address: 11 Youth Camp Lane; Naselle, Washington 98638				
Mailing Address (if different than above): Click or tap here to enter text.				
Telephone Number: (360) 484-3223				
The Facility Is:	☐ Military	☐ Private for Profit	☐ Private not for Profit	
☐ Municipal	☐ County	☒ State	☐ Federal	
Facility Type:	☐ Detention	☐ Correction	☐ Intake	☒ Other
Facility Mission: To transform lives by creating pathways to self-sufficiency through effective rehabilitation services and meaningful partnerships.				
Facility Website with PREA Information: https://www.dshs.wa.gov/ra/juvenile-rehabilitation				
Is this facility accredited by any other organization? ☐ Yes ☒ No				

Facility Administrator/Superintendent

Name: Pat Escamilla	**Title:** Superintendent
Email: escampm@dshs.wa.gov	**Telephone:** (360) 484-3223 Ext. 7576

Facility PREA Compliance Manager

Name: Cary A. Bloom	**Title:** PREA Compliance Manager
Email: bloomca@dshs.wa.gov	**Telephone:** (360) 484-3223 Ext. 7622

Facility Health Service Administrator

Name: Troy Wasmundt	**Title:** RN 3 (Nurse Manager)
Email: wasmundt@dshs.wa.gov	**Telephone:** (360) 484-3223 Ext. 7578

Facility Characteristics

Designated Facility Capacity: 86	**Current Population of Facility:** 84
Number of residents admitted to facility during the past 12 months	242

Number of residents admitted to facility during the past 12 months whose length of stay in the facility was for 10 days or more:	264
Number of residents admitted to facility during the past 12 months whose length of stay in the facility was for 72 hours or more:	281
Number of residents on date of audit who were admitted to facility prior to August 20, 2012:	0
Age Range of Population:	15-20
Average length of stay or time under supervision:	95 days
Facility Security Level:	Minimum to Medium
Resident Custody Levels:	Minimum to Medium
Number of staff currently employed by the facility who may have contact with residents:	107
Number of staff hired by the facility during the past 12 months who may have contact with residents:	21
Number of contracts in the past 12 months for services with contractors who may have contact with residents:	2

Physical Plant

Number of Buildings: 3 occupied living units; 16 total buildings	**Number of Single Cell Housing Units:** None, all have a mix of single and double. 56 single.
Number of Multiple Occupancy Cell Housing Units:	20 double cell units
Number of Open Bay/Dorm Housing Units:	None
Number of Segregation Cells (Administrative and Disciplinary:	4

Description of any video or electronic monitoring technology (including any relevant information about where cameras are placed, where the control room is, retention of video, etc.):

Cameras are in many areas. There is a system-wide expansion of the cameras anticipated, which will make the cameras more uniform from facility to facility and expand the ones in place. These are planned to cover blinds spots.

Medical

Type of Medical Facility:	Outpatient clinic in-house
Forensic sexual assault medical exams are conducted at:	St. John's Peace Health; Longview, Washington

Other

Number of volunteers and individual contractors, who may have contact with residents, currently authorized to enter the facility:	26
Number of investigators the agency currently employs to investigate allegations of sexual abuse:	15

Audit Findings

Audit Narrative

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.

PREA America LLC was retained 10-25-2017 to conduct PREA Audits for Washington State Department of Social and Health Services Rehabilitation Administration/Juvenile Rehabilitation facilities. The audit of Naselle Youth Center was scheduled for December 14 and 15. Notices about the audit were put up at the facility by October 31. An incomplete Pre-Audit Questionnaire and some supporting documentation was received starting November 20. Prior to the audit, phone calls and emails were exchanged in preparation for the audit, to review the itinerary and answer questions. The on-site audit was begun, as planned, at 8 AM December 14. PREA America DOJ Certified PREA Auditor Will Weir and PREA America Project Manager Tom Kovach arrived at the facility and met with facility administrators who provided a site review and introduction to the facility. Interviews and documentation reviews began right away after the site review. An exit conference was held at the conclusion of the on-site audit. In addition, a tele-conference call was held the following week including the Deputy Director, attempting to address the areas where the agency was yet to show compliance.

All documents received were reviewed, including logs, training files and curriculum. Background checks were randomly selected of staff, contractors and volunteers to verify the initial background check as well as the 5 year recheck requirement. Phone calls were made to listed advocates, to verify the advocacy required by the standards.

The Site Review included obtaining and studying the facility diagram of the physical plant. Observing staff and inmates and the supervision and movement along with casual conversation to ascertain if observations made were of "normal" supervision and movement. Random checks of to assure doors intended to be secured were locked. Random checks of PREA Hotline phones for functionality were made. All housing units and bathroom facilities were inspected for compliance for cross gender supervision. This included a camera review for those areas with cameras. All areas of the physical plants were observed, with attention to those areas which statistically are high risk for sexual abuse. PREA Postings were viewed. There was no third-party posting in the visitation area, so the audit team requested it be posted, and this was confirmed within the first 30 days after the on-site audit. Confirmation of the availability to staff of First Responder Duties was also a part of the site review.

Interviews were selected in accordance with the guidance of the Auditor Handbook with random selections of residents to ensure diversity of geographic location (from each housing unit), race, and those with risk factors. The audit team interviewed 16 residents, including at least 4 from each of the 3 housing units. Targeted interviews included 2 LGBTI residents, 2 alleged victims of sexual abuse and/or harassment, and 4 with learning, developmental or cognitive delays. One of the 16 residents initially selected refused to be interviewed, so a random selection was made to replace him.

The Audit team interviewed 12 facility staff, who were selected for: shift, gender and posting diversity at random. There were 5 facility staff interviewed for specialized staff functions, which were selected by their duties related to PREA implementation at the facility. 8 staff from the agency were also interviewed during the course of the audit which included the PREA Administrator, who also acted as the designee for the agency head. The agency staff all play supportive roles for the facility's efforts to comply with PREA. There

were 60 staff scheduled the days of the on-site audit, which were not in the specialized staff or administrative roles, including all three shifts and support positions such as kitchen, maintenance staff and programming staff. Of those 12, or one fifth, were interviewed.

The exit briefing addressed all aspects of the audit to date. No determination of compliance was given, but a number of requests were made by the audit team for additional verification of compliance, including every area mentioned in this report as areas where the facility (or agency) has not shown adequate verification of compliance.

Interviews indicated that staff were concerned about many of the same issues the facility had not yet shown compliance with. Staff and administrative interviews indicated that there is difficulty retaining adequate staffing at NYC. There was a desire for better communication, coordination and support. Certainly, staff indicate a knowledge that residents may respond better when they are supervised adequately and when incidents are responded to and investigated fully and followed up on promptly and appropriately. Several staff, and the LGBTI residents, and some residents who had been accused of sexual offenses, indicated fears about confidentiality violations by staff. Residents interviewed from Mariner Lodge gave affirmative responses regarding every area they were asked about, indicating no lack of PREA compliance they were aware of. However, of the remaining 12 residents from the other two lodges, 6 gave strong indications that staff do not supervise adequately or properly, 10 reported name-calling and other bullying type interactions between residents, and 6 said there was name-calling and inappropriate interactions between staff and residents.

On 01-22-2018, the auditor issued the PREA Audit Interim Report. In the weeks that followed a Corrective Action Plan (CAP) was developed, as described starting on page 7 of this report. Then, throughout the 180-day period after the issuance of the Interim Report, the audit team reviewed additional information and documentation, and engaged in emails and phone calls with agency and facility administrators to determine whether practices at the facility are consistent with the PREA standards. The 180 days of the CAP (the maximum amount of time allowed by the standards) ended July 14. This Final Report concludes the audit, and documents that the facility has not shown full compliance with all the PREA standards. Specifics of the audit, as it relates to each numbered standard, is contained throughout the remainder of this document.

Documentation reviewed includes: Washington State Juvenile Rehabilitation Pre-Audit Questionnaire Common Responses for All Facilities; NYC Pre-Audit Questionnaire, and revisions; Washington State Juvenile Justice & Rehabilitation Administration Community Standard 10: Applying PREA Juvenile Standards in Community Facilities; NYC Preamble (NYC Policy of Zero Tolerance of Sexual Abuse); Staffing Plan and Review; Coordinated Response; Population on the Tenth and Twentieth of the Month; Resident Handbook; Facility Schematic; Juvenile Rehabilitation PREA Volunteer/Contractor Acknowledgement; PREA Guide to the Prevention and Reporting of Sexual Misconduct Brochure; PREA Requirements for Volunteers/Contractors; Policy 1.23 Deciding to Hire or Promote Staff or Contractors; Policy 1.60 Managing Contracts; Policy 2.10 (13) Managing Youth Complaints; Policy 2.50 (36) Accessing Interpreter and Translation Services for Youth and Families; Policy 2.60 Managing Youth who are Foreign Nationals; Policy 3.20 (39) Assessing Sexually Aggressive or Vulnerable Youth (SAVY); Policy 4.30 Providing Health Care for JR Youth; Policy 4.60 (50) Ensuring the Health of Safety of LGBTQI Youth in JR; Policy 5.70 Conducting Searches; Policy 5.90 (49) Applying PREA Juvenile Standards in JR; 5.91 (34) Reporting Abuse or Neglect of JR Youth; Policy 6.20 Managing Residential Youth Communications; PREA Class Training PowerPoint; PREA Online Training Storyboard; The Culture of Abuse Continuum Handout; LGBTQI Handouts; Sexual Abuse Victim Advocates; The Code of Silence Handout; Undue Familiarity Red Flag Behaviors; Youth on Youth Red Flags for Sexual Victimization; PREA JR Youth Safety Guide; Youth Safety Guide Talking Points; PREA Youth Education Session Acknowledgement; PREA Youth Intake (Acknowledgement of Zero Tolerance); staff roster and schedule; resident roster; JR Policy 22 Assigning Room Confinement, Programmed Room Confinement and Isolation; Memorandum of Understanding (MOU) with Sexual Assault and Domestic Violence Prevention and Response Collaborative; MOU with Crisis

Support Network; Fingerprint-Based Background Check Notice; Contraband handout for staff (includes search protocols); and examples of Sexually Aggressive Vulnerable Youth Assessment (SAVY) and Sexual Orientation, Gender Identity and Expression (SOGIE) assessment instruments; Mental Health Tracking Log; Investigations; and policies from agency website regarding confidentiality and HIPAA. Additional documentation reviewed is referred to in narratives specific to each standard.

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.

Naselle Youth Camp is nestled in the forest near the Pacific coast of Washington State's Southwest corner. A former military camp for a radar facility, the campus has staff apartments a five-minute walk away. Part of the multi-acre campus is shared with the Department of Natural Resources, which maintains an office and garages and employs some of the youth. This park-like setting is complete with a stream running through the campus, walking trails, and several buildings. The campus is shaped like a large comma.

Upon entry is the Administration building. The facility administrator's office, as well as several senior staff offices, are located around the large conference room. Support staff offices and cubicles, bathrooms, and break areas are all located here.

Visitation is a large stand-alone building with staff by the front door. Youth are allowed to visit family in this building, which has a large room and a couple of bathrooms.

Eagle Lodge houses mental health staff in several offices, along with a breakroom, a small kitchen, and bathrooms. The Dining and Kitchen building is next. The dining area is large and has an open kitchen area. A fair-sized chapel is next door, across from the Commissary buildings.

A Medical building with multiple offices is next on the road. There is a large Maintenance building close to the Department of Natural Resources' buildings, down a short road. Some technical skills are taught here.

The road circles around to the School building at the far end. It is a modern building, with multiple classrooms and a modern gym. There is a staff desk by the entrance, and a teacher lounge area. There is a large open area, with the library at the far side and classrooms surrounding it. There is a large ball field next to the school.

In the middle are four lodges which house the youth: Cougar, Mariner, Harbor and Moolock. Moolock is not used for housing at this time. Harbor is split-level, while the other lodges are single level; otherwise, their layout is very much the same. The entrance is next to the program manager's office. There is a staff area which is situated to view the day room and housing wings. Some offices are down a short hall behind this staff station. Roughly 30 youth are in each lodge. Harbor houses a few more than the rest.

Cameras are in many areas. There is a system-wide expansion of the cameras anticipated, which will make the cameras more uniform from facility to facility and expand the ones in place. These are planned to cover blinds spots.

Summary of Audit Findings

*The summary should include the number of standards exceeded, number of standards met, and number of standards not met, **along with a list of each of the standards in each category**. If relevant, provide a summarized description of the corrective action plan, including deficiencies observed, recommendations*

made, actions taken by the agency, relevant timelines, and methods used by the auditor to reassess compliance.

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

Number of Standards Exceeded: 0

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Number of Standards Met: 33

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Number of Standards Not Met: 10

311, 313, 322, 334, 341, 342, 371, 373, 376, 401

Summary of Corrective Action (if any)

The following is a listing of the Standards Not Met. These are the same standards listed in this section of the PREA Audit Interim Report. The facility did not show full compliance during the corrective action period with any of the standards listed in the Interim Report and subsequent Corrective Action Plan (CAP).

Standard 115.311: Zero tolerance of sexual abuse and sexual harassment; PREA coordinator.

The facility PREA Compliance Manager (PCM) was not overseeing all the facility's PREA efforts until after the on-site audit. After the auditor received word that all the duties were assigned to him, he went on leave, delegating his duties to others. The CAP required updates regarding the status of the management and coordination of PREA at the facility, but none were received by the audit team after that time. The facility has not shown that PREA management and coordination is fully entrenched in the facility culture.

Standard 115.313: Supervision and monitoring.

NYC had not been reliably documenting deviations from their staffing plan. A system of documenting and tracking staffing ratios and plans was established during the CAP. The CAP required this documentation to be sent monthly and the facility complied with this requirement. However, the documentation revealed deviations from the staffing plan beyond what the PREA standards permit. The deviations were occurring daily. Subsection B of this standard requires the agency comply with the staffing plan at all times, except during limited and discrete exigent circumstances.

Standard 115.322: Policies to ensure referrals of allegations for investigations.
Standard 115.334: Specialized training: Investigations.
Standard 115.371: Criminal and administrative agency investigations.
Standard 115.373: Reporting to residents.
Standard 115.376: Disciplinary sanctions for staff.

At the time of the on-site audit and Interim Report, the agency had not shown compliance with these standards relating to investigations. At the end of the CAP, the agency has still not yet shown that all allegations are reliably and fully investigated by properly trained investigators, and documented as required. Also, the facility has not shown compliance with certain follow-up requirements such as reporting to residents and holding staff accountable. Significant progress was made toward compliance with this standard initially after the on-site audit, but the audit team was then notified by the PREA Administrator, and the PREA Administrator's supervisor, during a April 17 conference call, as well as by documentation provided by emails, that the current policy was no longer in practice and the facility investigators would no longer be doing investigations. The audit team was also notified during the conference call that if allegations do not name a perpetrator, the allegations will not be investigated. The investigative materials provided by the previous investigators, to show compliance, are obsolete because the policy is now different and different investigators are assigned. There was no verification provided of time frames, training, policy implementations, or investigative materials from the new investigators.

Standard 115.341: Screening for risk of victimization and abusiveness.
Standard 115.342: Use of screening information.

At the time of the on-site audit and the writing of the Interim Report, the facility had not provided an objective screening instrument, as this standard, and relevant FAQ's (Frequently Asked Questions developed by the U. S. Department of Justice available on the PREA Resource Center website) require. Instead, there was a separate screening regarding the LGBTI questions, which was administered by medical staff, but which did not then become integrated with "all" the other screening information toward keeping residents safe, as required in this standard. Also, interviews indicated concerns by several staff about inappropriate controls on the dissemination of screening information, due to information security risks. The collaboratively developed CAP regarding standards 115.341 and 115.342 stated that the agency and/or facility would,

"1. Provide to the auditor a memo regarding changes to how SOGIE information is collected, stored, and accessed as integrated into a single uniform screening tool.
2. Conduct a meeting with IT expert(s) and administrator(s) at DSHS to learn effective ways to resolve the breaches of confidentiality. Effective means that techniques will be used that have worked before to resolve similar problems and are not a repeat of "click through the screens and sign a form" training that has not been effective.
3. Devise a plan based on the expert information.
4. Implement the plan.
5. Provide the plan and verification of implementation to the audit team.
6. Review confidentiality and related IT policies with staff and provide evidence that staff understood the review.
7. The auditor will be provided a complete list of Naselle employees who have computer access to this information, and why. Auditor will interview random staff from these rosters by phone @05-02-2018."

The audit team was informed verbally, and in writing, that the agency would not fully complete this section of the collaboratively developed CAP. Although the agency provided some additional training regarding confidentiality, and issued a memo to improve information security, the agency provided no alternative CAP tasks, or evidence, that showed full compliance with this standard.

Standard 115.401: Frequency and scope of audits.

During the Pre-Audit phase, the auditor was provided with policies that were out of date and a Pre-Audit Questionnaire (PAQ) that was incomplete and contained inaccuracies. The CAP requirements for this standard were:

"1. Notify auditors of any new policies established during the CAP
2. Confirm which policy versions are actually in place (2.10 & 4.30)

3. Submit a revised and complete pre-audit questionnaire to ensure all questions are answered and numbers are accurate."
The facility did not show full compliance with these tasks, or with this standard. The audit team was informed that some policies were revised during the CAP, then did not receive the policies.

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 Naselle Youth Center (NYC) is operated by the Washington State Department of Social and Health Services (WSDSHS or DSHS) and utilizes the written policies of WSDSHS Juvenile Administration (JA), which oversees the Juvenile Rehabilitation (JR) program. These policies mandate zero tolerance toward all forms of sexual abuse and sexual harassment, and they outline how NYC, and other agency facilities, will implement the agency's approach to preventing, detecting, and responding to sexual abuse and sexual harassment. The policies include definitions of prohibited behaviors regarding sexual abuse and sexual harassment and include sanctions for those found to have participated in prohibited behaviors. The policies include a description of agency strategies and responses to reduce and prevent sexual abuse and sexual harassment of residents. The agency employs an agency-wide PREA Administrator, not a "Coordinator". PREA Administrator Eric Crawford answers to Debbie Lyne, Program Administrator of Institutions. During the Pre-Audit and On-Site audit process, there was a PREA Compliance Manager (PCM) at the facility who was not overseeing all of the facility's PREA efforts until after the on-site audit. For example, he did not know what happened if employees were accused of sexual abuse or harassment of residents. After the on-site audit the auditor was told the PCM would start fully coordinating PREA at the facility. However, his role fully managing the facility's efforts to comply with the PREA standards had not been fully entrenched in the facility culture when he had to take extended leave and delegate his duties.

Corrective Action Required:
The Corrective Action (CAP) Plan was a collaboration between the PREA Administrator for the Agency and the Auditor. The PREA Administrator drafted the initial draft of the plan based on the exit conference held at the facility, the phone conference held after the on-site meeting and numerous subsequent emails and phone calls. Some changes where sent back and forth, and the final draft was based on the final input of the PREA Administrator. The CAP, with all the PREA Administrator's final requested changes, was updated to its final version on 02-19-2018. This plan acknowledged that on 01-08-2018, Cary Bloom, the PCM, had sent a description of the way the PCM duties were to be reassigned during his absence. The CAP required "updates as duties change." The audit team received no updates, despite reminding the PREA Administrator that these were required as agreed. The CAP also required an "Outline of who is responsible for what duties pertaining to Naselle's PREA efforts" that "Should include duties of anyone playing a role in the management of PREA." This outline was never received. Comments made by the PREA Administrator during the on-site audit were repeated during a phone conference 04-17-2018, in front of his supervisor, stating, "I can't make them [facility administrators] do anything." These comments made by the PREA Administrator as to the limits of his authority prompted the auditor to ask questions and request follow-up documentation from the supervisor as to the PREA Administrator's roles and limits of his ability to effect change to attain PREA compliance. She later provided documentation of his authority by providing the DSHS Position Description, and two updated organizational charts. However, she indicated during the 04-17-2018 conference call that the agency was being continually restructured. She was not surprised that the auditor could not find an organizational chart on the agency website, a site which she finds unreliable, that included a place for a PREA Administrator or Coordinator. She said that the PREA Administrator "only influences" and cannot enforce anything. If a facility superintendent refused to comply with the

PREA Administrator's requests, it would have to go through several upper-level administrators before any change would be required or enforced. She was asked for any examples where the PREA Administrator had ever identified any lack of PREA compliance and then took steps toward resolution. She could think of no examples. Regarding the structure of the agency, she stated that the Organizational Chart could be updated weekly because of all the constant restructuring by two new Division Directors. Another new Division Director is coming in 2019, likely imposing even more changes. She later sent the auditor an email indicating that she believes the PREA Administrator Job Description is proof enough that they are compliant with this requirement of the standard.

Analysis:
The facility PREA Compliance Manager acknowledged during the on-site audit that he has not been fully coordinating the facility's efforts to comply with the PREA standards. Other interviews and documentation supported this acknowledgement and no evidence was provided that undermined the finding of "Does Not Meet Standard" in the Interim Report. After the on-site audit the PCM delegated his duties to others and went on extended leave. The CAP required PREA management at the facility be implemented and the auditor updated. This was not shown to have been done. At the conclusion of the corrective action period, the audited facility should have taken all the steps agreed upon with the auditor. In addition, the agency indicated lack of compliance at the agency level. The PREA Administrator and his supervisor have shown, that, in practice, the agency does not have an upper-level PREA Coordinator with the authority to develop, implement, and oversee agency efforts to comply with the PREA standards in all of its facilities.

Finding:
Neither the agency nor the facility have shown full compliance with this standard.

Standard 115.312: Contracting with other entities for the confinement of residents

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

115.312 (a)

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

115.312 (b)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

The agency has entered into or renewed contracts for the confinement of its residents on or after the previous audit, but the facility has not. PREA Standards state that a public agency that contracts for the confinement of its residents with private agencies or other entities, including other government agencies, will include in any new contract or contract renewal the entity's obligation to adopt and comply with the PREA standards. This standard is not applicable to the facility, but is applicable to the agency, which requires compliance. The PREA Administrator provided the contract facility's current PREA Audit Final Report to verify compliance with this standard.

Analysis:
At the time of the Interim Report the facility and agency had shown compliance with this standard, so no corrective action was required. During the corrective action period no information was received by the audit team to undermine the finding of "Meets Standard" in the Interim Report.

Finding:
The facility has shown compliance with this standard in all material ways for the relevant review period.

Standard 115.313: Supervision and monitoring

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

115.313 (a)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

115.313 (b)

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

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

115.313 (c)

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

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

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

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

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

115.313 (d)

- In the past 12 months, has the facility, in consultation with the agency PREA 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 Interim PREA Audit Report found that Naselle Youth Center had a staffing plan, but that they had not been reliably documenting deviations from the plan. The finding of "Does Not Meet Standard" was based on reviews of policies, staffing plans, staffing plan reviews, population totals for the 10th and 20th of each month, staff rosters, resident rosters, and interviews with the agency PREA Administrator, the facility PREA Compliance Manager and the facility administrators such as the Assistant Superintendent. There was general agreement among staff and administrators that additional staffing would be helpful and that it has been a challenge to keep NYC fully staffed. The interviews of residents from Cougar and Harbor Lodges were particularly revealing regarding the need for adequate staffing. 6 of these residents made statements directly indicating a lack of staffing. They said that when their assigned staff were needed they were sometimes outside the Lodge, too busy, or didn't care. 6 of the residents told about inappropriate communication between staff and residents, and between staff and resident's families. The audit team was told that family members have been referred to as "bitches" and that residents have been called "ladies" and "girls" by staff. They also told of residents being verbally abusive to staff. Some felt that complaining didn't help or made things worse. It was difficult to get some residents to provide specific examples of what they meant, but some said staff ignore and deny while others over-react to problems. 10 residents complained about name-calling and bullying type behavior between residents. Residents reportedly call each other names, engage in fights and horseplay, promote gang association, and engage in various forms of teasing and bullying.

Corrective Action Required:
Documentation begun within the 30 days after the on-site audit. A system of documenting and tracking staffing ratios and plans was firmly established during the CAP. The CAP required this documentation to be sent monthly and the facility complied with this requirement. However, the documentation revealed deviations from the staffing plan beyond what the PREA standards permit. The deviations were occurring daily. Subsection B of this standard requires the agency comply with the staffing plan except during limited and discrete exigent circumstances. Documentation provided during the corrective

action period indicated the deviations are occurring daily due to the ongoing “funded staff level.” For example, the report for July 2018 stated, “Harbor Lodge by our staffing model only has 2 grave yard staff assigned to the living unit. Harbor is funded for 37 residents. Graveyard shifts by PREA standard are 1 to 16. In the month of June all date Harbor lodge had more than 32 residents.”

Analysis:
Although the facility complied with the CAP by documenting deviations from the staffing plan, the documentation provided showed that the facility is not in compliance with the staffing ratio requirements of this standard and the agency policy.

Finding:
Since the facility fails, on a daily basis, to meet the required staffing plan ratios, the facility has not shown compliance with the staffing ratio requirements of this standard, therefore the facility is not compliant in all material ways with this standard.

Standard 115.315: Limits to cross-gender viewing and searches

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

115.315 (a)

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

115.315 (b)

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

115.315 (c)

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

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

115.315 (d)

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

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

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

115.315 (e)

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

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

115.315 (f)

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

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

According to the PAQ, staff training, and the Washington State Juvenile Justice and Rehabilitation Administration Policy 5.90 (49) Applying the PREA Juvenile Standards in JR, NYC does not conduct any kind of cross-gender searches of residents except in exigent circumstances (which are fully documented and justified), or when performed by medical practitioners. Documentation shows no cross-gender searches occurring in the past 12 months. Residents shower one at a time, 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. Staff of the opposite gender announce their presence when entering a resident housing unit. Staff are forbidden from searching or physically examining a transgender or intersex resident for the sole purpose of determining the resident's genital status. If the resident's genital status is unknown, it may be determined during conversations with the resident, by reviewing medical records, or, if necessary, by learning that information as part of a broader medical examination conducted in private by a medical practitioner. The agency has trained security staff in how to conduct cross-gender pat-down searches in exigent circumstances, and searches of transgender and intersex residents, in a professional and respectful manner, and in the least-intrusive manner possible, consistent with security needs. Interviews with residents indicated no worries about any part of this standard being violated.

Analysis:
The information available to the auditor at the time of the PREA Audit Interim Report indicated that the facility had shown compliance with this standard. No corrective action was required. No information obtained since the time that report was completed has contradicted the finding of "Meets Standard."

Finding:
The facility has shown compliance with this standard in all material ways for the relevant review period.

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.

NYC has established procedures to provide disabled residents and 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. Agency policy (Washington State Juvenile Justice and Rehabilitation Administration Policy 5.90 (49) Applying the PREA Juvenile Standards in JR, and other directives) 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 ß 115.364, or the investigation of the resident's allegations. According to the PAQ and interviews with staff, there have been no instances where resident interpreters, readers, or other types of resident assistants were used in the 12 months prior to the on-site audit. Interviews indicate residents, and possibly their families, will be offered interpreters, as appropriate.

Analysis:
The information available to the auditor at the time of the PREA Audit Interim Report indicated that the facility had shown compliance with this standard. No corrective action was required. No information obtained since the time of that report has contradicted the finding of "Meets Standard."

Finding:
The facility has shown compliance with this standard in all material ways for the relevant review period.

Standard 115.317: Hiring and promotion decisions

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

115.317 (a)

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

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

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

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

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

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

115.317 (b)

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

115.317 (c)

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

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

- Before hiring new employees, who may have contact with residents, does the agency: Consistent with Federal, State, and local 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)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

NYC 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 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 the activity described above. 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. Files reviewed by the auditor, and interviews with administrators, indicate the agency conducts criminal background record checks, consults any child abuse registry maintained by the State or locality in which the employee would work; and 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 there have been 26 persons hired who may have contact with residents who have had criminal background record checks completed, representing 100% of persons hired. Criminal background checks of employees and contractors are completed at least every five years. In addition, agency policy states that material omissions regarding such misconduct, or the provision of materially false information, will be grounds for termination. Interviews with administrators, and reviews of 3 random employee background check documentations, indicate this system is fully in place, and even includes participation in a nationwide fingerprint system.

Analysis:
The information available to the auditor at the time of the PREA Audit Interim Report indicated that the facility had shown compliance with this standard. No corrective action was required. No information obtained since the time that report was completed has contradicted the finding of “Meets Standard.”

Finding:
The facility has shown compliance with this standard in all material ways for the relevant review period.

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 facility has made a substantial expansion or modification in the past 12 months and has updated a video monitoring system. Documentation provided, as well as interviews with administrators, indicate sexual safety is considered when updates occur.

Analysis:
The information available to the auditor at the time of the PREA Audit Interim Report indicated that the facility had shown compliance with this standard. No corrective action was required. No information obtained since the time that report was completed has contradicted the finding of "Meets Standard."

Finding:
The facility has shown compliance with this standard in all material ways for the relevant review period.

RESPONSIVE PLANNING

Standard 115.321: Evidence protocol and forensic medical examinations

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

115.321 (a)

- If the agency is responsible for investigating allegations of sexual abuse, does the agency follow a uniform evidence protocol that maximizes the potential for obtaining usable physical evidence for administrative proceedings and criminal prosecutions? (N/A if the agency/facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations.)
  ☒ Yes ☐ No ☐ NA

115.321 (b)

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

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

115.321 (c)

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

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

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

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

115.321 (d)

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

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

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

115.321 (e)

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

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

115.321 (f)

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

115.321 (g)

- Auditor is not required to audit this provision.

115.321 (h)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

The auditor was provided policy (Washington State Juvenile Justice and Rehabilitation Administration Policy 5.90 (49) Applying the PREA Juvenile Standards in JR) and other documentation to prove that the agency is responsible to make sure criminal and/or administrative investigations are completed regarding all allegations of sexual abuse and harassment. At the time of the on-site audit, the facility had two trained investigators to conduct administrative investigations, but the Washington State Patrol and local law enforcement conducted criminal investigations. According to the PAQ, and interviews with the facility's medical professionals, there were no forensic medical exams conducted or indicated during the 12 months prior to the on-site audit. The Memorandum of Understanding for Victim Advocate Services, and the Naselle Youth Camp Sexual Assault Response Plan also support practices consistent with this standard. The auditor verified outside confidential support services by speaking with Jennifer Mitchell, General Crimes Program Coordinator at Crisis Support Network.

Analysis:

The information available to the auditor at the time of the PREA Audit Interim Report indicated that the facility had shown compliance with this standard. No corrective action was required. No information obtained since the time that report was completed has contradicted the finding of “Meets Standard.”

Finding:
The facility has shown compliance with this standard in all material ways for the relevant review period.

Standard 115.322: Policies to ensure referrals of allegations for investigations

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

115.322 (a)

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

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

115.322 (b)

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

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

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

115.322 (c)

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

115.322 (d)

- Auditor is not required to audit this provision.

115.322 (e)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

Although agency policy (Washington State Juvenile Justice and Rehabilitation Administration Policy 5.90 (49) Applying the PREA Juvenile Standards in JR) requires that an administrative or criminal investigation be completed for all allegations of sexual abuse and sexual harassment, at the time of the Interim PREA Audit Report, the agency had not yet shown that all allegations had been fully investigated and documented as required. The number of allegations and investigations changed during the period of time including the pre-audit work, on-site audit, and 30 days after the audit. This was complicated by the facility PREA Compliance Manager not having full information regarding investigations that involve allegations against staff. Apparently, no other administrators were checking these investigations for compliance either. During the 30-day period after the on-site audit, the auditor was notified that it was decided that the PREA Compliance Manager will be given access to this information in order to manage compliance and collect data required for reporting. The Interim Report stated that the Corrective Action Plan (CAP) would monitor whether this recent change was a sufficient improvement that would work for the facility and agency.

Corrective Action Required:
The CAP required the auditor be provided updates regarding PREA management at Naselle Youth Camp, but none of these updates were received after the CAP was agreed upon. In addition, the CAP section regarding standard 115.322 stated, "1. All new allegations received since the on-site audit, regarding sexual abuse or harassment, will be reported to the auditor. Investigations of the allegations will be completed upon completion of the investigations. 2. Interviews with investigators." Initially significant progress seemed to be occurring regarding compliance. The auditor received several investigations to review and they appeared to be compliant with the applicable standards. The audit team provided positive feedback to the facility and the agency to indicate that the documentation provided, and the investigative interview conducted, showed progress toward showing compliance with the standard. The agency was reminded, however, that compliance has to be verified and maintained throughout the duration of the CAP, so all new allegations and investigations must continue to be provided to the auditor, as explicitly stated in the CAP. The audit team was then notified by the PREA Administrator, and the PREA Administrator's supervisor, during a April 17 conference call, as well as by documentation provided by emails, that the current policy was no longer in practice and the current investigators would no longer be doing the investigations. The audit team was also notified during the conference call that if allegations do not name a perpetrator, the allegations will not be investigated. The auditor has determined that the previous materials provided for compliance cannot be used because the policy is now different and different investigators are assigned. There was no verification provided of time frames, policy implementations, or investigative materials from the new investigators.

Therefore, as of the date of this report, the facility has not shown sustained compliance with this standard.

Analysis:
The facility has not shown compliance with the standard, or the CAP, regarding the investigators who are currently assigned to conduct investigations. Compliance work that was completed regarding previous investigators who are no longer allowed to do investigations is not relevant to current compliance or practice. In addition, facilities are required to show sustained compliance, which has not been achieved.

Finding:
The facility does not show compliance with this standard.

TRAINING AND EDUCATION

Standard 115.331: Employee training

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

115.331 (a

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

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

- Does the agency train all employees who may have contact with residents on: Residents' right to be free from sexual abuse and sexual harassment ☒ Yes ☐ No

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

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

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

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

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

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

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

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

115.331 (b)

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

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

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

115.331 (c)

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

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

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

115.331 (d)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

The agency trains all employees who may have contact with residents on the following required matters: zero-tolerance policy for sexual abuse and sexual harassment; how to fulfill responsibilities under agency sexual abuse and sexual harassment prevention, detection, reporting, and response policies and procedures; residents' right to be free from sexual abuse and sexual harassment; the right of residents and employees to be free from retaliation for reporting sexual abuse and sexual harassment; the dynamics of sexual abuse and sexual harassment in juvenile facilities; the common reactions of juvenile victims of sexual abuse and sexual harassment; 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; how to avoid inappropriate relationships with residents; how to communicate effectively and professionally with residents, including lesbian, gay, bisexual, transgender, intersex, or gender-nonconforming residents; and how to comply with relevant laws related to mandatory reporting of sexual abuse to outside authorities, including relevant laws regarding the applicable age of consent. From training curriculum: "PREA training is divided into two sections: Section 1 is this on-line training. Section 2 is an in-person classroom training. The online training serves as an introduction to PREA in the Juvenile Rehabilitation work environment and fulfills the training requirement for some individuals. Many of those who work with our clients will also be required to attend the Instructor-Led course. The online training is intended to be completed prior to participating in the classroom training" (Credit to Articulate Storyline; articulate.com). The audit team reviewed staff verification of acknowledgements of training. All staff interviewed indicated they had been trained.

Analysis:
The information available to the auditor at the time of the PREA Audit Interim Report indicated that the facility had shown compliance with this standard. No corrective action was required. No information obtained since the time that report was completed has contradicted the finding of "Meets Standard."

Finding:
The facility has shown compliance with this standard in all material ways for the relevant review period.

Standard 115.332: Volunteer and contractor training

All Yes/No Questions Must Be Answered by the Auditor to Complete th e 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.

All volunteers and contractors who have contact with residents are required to be trained on their responsibilities under the agency's policies and procedures regarding sexual abuse and sexual harassment prevention, detection, and response. Before they have contact with residents, volunteers have to be trained in the agency's policies and procedures regarding sexual abuse and sexual harassment prevention, detection, and response. The level and type of training provided to volunteers and contractors is to be based on the services they provide and level of contact they have with residents. All volunteers and contractors who have contact with residents must be notified of the agency's zero-tolerance policy regarding sexual abuse and sexual harassment and informed how to report such incidents. The agency is required to maintain documentation confirming that volunteers/contractors understand the training they receive. This documentation was reviewed. NYC has 25 volunteers and/or contractors.

Analysis:
The information available to the auditor at the time of the PREA Audit Interim Report indicated that the facility had shown compliance with this standard. No corrective action was required. No information obtained since the time that report was completed has contradicted the finding of "Meets Standard."

Finding:
The facility has shown compliance with this standard in all material ways for the relevant review period.

Standard 115.333: Resident education

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

115.333 (a)

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

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

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

115.333 (b)

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

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

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

115.333 (c)

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

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

115.333 (d)

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

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

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

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

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

115.333 (e)

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

115.333 (f)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

The 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. The agency maintains documentation of resident participation in PREA education sessions, and the auditor reviewed random samples of this documentation, as well as the resident training curriculum and handouts. 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 agency provides 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. All residents interviewed indicated they received information about PREA.

Analysis:
The information available to the auditor at the time of the PREA Audit Interim Report indicated that the facility had shown compliance with this standard. No corrective action was required. No information obtained since the time that report was completed has contradicted the finding of "Meets Standard."

Finding:
The facility has shown compliance with this standard in all material ways for the relevant review period.

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.

At the time of the writing of the PREA Audit Interim Report, the auditor had received very little information about the agency's training of sexual abuse investigators. The agency policy requires that investigators are trained in conducting sexual abuse investigations in confinement settings. The training is to 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. During interviews, investigators did not show a complete understanding of investigative requirements and the meanings of investigative findings.

Corrective Action Requirements:
The CAP requirements agreed to under this standard were:
"1. Facility investigators shall complete a refresher of the "Investigating Sexual Abuse in a Confinement Setting" training provided through the National Institute of Corrections (NIC) and provide evidence that the investigators completed the training (certificate of completion via NIC or acknowledgment of date of completion).
2. Train investigation staff to the updated investigation report and the difference between substantiated, unsubstantiated and unfounded, and provide evidence that the investigators understood the training.
3. Provide to the auditor a completed investigation (occurring after the on-site audit) to include all documentation required to fully complete an investigation."

Investigations completed by one facility investigator were provided to the audit team, and these investigations seemed to be consistent with this standard. The audit team provided positive feedback to the facility and the agency to indicate that the documentation provided showed compliance with the standard. The agency was reminded, however, that compliance has to be verified and maintained throughout the duration of the CAP, so all new allegations and investigations must continue to be provided to the auditor, as explicitly stated in the CAP. Also, the facility provided verification that their two investigators had completed the training required. The audit team was then notified by the PREA Administrator, and the PREA Administrator's supervisor, during a April 17 conference call, as well as by documentation provided by emails, that the current policy was no longer in place and the current investigators would no longer be doing the investigations. The audit team was also notified during the conference call that if allegations do not list a perpetrator, the allegations will not be investigated. The auditor has determined that the previous materials provided for compliance cannot be used because the policy is now different and different investigators are assigned. There was no verification provided of time frames, policy implementations, investigator training, or investigative materials regarding the new investigators. Therefore, as of the date of this report, the facility has not shown sustained compliance with this standard.

Analysis:
The facility has not shown compliance with the standard, or the CAP, regarding the investigators who are currently assigned. Compliance work that was completed regarding previous investigators who are no longer allowed to do investigations is not relevant to current compliance or practice. In addition, facilities are required to show sustained compliance, which has not been shown at NYC.

Finding:
The facility does not show compliance with this standard.

Standard 115.335: Specialized training: Medical and mental health care

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

115.335 (a)

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

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

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

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

115.335 (b)

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

115.335 (c)

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

115.335 (d)

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

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

The agency has a policy related to the training of medical and mental health practitioners who work regularly in its facilities. Medical and mental health care practitioners who work regularly at this facility have received the training, but they do not conduct forensic exams, but would assist law enforcement if requested. The training teaches how to detect and assess signs of sexual abuse and sexual harassment; how to preserve physical evidence of sexual abuse; how to respond effectively and professionally to juvenile victims of sexual abuse and sexual harassment; and how and to whom to report allegations or suspicions of sexual abuse and sexual harassment. Verification that this standard is and has been in practice was determined through a review of policy, training, other documentation, and interviews conducted.

Analysis:
The information available to the auditor at the time of the PREA Audit Interim Report indicated that the facility had shown compliance with this standard. No corrective action was required. No information obtained since the time that report was completed has contradicted the finding of "Meets Standard."

Finding:
The facility has shown compliance with this standard in all material ways for the relevant review period.

SCREENING FOR RISK OF SEXUAL VICTIMIZATION AND ABUSIVENESS

Standard 115.341: Screening for risk of victimization and abusiveness

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

115.341 (a)

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

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

115.341 (b)

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

115.341 (c)

- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Prior sexual victimization or abusiveness? ☒ Yes ☐ No
- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Any gender nonconforming appearance or manner or identification as lesbian, gay, bisexual, transgender, or intersex, and whether the resident may therefore be vulnerable to sexual abuse? ☒ Yes ☐ No
- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Current charges and offense history? ☒ Yes ☐ No
- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Age? ☒ Yes ☐ No
- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Level of emotional and cognitive development? ☒ Yes ☐ No
- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Physical size and stature? ☒ Yes ☐ No
- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Mental illness or mental disabilities? ☒ Yes ☐ No
- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Intellectual or developmental disabilities? ☒ Yes ☐ No
- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Physical disabilities? ☒ Yes ☐ No
- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: The resident's own perception of vulnerability? ☒ Yes ☐ No
- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Any other specific information about individual residents that may indicate heightened needs for supervision, additional safety precautions, or separation from certain other residents? ☒ Yes ☐ No

115.341 (d)

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

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

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

115.341 (e)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

At the time of the on-site audit and the writing of the Interim Report, the facility had not provided an objective screening instrument, as this standard, and relevant FAQ's (Frequently Asked Questions developed by the U. S. Department of Justice available on the PREA Resource Center website) require. Instead, there was a separate screening regarding the LGBTI questions, which was administered by medical staff, but which did not then become integrated with "all" the other screening information toward keeping residents safe, as required in this standard. Also, interviews indicated concerns by several staff about inappropriate controls on the dissemination of screening information, due to information security risks. They said that some staff are known to access screening information on the computer, including information about youth not at Naselle and not coming to Naselle, for recreational purposes and talk about it where they can be overheard by others, possibly including residents. Interviews with administrators verified that it the controls on the computer system are so lax is possible for hundreds of staff, without a need or right to know, to access protected and sensitive information regarding youth from across the state. Medical staff explained that this is the reason they refused to put the LGBTI information on the computer system with other information. Their SOGIE information is computerized, but more difficult to locate by unscrupulous staff. Policy requires that the alleged breaches of confidentiality regarding protected information be reported to the agency's Privacy

Officer. The auditor provided the policy to the PREA Administrator and requested that he make the report.

Corrective Action Requirements:
The collaboratively developed CAP regarding standards 115.341 and 115.342 stated that the agency and/or facility would,
"1. Provide to the auditor a memo regarding changes to how SOGIE information is collected, stored, and accessed as integrated into a single uniform screening tool.
2. Conduct a meeting with IT expert(s) and administrator(s) at DSHS to learn effective ways to resolve the breaches of confidentiality. Effective means that techniques will be used that have worked before to resolve similar problems and are not a repeat of "click through the screens and sign a form" training that has not been effective.
3. Devise a plan based on the expert information.
4. Implement the plan.
5. Provide the plan and verification of implementation to the audit team.
6. Review confidentiality and related IT policies with staff and provide evidence that staff understood the review.
7. The auditor will be provided a complete list of Naselle employees who have computer access to this information, and why. Auditor will interview random staff from these roster by phone @05-02-2018."

After the on-site audit the auditor received a phone call regarding staff being in tears about the requirement to combine the SOGIE information with the other screening information because they felt it amounted to outing LGBTI youth. They expressed no confidence that the agency has training or computer user authorizations in place to effectively protect vulnerable youth. The auditor sent an email to the privacy officer inquiring whether the alleged breaches in confidentiality were reported to her as required. On February 16, 2018, she replied. She stated that other concerns about the privacy of youth information had been reported to her in December, but not the ones the auditor inquired about. She stated that regarding breaches of information involving less than 500 individuals "the incident should be reported to the program's Privacy Coordinator within 24 hours. Based on recent inquires from Eric Crawford, I believe there was some confusion about whether the alleged misuse of resources and client information being accessed by staff amounted to a violation of policy that needed to be reported. I informed him that it was and now that I am aware of this issue we are working to remedy it immediately." She requested additional information and it was provided, including names of facility administrators who knew about the issue. Both members of the audit team were then contacted by investigators who stated that they cannot investigate unless we tell them the names of the individuals who made the allegations. We told them that our interviews with residents and line staff are confidential, but we have provided all the names of facility administrators who can help verify the concerns and narrow down the locations and computers involved, etc. The investigators, and their supervisor also on the line, pressured the auditors to break confidentiality, but the audit team refused. We were told that without these names, they would not complete their investigation. The audit team then notified the PREA Administrator regarding these conversations and informed him that the agency did not appear to be investigating alleged breaches of confidential information obtained during PREA screenings. This was discussed with the PREA Administrator and his supervisor during a phone conference on April 17. Both agreed with the agency privacy investigators and stated that without names of perpetrators, allegations cannot be investigated. Deputy Director Lyne expanded this to include PREA allegations of sexual abuse and neglect, saying they cannot complete investigations if they do not know who to investigate. They were told by the audit team that the PREA standards require investigations of all allegations, regardless of whether the perpetrator is named, but they did not correct or withdraw their statements. They did say, however, that they will do everything they can to protect residents. The audit team expressed that additional items needed to be added to the CAP, but the audit team was informed verbally, and in writing, that the agency would not complete this section of the CAP.

The agency provided no alternative CAP tasks that could be used to verify compliance. Information was provided to the audit team about some general privacy training that had been completed by staff and administrators. Also, they provided a memo that stated policy changes have been made regarding the administration of the SOGIE, and another memo about the tightening of privacy controls, but the updated policy was not provided, and verification of implementation was not provided.

Analysis:
Since the facility has not followed the CAP, or proposed alternative acceptable tasks they can complete to show compliance with this standard, the finding of "Does Not Meet Standard" issued in the Interim Report must remain the auditor's finding according to the rules provided to auditors by the U.S. Department of Justice via the PREA Resource Center and PREA Management Office.

Finding:
The facility has not shown full compliance with this standard.

Standard 115.342: Use of screening information

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

115.342 (a)

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

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

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

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

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

115.342 (b)

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

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

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

- Do residents in isolation receive daily visits from a medical or mental health care clinician? ☒ Yes ☐ No

- Do residents also have access to other programs and work opportunities to the extent possible? ☒ Yes ☐ No

115.342 (c)

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

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

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

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

115.342 (d)

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

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

115.342 (e)

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

115.342 (f)

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

115.342 (g)

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

115.342 (h)

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

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

115.342 (i)

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

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.

As mentioned in the previous standard, at the time of the on-site audit, the facility did not use one objective screening instrument, as this standard, and relevant FAQ's (Frequently Asked Questions developed by the U. S. Department of Justice available on the PREA Resource Center website), require. There was a separate screening regarding the LGBTI questions, which was administered by medical staff, but which did not then become integrated with "all" the other screening information toward

keeping residents safe. Also, interviews indicated concerns by staff about appropriate controls on the dissemination of screening information, due to information security risks. They said that some staff are known to access screening information on the computer, including information about youth not at Naselle and not being placed at Naselle, for recreational purposes and talk about the information where they can be overheard by others, possibly including residents. Interviews with administrators verified that it the controls on the computer system are so lax it is possible for hundreds of staff from various facilities, without a need or right to know, to access protected and sensitive information regarding youth from across the state. Medical staff explained that this is the reason they refused to put the LGBTI information on the computer system with other information. Their SOGIE information is computerized, but more difficult to locate by unscrupulous staff. Policy requires that the alleged breaches of confidentiality regarding protected information be reported to the agency's Privacy Officer. The auditor provided the policy to the PREA Administrator and requested that he make the report.

Corrective Action Requirements:

The collaboratively developed CAP regarding standards 115.341 and 115.342 stated that the agency and/or facility would,

"1. Provide to the auditor a memo regarding changes to how SOGIE information is collected, stored, and accessed as integrated into a single uniform screening tool.

2. Conduct a meeting with IT expert(s) and administrator(s) at DSHS to learn effective ways to resolve the breaches of confidentiality. Effective means that techniques will be used that have worked before to resolve similar problems and are not a repeat of "click through the screens and sign a form" training that has not been effective.

3. Devise a plan based on the expert information.

4. Implement the plan.

5. Provide the plan and verification of implementation to the audit team.

6. Review confidentiality and related IT policies with staff and provide evidence that staff understood the review.

7. The auditor will be provided a complete list of Naselle employees who have computer access to this information, and why. Auditor will interview random staff from these roster by phone @05-02-2018."

After the on-site audit the auditor received a phone call regarding staff being in tears about the requirement to combine the SOGIE information with the other screening information because they felt it amounted to outing LGBTI youth. They expressed no confidence that the agency has training or computer user authorizations in place to effectively protect vulnerable youth. The auditor sent an email to the privacy officer inquiring whether the alleged breaches in confidentiality were reported to her as required. On February 16, 2018, she replied. She stated that other concerns about the privacy of youth information had been reported to her in December, but not the ones the auditor inquired about. She stated that regarding breaches of information involving less than 500 individuals "the incident should be reported to the program's Privacy Coordinator within 24 hours. Based on recent inquiries from Eric Crawford, I believe there was some confusion about whether the alleged misuse of resources and client information being accessed by staff amounted to a violation of policy that needed to be reported. I informed him that it was and now that I am aware of this issue we are working to remedy it immediately." She requested additional information and it was provided, including names of facility

administrators who knew about the issue. Both members of the audit team were then contacted by investigators who stated that they cannot investigate unless we tell them the names of the individuals who made the allegations. We told them that our interviews with residents and line staff are confidential, but we have provided all the names of facility administrators who can help verify the concerns and narrow down the locations and computers involved, etc. The investigators, and their supervisor also on the line, pressured the auditors to break confidentiality, but the audit team refused. We were told that without these names, they would not complete their investigation. The audit team then notified the PREA Administrator regarding these conversations and informed him that the agency did not appear to be investigating alleged breaches of confidential information obtained during PREA screenings. This was discussed with the PREA Administrator and his supervisor during a phone conference on April 17. Both agreed with the agency privacy investigators and stated that without names of perpetrators, allegations cannot be investigated. Deputy Director Lyne expanded this to include PREA allegations of sexual abuse and neglect, saying they cannot complete investigations if they do not know who to investigate. They were told by the audit team that the PREA standards require investigations of all allegations, regardless of whether the perpetrator is named, but they did not correct or withdraw their statements. They did say, however, that they will do everything they can to protect residents. The audit team expressed that additional items needed to be added to the CAP, but the audit team was informed verbally, and in writing, that the agency would not complete this section of the CAP. The agency provided no alternative CAP tasks that could be used to verify compliance. Information was provided to the audit team about some general privacy training that had been completed by staff and administrators. Also, they provided a memo that stated policy changes have been made regarding the administration of the SOGIE, and another memo about the tightening of privacy controls, but the updated policy was not provided, and verification of implementation was not provided.

Analysis:

Since the facility has not followed the CAP or proposed alternative acceptable tasks they can complete to show compliance with this standard, the finding of “Does Not Meet Standard” issued in the Interim Report must remain the auditor’s finding according to the rules provided to auditors by the U.S. Department of Justice via the PREA Resource Center and PREA Management Office.

Finding:

The facility has not shown full compliance with this standard.

REPORTING

Standard 115.351: Resident reporting

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

115.351 (a)

- Does the agency provide multiple internal ways for residents to privately report: Sexual abuse and sexual harassment? ☒ Yes ☐ No

- Does the agency provide multiple internal ways for residents to privately report: Retaliation by other residents or staff for reporting sexual abuse and sexual harassment? ☒ Yes ☐ No

- Does the agency provide multiple internal ways for residents to privately report: Staff neglect or violation of responsibilities that may have contributed to such incidents? ☒ Yes ☐ No

115.351 (b)

- Does the agency also provide at least one way for residents to report sexual abuse or sexual harassment to a public or private entity or office that is not part of the agency? ☒ Yes ☐ No

- Is that private entity or office able to receive and immediately forward resident reports of sexual abuse and sexual harassment to agency officials? ☒ Yes ☐ No

- Does that private entity or office allow the resident to remain anonymous upon request? ☒ Yes ☐ No

- Are residents detained solely for civil immigration purposes provided information on how to contact relevant consular officials and relevant officials at the Department of Homeland Security to report sexual abuse or harassment? ☒ Yes ☐ No

115.351 (c)

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

- Do staff members promptly document any verbal reports of sexual abuse and sexual harassment? ☒ Yes ☐ No

115.351 (d)

- Does the facility provide residents with access to tools necessary to make a written report? ☒ Yes ☐ No

- Does the agency provide a method for staff to privately report sexual abuse and sexual harassment of residents? ☒ Yes ☐ No

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

Washington State Juvenile Justice & Rehabilitation Administration Policy 590 (49) Applying the PREA Juvenile Standards in JR was reviewed by the auditor. The first 4 pages of this policy provides support for the requirements of this standard. Also, the facility provides handouts and other materials to assist understanding and compliance with the standard. Procedures have been established 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. All residents interviewed by the auditor knew they can report to any staff in writing or verbally, and that they can report by calling phone numbers they have been given and that have been posted around the facility. They also knew they can have someone on the outside, such as a family member or friend, make the report on their behalf. 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, as well. Also, policy mandates that staff accept reports of sexual abuse and sexual harassment made verbally, in writing, anonymously, and from third parties. The agency has established procedures for staff to privately report sexual abuse and sexual harassment of residents, and interviews indicate staff are aware of their options. NYC staff are required to report "immediately and without delay."

Analysis:
The information available to the auditor at the time of the PREA Audit Interim Report indicated that the facility had shown compliance with this standard. No corrective action was required. No information obtained since the time that report was completed has contradicted the finding of "Meets Standard."

Finding:
The facility has shown compliance with this standard in all material ways for the relevant review period.

Standard 115.352: Exhaustion of administrative remedies

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

115.352 (a)

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

115.352 (b)

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

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

115.352 (c)

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

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

115.352 (d)

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

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

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

115.352 (e)

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

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

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

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

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

115.352 (f)

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

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

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

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

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

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

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

115.352 (g)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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NYC abides by the State of Washington's Department of Social and Health Services Juvenile Rehabilitation policy regarding complaints, which was recently updated. This is an administrative process that incorporates PREA standards. Many agencies, and the language used in this PREA Standard, call these complaints "grievances", but JR labels them "complaints". Policy 2.10, Handling Youth Complaints, effective 8/15/2017, states, in section 5, "5.3. Complaints will be screened for allegations of sexual abuse or sexual harassment prior to assigning a staff to respond. 5.3.1. If a written complaint alleges sexual abuse or neglect, the local PREA Compliance Manager must be notified immediately, and the PREA Administrator or designee must be contacted within one business day of receiving the complaint. 5.3.2. Complaints alleging abuse and neglect must be reported in accordance with Policy 5.91, Reporting Abuse and Neglect of JR Youth and Policy 5.90, Applying the PREA Juvenile Standards in JR." Later in Section 10 of the policy, labeled Complaints Regarding Sexual Abuse or Sexual Harassment, it states, "10. Youth must be allowed to privately report the following items verbally, anonymously, or in writing (PREA Standard 115.351 (a)): 10.1. Incidents of sexual abuse and sexual harassment, 10.2. Retaliation by other youth or staff for reporting incidents 10.3. Staff neglect or violation of responsibilities that may have contributed to such incidents. 11. Staff must accept verbal reports, anonymous reports, written reports and reports from third parties regarding abuse or harassment of youth. (PREA Standard 115.351 (c)) 11.1. Complaints alleging abuse and/or harassment must be reported in accordance with Policy 5.91, Reporting Abuse and Neglect of JR Youth and Policy 5.90, Applying the PREA Juvenile Standards in JR. 11.2. Staff will document all reports on an Incident Report in ACT. 11.3. Staff will document the resolution and response for third parties using the Complaint Resolution and Response form (DSHS Form 20-263). 12. Youth must be provided a way to report abuse or harassment to Child Protective Services (CPS), allowing the youth to remain anonymous upon request. Children's Administration must receive and immediately forward youth reports to JR officials. (PREA Standard 115.351 (b)). Youth must be allowed to contact CPS directly at 1-866-END-HARM. 13. There is no time limit on when youth may submit a complaint regarding an allegation of sexual abuse. (PREA Standard 115.352 (b)(1)) 14. JR must assure that youth who allege sexual abuse may submit a complaint without submitting it to the staff member who is the alleged perpetrator. The complaint may not be referred to the staff member who is the alleged perpetrator for resolution. (PREA Standard 115.352 (c)) 15. JR may discipline a youth for filing a complaint related to alleged sexual abuse only where it is demonstrated that the youth filed the complaint in bad faith. (PREA Standard 115.352 (g)). 16. The Superintendent, Regional Administrator or designee will inform the victim of circumstances surrounding an allegation of sexual abuse. Communication will be documented on the existing Incident Report or Administrative Report of Incident. (PREA Standard 115. 373(a)) 16.1. Following an investigation into a youth's allegation of sexual abuse, the victim must be informed in writing as to whether the allegation has been determined to be substantiated, unsubstantiated, or unfounded. (PREA Standard 115. 373(a)) 16.2. Except when an allegation has been determined to be unfounded, following a youth's allegation that he or she has been sexually

abused by a staff member, the Superintendent, Regional Administrator or designee must inform the youth (DSHS Form 20-293) when: (PREA Standard 115. 373(c)) 16.2.1. The staff is no longer employed at the facility. 16.2.2. The staff has been indicted on a charge related to sexual abuse within the facility. 16.2.3. The staff has been convicted on a charge related to sexual abuse within the facility. 16.3. Following a youth's allegation that he or she has been sexually abused by another youth, the Superintendent, Regional Administrator or designee must inform the youth (DSHS Form 20-294) whenever either of the following occur (PREA Standard 115.373(d)) 16.3.1. The alleged abuser has been indicted on a charge related to sexual abuse within the facility. 16.3.2. The alleged abuser has been convicted on a charge related to sexual abuse within the facility. 16.4. The obligation to inform the youth under sections 15.1, 15.2, and 15.3 of this policy shall terminate if the youth is released from JR care. (PREA Standard 115.373(f))" The policy 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. The policy requires all complaints to be responded to within 7 days and appeals to be responded to within 21 days. The complaint system shares the same box with PREA complaints. However, interviews with the PREA Administrator, PREA Compliance Manager, and other administrators, indicate that allegations of sexual abuse and harassment placed in the box are removed and handled according to PREA policies, outside of the complaint system. It appears that, perhaps out of an abundance of caution, the policies of both systems have been made PREA compliant. Brian Harlow, PREA Compliance Manager/Residential Programs explained that his office maintains documentation regarding both systems and provided the auditor with an example spreadsheet. One benefit of this tracking system would be to catch harassment that might otherwise be missed. Incidents involving a single use of abusive language, for example, may not be viewed as harassment because, by PREA definition, harassment is "repeated". However, if a resident is written up for several single incidents of sexually abusive language, the PREA office will evaluate the incidents closely to see if the situation might indicate a suspicion of sexual harassment. If so, an investigation would be initiated. The auditor believes the facility has shown compliance with this standard, despite the PREA Administrator's repeated insistence that this standard does not apply. The auditor has discussed this issue through the systems provided to assist auditors via the PREA Resource Center. Since this is a facility audit rather than an agency audit, and the facility appears to follow this standard despite the agency, the facility can be found to be in compliance with the standard. The audit team found no effort by the agency to hinder the facility from following this standard and related policies.

Analysis:
The information available to the auditor at the time of the PREA Audit Interim Report indicated that the facility had shown compliance with this standard. No corrective action was required. No information obtained since the time that report was completed has contradicted the finding of "Meets Standard."

Finding:
The facility has shown compliance with this standard in all material ways for the relevant review period.

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 assessible mailing

addresses and telephone numbers, including toll-free hotline numbers where available, of local, State, or national victim advocacy or rape crisis organizations? ☒ Yes ☐ No

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

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

115.353 (b)

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

115.353 (c)

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

- Does the agency maintain copies of agreements or documentation showing attempts to enter into such agreements? ☒ Yes ☐ No

115.353 (d)

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

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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not meet the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Washington State Juvenile Justice and Rehabilitation Administration Policy 5.90 (49) Applying the PREA Juvenile Standards in JR is just one of the policies supporting this standard. Providing Health Care to Youth policy, The Memorandum of Understanding for Victim Advocate Services, and the Naselle Youth Camp Sexual Assault Response Plan also support practices consistent with this standard. NYC provides residents access to outside victim advocates for emotional support services related to sexual abuse and by providing, posting, and otherwise making accessible the mailing addresses and telephone numbers of sexual abuse advocates. Staff and administrators verify that the facility does inform residents, prior to giving them access to outside support services, the extent to which such communications will be monitored and 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. The facility provides residents with reasonable and confidential access to their attorneys or other legal representation, as well as reasonable access to parents or legal guardians. Interviews with staff and residents confirm a belief that outside support is available. Residents interviewed state they feel safe and are convinced they could report anything without retaliation, and could use outside services if needed, and that they can have private visits. The auditor verified outside confidential support services by speaking with Jennifer Mitchell, General Crimes Program Coordinator at Crisis Support Network.

Analysis:
The information available to the auditor at the time of the PREA Audit Interim Report indicated that the facility had shown compliance with this standard. No corrective action was required. No information obtained since the time that report was completed has contradicted the finding of “Meets Standard.”

Finding:
The facility has shown compliance with this standard in all material ways for the relevant review period.

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 agency provides a method to receive third-party reports of resident sexual abuse or sexual harassment. The audit team was provided a digital picture of the End Harm reporting line, which was posted in the NYC visitation area after the on-site audit. Policy clearly states any staff member is required to take complaints, and complaints can be anonymous. Also, the agency website explains ways to report, and provides methods to report: https://www.dshs.wa.gov/ra/juvenile-rehabilitation/prison-rape-elimination-act-compliance

Analysis:
The information available to the auditor at the time of the PREA Audit Interim Report indicated that the facility had shown compliance with this standard. No corrective action was required. No information obtained since the time that report was completed has contradicted the finding of "Meets Standard."

Finding:
The facility has shown compliance with this standard in all material ways for the relevant review period.

OFFICIAL RESPONSE FOLLOWING A RESIDENT REPORT

Standard 115.361: Staff and agency reporting duties

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

115.361 (a)

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

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

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

115.361 (b)

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

115.361 (c)

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

115.361 (d)

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

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

115.361 (e)

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

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

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

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

115.361 (f)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

It is required that all staff report immediately and according to agency policy: any knowledge, suspicion, or information they receive regarding an incident of sexual abuse or sexual harassment that occurred. Washington State Juvenile Justice and Rehabilitation Administration Policy 5.90 (49) Applying the PREA Juvenile Standards in JR also requires the reporting of any retaliation against residents or staff who reported such an incident, as well as any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation. The agency requires all staff to comply with any applicable mandatory child abuse reporting laws, as well as reports, as (and when) appropriate, to licensing agencies. 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. Medical and mental health practitioners are mandated reporters and are required to inform residents, at the initiation of services, of their duty to report and the limitations of confidentiality. Upon receiving any allegation of sexual abuse, the facility promptly reports 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 will 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 head or designee will also report the allegation to the juvenile's attorney or other legal representative of record within 14 days of receiving the allegation. Interviews with the Superintendent, Assistant Superintendent and PREA Compliance Manager, and others, indicate administrators are aware of these policies, and follow them. Also, the audit team reviewed reports that have been made, and screenings completed, in compliance with this standard.

Analysis:
The information available to the auditor at the time of the PREA Audit Interim Report indicated that the facility had shown compliance with this standard. No corrective action was required. No information obtained since the time that report was completed has contradicted the finding of "Meets Standard."

Finding:
The facility has shown compliance with this standard in all material ways for the relevant review period.

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.

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. In the past 12 months, according to the PAQ, there have been no instances in which the facility determined that a resident was subject to substantial risk of imminent sexual abuse. Interviews with both residents and staff indicate a belief that the facility will follow this standard. Washington State Juvenile Justice and Rehabilitation Administration Policy 5.90 (49) Applying the PREA Juvenile Standards in JR provides written requirements in compliance with this policy, as well as the staff training curriculum and related handouts.

Analysis:
The information available to the auditor at the time of the PREA Audit Interim Report indicated that the facility had shown compliance with this standard. No corrective action was required. No information obtained since the time that report was completed has contradicted the finding of "Meets Standard."

Finding:
The facility has shown compliance with this standard in all material ways for the relevant review period.

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 facility has a policy (Washington State Juvenile Justice and Rehabilitation Administration Policy 5.90 (49) Applying the PREA Juvenile Standards in JR; Section 20) requiring that, upon receiving an allegation that a resident was sexually abused while confined at another facility, the Facility Administrator, as soon as possible (but no later than 72 hours), must notify the head of the facility or appropriate office of the agency or facility where sexual abuse is alleged to have occurred. Protective Services and law enforcement will also be contacted as appropriate. There have been no such reports in the past 12 months, so the auditor did not have this type of documentation to review in determining compliance. The agency is required to document that it has provided such notification within 72 hours of receiving the allegation. The policy also requires that allegations received from other facilities/agencies are investigated in accordance with the PREA standards. Interviews with the PREA Administrator (who served as the designee for the Agency Head), the facility Superintendent, and PREA Compliance Manager indicate and understanding of this standard.

Analysis:

The information available to the auditor at the time of the PREA Audit Interim Report indicated that the facility had shown compliance with this standard. No corrective action was required. No information obtained since the time that report was completed has contradicted the finding of “Meets Standard.”

Finding:
The facility has shown compliance with this standard in all material ways for the relevant review period.

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 agency has a first responder policy for allegations of sexual abuse. Washington State Juvenile Justice and Rehabilitation Administration Policy 5.90 (49) Applying the PREA Juvenile Standards in JR provides the official policy and the Naselle Youth Camp Sexual Assault Response Plan guides the actions at this facility. Staff and administrators interviewed seem to know the basics of these first responder duties and know whom to call, and how to get questions answered.

Analysis:
The information available to the auditor at the time of the PREA Audit Interim Report indicated that the facility had shown compliance with this standard. No corrective action was required. No information obtained since the time that report was completed has contradicted the finding of "Meets Standard."

Finding:
The facility has shown compliance with this standard in all material ways for the relevant review period.

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.

NYC has 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. This plan, called the Naselle Youth Camp Sexual Assault Response Plan, was provided to the auditor, and discussed during interviews with the PREA Administrator, Investigators, PREA Compliance Manager, and others. The written policy, as well as practice, requires the plan to be reviewed and updated at least annually for accuracy. Supportive of the Coordinated Response Plan is NYC's participation in the Sexual Assault and Domestic Violence Prevention and Response Collaborative Memorandum of Understanding with the Crisis Support Network, Pacific County's Sheriff's Office, Pacific County Prosecuting Attorney's Office, Shoalwater Bay Tribe Police Department, City of South Bend Police Department, City of Raymond Police Department, City of Long Beach Police Department, and Raymond School District.

Analysis:
The information available to the auditor at the time of the PREA Audit Interim Report indicated that the facility had shown compliance with this standard. No corrective action was required. No information obtained since the time that report was completed has contradicted the finding of "Meets Standard."

Finding:
The facility has shown compliance with this standard in all material ways for the relevant review period.

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.

Compliance with this standard was verified through a review of the applicable section of their collective bargaining agreement. Interviews with staff with HR responsibilities, and forms to be used regarding staff misconduct, indicate the facility maintains the ability to protect residents from abusers. The Washington State Juvenile Justice and Rehabilitation Administration Policy 5.90 (49) Applying the PREA Juvenile Standards in JR also makes this clear.

Analysis:
The information available to the auditor at the time of the PREA Audit Interim Report indicated that the facility had shown compliance with this standard. No corrective action was required. No information obtained since the time that report was completed has contradicted the finding of "Meets Standard."

Finding:
The facility has shown compliance with this standard in all material ways for the relevant review period.

Standard 115.367: Agency protection against retaliation

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

115.367 (a)

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

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

115.367 (b)

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

115.367 (c)

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

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

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

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

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

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

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

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

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

115.367 (d)

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

115.367 (e)

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

115.367 (f)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

NYC has a policy to protect all residents and staff, or any cooperating individual who reports sexual abuse or sexual harassment or cooperates with sexual abuse or sexual harassment investigations, from retaliation by other residents or staff. The PREA Compliance Manager, Cary Bloom, and Associate Superintendent Spencer Mooers, are tasked with primary responsibility for monitoring retaliation, with assistance from HR, as well as from agency PREA Administrator Eric Crawford. They monitor 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. They examine resident disciplinary reports, housing or program changes, or negative performance reviews or reassignments of staff. They continue such monitoring beyond 90 days, if the initial monitoring indicates a continuing need. In the case of residents, such monitoring also includes periodic status checks. The agency/facility acts promptly to remedy any such retaliation. The auditor reviewed allegations of sexual abuse and/or harassment received by the facility during the past 12 months and found good documentation of retaliation monitoring. Washington State Juvenile Justice and Rehabilitation Administration Policy 5.90 (49) Applying the PREA Juvenile Standards in JR, Section 28, codifies the requirements of this standard.

Analysis:
The information available to the auditor at the time of the PREA Audit Interim Report indicated that the facility had shown compliance with this standard. No corrective action was required. No information obtained since the time that report was completed has contradicted the finding of "Meets Standard."

Finding:
The facility has shown compliance with this standard in all material ways for the relevant review period.

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 agency has a policy that residents who allege to have suffered sexual abuse may only be placed in isolation as a last resort. In the past 12 months no residents have been isolated or segregated at NYC for their protection, according to interviews conducted and reports reviewed. Policies to support this standard include the Washington State Juvenile Justice and Rehabilitation Administration Policy 5.90 (49) Applying the PREA Juvenile Standards in JR.

Analysis:
The information available to the auditor at the time of the PREA Audit Interim Report indicated that the facility had shown compliance with this standard. No corrective action was required. No information obtained since the time that report was completed has contradicted the finding of "Meets Standard."

Finding:
The facility has shown compliance with this standard in all material ways for the relevant review period.

INVESTIGATIONS

Standard 115.371: Criminal and administrative agency investigations

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

115.371 (a)

- When the agency conducts its own investigations into allegations of sexual abuse and sexual harassment, does it do so promptly, thoroughly, and objectively? [N/A if the agency/facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations. See 115.321(a).] ☐ Yes ☒ No ☐ NA

- Does the agency conduct such investigations for all allegations, including third party and anonymous reports? [N/A if the agency/facility is not responsible for conducting any form of

criminal OR administrative sexual abuse investigations. See 115.321(a).]
☐ Yes ☒ No ☐ NA

115.371 (b)

- Where sexual abuse is alleged, does the agency use investigators who have received specialized training in sexual abuse investigations involving juvenile victims as required by 115.334? ☐ Yes ☒ No

115.371 (c)

- Do investigators gather and preserve direct and circumstantial evidence, including any available physical and DNA evidence and any available electronic monitoring data? ☒ Yes ☐ No

- Do investigators interview alleged victims, suspected perpetrators, and witnesses?
☒ Yes ☐ No

- Do investigators review prior reports and complaints of sexual abuse involving the suspected perpetrator? ☒ Yes ☐ No

115.371 (d)

- Does the agency always refrain from terminating an investigation solely because the source of the allegation recants the allegation? ☒ Yes ☐ No

115.371 (e)

- When the quality of evidence appears to support criminal prosecution, does the agency conduct compelled interviews only after consulting with prosecutors as to whether compelled interviews may be an obstacle for subsequent criminal prosecution? ☒ Yes ☐ No

115.371 (f)

- Do agency investigators assess the credibility of an alleged victim, suspect, or witness on an individual basis and not on the basis of that individual's status as resident or staff?
☒ Yes ☐ No

- Does the agency investigate allegations of sexual abuse without requiring a resident who alleges sexual abuse to submit to a polygraph examination or other truth-telling device as a condition for proceeding? ☒ Yes ☐ No

115.371 (g)

- Do administrative investigations include an effort to determine whether staff actions or failures to act contributed to the abuse? ☐ Yes ☒ No

- Are administrative investigations documented in written reports that include a description of the physical evidence and testimonial evidence, the reasoning behind credibility assessments, and investigative facts and findings? ☐ Yes ☒ No

115.371 (h)

- Are criminal investigations documented in a written report that contains a thorough description of the physical, testimonial, and documentary evidence and attaches copies of all documentary evidence where feasible? ☐ Yes ☒ No

115.371 (i)

- Are all substantiated allegations of conduct that appears to be criminal referred for prosecution? ☒ Yes ☐ No

115.371 (j)

- Does the agency retain all written reports referenced in 115.371(g) and (h) for as long as the alleged abuser is incarcerated or employed by the agency, plus five years unless the abuse was committed by a juvenile resident and applicable law requires a shorter period of retention? ☒ Yes ☐ No

115.371 (k)

- Does the agency ensure that the departure of an alleged abuser or victim from the employment or control of the agency does not provide a basis for terminating an investigation? ☒ Yes ☐ No

115.371 (l)

- Auditor is not required to audit this provision.

115.371 (m)

- When an outside entity investigates sexual abuse, does the facility cooperate with outside investigators and endeavor to remain informed about the progress of the investigation? (N/A if an outside agency does not conduct administrative or criminal sexual abuse investigations. See 115.321(a).) ☒ Yes ☐ No ☐ NA

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's

conclusions. This discussion must also include corrective action recommendations where the facility does not meet the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

According to the investigations reviewed during the Pre-Audit and On-Site Audit Process, the administrative investigations completed by facility investigators into allegations of sexual abuse and sexual harassment were not always done promptly, thoroughly, and objectively for all allegations. These administrative investigations did not always include a documented effort to determine whether staff actions or failures to act contributed to the abuse. Investigations reviewed were not always documented in written reports which include a description of the physical and testimonial evidence, the reasoning behind credibility assessments, and investigative facts and findings.

Corrective Action Required:
The CAP addressed the deficiencies identified, and completed investigations were provided to the audit team that seemed to be consistent with all parts of this standard. The audit team provided positive feedback to the facility and the agency to indicate that the documentation provided showed compliance with the standard. The agency was reminded, however, that compliance has to be verified and maintained throughout the duration of the CAP, so all new allegations and investigations must continue to be provided to the auditor, as explicitly stated in the CAP. The audit team was then notified by the PREA Administrator, and the PREA Administrator's supervisor, during a April 17 conference call, as well as by documentation provided by emails, that the current policy was no longer in place and the current investigators would no longer be doing the investigations. The audit team was also notified during the conference call that if allegations do not list a perpetrator, the allegations will not be investigated. The auditor has determined that the previous materials provided for compliance cannot be used because the policy is now different and different investigators are assigned. There was no verification provided of time frames, policy implementations, or investigative materials from the new investigators. Therefore, as of the date of this report, the facility has not shown sustained compliance with this standard.

Analysis:
The facility has not shown compliance with the standard, or the CAP, regarding the investigators who are currently assigned. Compliance work that was completed regarding previous investigators who are no longer allowed to do investigations is not relevant to current compliance or practice. In addition, facilities are required to show sustained compliance.

Finding:
The facility does not show compliance with this standard.

Standard 115.372: Evidentiary standard for administrative investigations

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

115.372 (a)

- Is it true that the agency does not impose a standard higher than a preponderance of the evidence in determining whether allegations of sexual abuse or sexual harassment are substantiated? ☒ Yes ☐ No

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

As verified by interviews with administrators and a review of policy (Washington State Juvenile Justice and Rehabilitation Administration Policy 5.90 (49) Applying the PREA Juvenile Standards in JR), the agency imposes a standard of a preponderance of the evidence when determining whether allegations of sexual abuse or sexual harassment are substantiated. Although this standard was not on the CAP, it was demonstrated during the CAP when the auditor reviewed investigations completed by the facility's assigned investigator. Although the agency states there is a revised policy (which has not been provided to the audit team), and states that the facility investigator will no longer be doing investigations, there is no indication that the agency is undermining the facility's demonstrated compliance with this standard.

Analysis:
The information available to the auditor at the time of the PREA Audit Interim Report indicated that the facility had shown compliance with this standard. No corrective action was required. No information obtained since the time that report was completed has contradicted the finding of "Meets Standard."

Finding:
The facility has shown compliance with this standard in all material ways for the relevant review period.

Standard 115.373: Reporting to residents

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

115.373 (a)

- Following an investigation into a resident's allegation that he or she suffered sexual abuse in an agency facility, does the agency inform the resident as to whether the allegation has been determined to be substantiated, unsubstantiated, or unfounded? ☒ Yes ☐ No

115.373 (b)

- If the agency did not conduct the investigation into a resident's allegation of sexual abuse in an agency facility, does the agency request the relevant information from the investigative agency in order to inform the resident? (N/A if the agency/facility is responsible for conducting administrative and criminal investigations.) ☒ Yes ☐ No ☐ NA

115.373 (c)

- Following a resident's allegation that a staff member has committed sexual abuse against the resident, unless the agency has determined that the allegation is unfounded, or unless the resident has been released from custody, does the agency subsequently inform the resident whenever: The staff member is no longer posted within the resident's unit? ☐ Yes ☒ No

- Following a resident's allegation that a staff member has committed sexual abuse against the resident, unless the agency has determined that the allegation is unfounded, or unless the resident has been released from custody, does the agency subsequently inform the resident whenever: The staff member is no longer employed at the facility? ☐ Yes ☒ No

- Following a resident's allegation that a staff member has committed sexual abuse against the resident, unless the agency has determined that the allegation is unfounded, or unless the resident has been released from custody, does the agency subsequently inform the resident whenever: The agency learns that the staff member has been indicted on a charge related to sexual abuse in the facility? ☐ Yes ☒ No

- Following a resident's allegation that a staff member has committed sexual abuse against the resident, unless the agency has determined that the allegation is unfounded, or unless the resident has been released from custody, does the agency subsequently inform the resident whenever: The agency learns that the staff member has been convicted on a charge related to sexual abuse within the facility? ☐ Yes ☒ No

115.373 (d)

- Following a resident's allegation that he or she has been sexually abused by another resident, does the agency subsequently inform the alleged victim whenever: The agency learns that the alleged abuser has been indicted on a charge related to sexual abuse within the facility? ☒ Yes ☐ No

- Following a resident's allegation that he or she has been sexually abused by another resident, does the agency subsequently inform the alleged victim whenever: The agency learns that the alleged abuser has been convicted on a charge related to sexual abuse within the facility? ☒ Yes ☐ No

115.373 (e)

- Does the agency document all such notifications or attempted notifications? ☐ Yes ☒ No

115.373 (f)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

Although the agency has a policy requiring that any resident who makes an allegation that he or she suffered sexual abuse in the facility is notified as to whether the allegation has been determined to be substantiated, unsubstantiated, or unfounded following an investigation, and that the notification is documented, it was not clear at the time of the Interim PREA Audit Report whether this standard was fully implemented in the agency culture regarding all investigations. Not all investigative paperwork reviewed, or interviews with investigators, indicated a sustained and reliable practice of accurately notifying residents of investigative findings.

Corrective Action Required:
The CAP addressed the deficiencies identified, and completed investigations were provided to the audit team, including notification of residents. In addition, the facility investigators provided documentation that they had completed additional training. The audit team provided positive feedback to the facility and the agency to indicate that the documentation provided showed compliance with the standard. The agency was reminded, however, that compliance has to be verified and maintained throughout the duration of the CAP, so all new allegations and investigations must continue to be provided to the auditor, as explicitly stated in the CAP. The audit team was then notified by the PREA Administrator, and the PREA Administrator's supervisor, during an April 17 conference call, as well as by documentation provided via email, that the current investigative policy/procedure was no longer in place and the current investigators would no longer be doing the investigations. This means the previous materials provided for compliance cannot be used because the policy is now different and different investigators are assigned. Despite promises, there was no verification provided of time frames, policy implementations, investigative training, or notifications to residents from the new investigators. Therefore, as of the date of this Final Report, the facility has not shown sustained compliance with this standard.

Analysis:
The facility has not shown compliance with the standard, or the CAP, regarding the investigators who are currently assigned. Compliance work that was completed regarding previous investigators who are no longer allowed to do investigations is not relevant to current compliance or practice. In addition, facilities are required to show sustained compliance.

Finding:
The facility does not meet this standard.

DISCIPLINE

Standard 115.376: Disciplinary sanctions for staff

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

115.376 (a)

- Are 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.

Some documentation regarding allegations and investigations regarding staff were not made available to the auditor for review by the time of the writing of the Interim Report. These documents were not available to the PREA Compliance Manager either. The Interim Report explained that verification of this standard cannot be accomplished until verification of § 115.371 (above) is accomplished. Investigations have to be done according to standards and policies before adequate judgments can be made regarding whether the related disciplinary sanctions for staff are justified. Also, compliance with this standard is connected with § 115.311. Interviews with the facility PREA Compliance Manager, facility investigators, and facility Assistant Superintendent indicated that nobody was keeping track of whether investigations of employees were PREA compliant. The investigations were reviewed by the facility Superintendent, and other high-ranking officials, but not for PREA compliance. The agency PREA Administrator acknowledged that the investigations he reviewed were not being completed correctly. He requested the auditor to do training during the on-site audit and/or exit briefing. He stated that the investigators do not listen to or heed his instructions. The Interim Report stated, “Since investigations regarding staff have not been shown, during this audit, to be subject to PREA compliance management, verification of compliance of this standard needs to be achieved during the Corrective Action Period.”

Corrective Action Required:
The CAP addressed the deficiencies identified regarding investigations, and completed investigations were provided to the audit team, absent any indications of sanctions (or lack of sanctions) for accused staff. The auditor interviewed a facility investigator during the CAP who seemed to understand this standard. Documentation was provided that indicated facility investigators had been given additional investigative training. However, the PREA management issue regarding employees was never shown to be resolved. The audit team was then notified by the PREA Administrator, and the PREA Administrator’s supervisor, during a conference call, as well as by documentation provided via email, that the current policy regarding investigations was no longer in place and the current investigators would no longer be doing investigations. One document indicated there had been findings, other than those in this audit, that there were problems with investigations. While a change in course might have been a wise decision, this made the extra training, documentation reviews, interviews, and CAP, no longer relevant to current compliance. The audit team offered to negotiate changes to the CAP and/or review anything that could be used to verify compliance. Nothing was provided to show compliance with this standard going forward under any proposed new system.

Analysis:
Since the issues related to staff accountability raised in the PREA Audit Interim Report and subsequent CAP were not fully resolved; and since new concerns were raised about compliance during the corrective action period, that were not resolved; the finding of “Does not Meet Standard” in the Interim Report remains in effect. Information about how facilities can show compliance was always available from the audit team as well as the PREA Resource Center throughout this process. Instructions regarding how auditors can determine compliance is available in auditor training and in the PREA Auditor’s Handbook. The agency PREA Administrator is a DOJ Certified PREA Auditor and acknowledged that he can access all resources.

Finding:
The facility has not shown full compliance with this standard.

Standard 115.377: Corrective action for contractors and volunteers

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

115.377 (a)

- Is any contractor or volunteer who engages in sexual abuse prohibited from contact with residents? ☒ Yes ☐ No
- Is any contractor or volunteer who engages in sexual abuse reported to: Law enforcement agencies (unless the activity was clearly not criminal)? ☒ Yes ☐ No
- Is any contractor or volunteer who engages in sexual abuse reported to: Relevant licensing bodies? ☒ Yes ☐ No

115.377 (b)

- In the case of any other violation of agency sexual abuse or sexual harassment policies by a contractor or volunteer, does the facility take appropriate remedial measures, and consider whether to prohibit further contact with residents? ☒ Yes ☐ No

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

NYC 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, according to the PAQ, no contractors or volunteers have been reported to law enforcement agencies and relevant licensing bodies for engaging in sexual abuse of residents, because there were no allegations or findings. 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. Compliance with this standard was verified through a review of policy (Washington State Juvenile Justice and Rehabilitation Administration Policy 5.90 (49) Applying the PREA Juvenile Standards in JR; Section 34), other documentation provided to volunteers, and interviews with administrators who supervise volunteers.

Analysis:

The information available to the auditor at the time of the PREA Audit Interim Report indicated that the facility had shown compliance with this standard. No corrective action was required. No information obtained since the time that report was completed has contradicted the finding of “Meets Standard.”

Finding:
The facility has shown compliance with this standard in all material ways for the relevant review period.

Standard 115.378: Interventions and disciplinary sanctions for residents

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

115.378 (a)

- Following an administrative finding that a resident engaged in resident-on-resident sexual abuse, or following a criminal finding of guilt for resident-on-resident sexual abuse, may residents be subject to disciplinary sanctions only pursuant to a formal disciplinary process? ☒ Yes ☐ No

115.378 (b)

- Are disciplinary sanctions commensurate with the nature and circumstances of the abuse committed, the resident’s disciplinary history, and the sanctions imposed for comparable offenses by other residents with similar histories? ☒ Yes ☐ No

- In the event a disciplinary sanction results in the isolation of a resident, does the agency ensure the resident is not denied daily large-muscle exercise? ☒ Yes ☐ No

- In the event a disciplinary sanction results in the isolation of a resident, does the agency ensure the resident is not denied access to any legally required educational programming or special education services? ☒ Yes ☐ No

- In the event a disciplinary sanction results in the isolation of a resident, does the agency ensure the resident receives daily visits from a medical or mental health care clinician? ☒ Yes ☐ No

- In the event a disciplinary sanction results in the isolation of a resident, does the resident also have access to other programs and work opportunities to the extent possible? ☒ Yes ☐ No

115.378 (c)

- When determining what types of sanction, if any, should be imposed, does the disciplinary process consider whether a resident’s mental disabilities or mental illness contributed to his or her behavior? ☒ Yes ☐ No

115.378 (d)

- If the facility offers therapy, counseling, or other interventions designed to address and correct underlying reasons or motivations for the abuse, does the facility consider whether to offer the offending resident participation in such interventions? ☒ Yes ☐ No

- If the agency requires participation in such interventions as a condition of access to any rewards-based behavior management system or other behavior-based incentives, does it always refrain from requiring such participation as a condition to accessing general programming or education? ☒ Yes ☐ No

115.378 (e)

- Does the agency discipline a resident for sexual contact with staff only upon a finding that the staff member did not consent to such contact? ☒ Yes ☐ No

115.378 (f)

- For the purpose of disciplinary action does a report of sexual abuse made in good faith based upon a reasonable belief that the alleged conduct occurred NOT constitute falsely reporting an incident or lying, even if an investigation does not establish evidence sufficient to substantiate the allegation? ☒ Yes ☐ No

115.378 (g)

- Does the agency always refrain from considering non-coercive sexual activity between residents to be sexual abuse? (N/A if the agency does not prohibit all sexual activity between residents.) ☒ Yes ☐ No ☐ NA

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

According to a review of Washington State Juvenile Justice and Rehabilitation Administration Policy 5.90 (49) Applying the PREA Juvenile Standards in JR, the facility is governed by policy consistent with this standard. Verification of compliance with this standard was also based on interviews with staff and administrators who make administrative determinations regarding youth misconduct, investigative materials received, and materials provided for youth regarding their rules and rights.

Analysis:

The information available to the auditor at the time of the PREA Audit Interim Report indicated that the facility had shown compliance with this standard. No corrective action was required. No information obtained since the time that report was completed has contradicted the finding of “Meets Standard.”

Finding:
The facility has shown compliance with this standard in all material ways for the relevant review period.

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.

All residents at Naselle Youth Camp who have disclosed any prior sexual victimization during a screening pursuant to ß115.341 are offered a follow-up meeting with a medical or mental health practitioner within 14 days of the intake screening. In the past 12 months all residents who disclosed prior victimization during screening were offered a follow-up meeting with a medical or mental health practitioner, according to the PAQ and interviews with the PREA Compliance Manager who keeps records of these referrals. Medical and mental health staff interviewed also indicated that they maintain secondary materials documenting compliance with the above required services. Compliance with this standard was also verified through a review of policy, screenings provided to the audit team, and interviews with screeners and administrators.

Analysis:
The information available to the auditor at the time of the PREA Audit Interim Report indicated that the facility had shown compliance with this standard. No corrective action was required. No information obtained since the time that report was completed has contradicted the finding of "Meets Standard."

Finding:
The facility has shown compliance with this standard in all material ways for the relevant review period.

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.

According to policy reviewed, and interviews conducted, 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 to be determined by medical and mental health practitioners according to their professional judgment. Medical and mental health staff document the timeliness of emergency medical treatment and crisis intervention services 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 sexually transmitted infection prophylaxis. Treatment services will be provided to the victim without financial cost, and regardless of whether the victim names the abuser or cooperates with the investigation. Information about these services is provided in the Resident Handbook, as well as in signs posted in the facility, which are well-placed, and which are easy to understand. The End Harm Hotline, 1-866-363-4276, answered by Child Protective Services, is posted. Information is also posted about how to access advocacy and medical services regarding sexual abuse. Advocacy is provided by Crisis Support Network (800-435-7276). The auditor reviewed the Memorandum of Understanding between NYC and Crisis Support Network and called the 24-hour Crisis Support Network Help Line. The auditor spoke with Advocate Jennifer Mitchell, who is also the General Crimes Program Coordinator. She confirms a working relationship with NYC involving training of both staff and residents and knows of no barriers to a NYC youth receiving services from

their network. For forensic exams, Sexual Assault Nurse Examiners (SANEs) are available at Peace Health St. John Medical Center in Longview, Washington.

Analysis:
The information available to the auditor at the time of the PREA Audit Interim Report indicated that the facility had shown compliance with this standard. No corrective action was required. No information obtained since the time that report was completed has contradicted the finding of “Meets Standard.”

Finding:
The facility has shown compliance with this standard in all material ways for the relevant review period.

Standard 115.383: Ongoing medical and mental health care for sexual abuse victims and abusers

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

115.383 (a)

- Does the facility offer medical and mental health evaluation and, as appropriate, treatment to all residents who have been victimized by sexual abuse in any prison, jail, lockup, or juvenile facility? ☒ Yes ☐ No

115.383 (b)

- Does the evaluation and treatment of such victims include, as appropriate, follow-up services, treatment plans, and, when necessary, referrals for continued care following their transfer to, or placement in, other facilities, or their release from custody? ☒ Yes ☐ No

115.383 (c)

- Does the facility provide such victims with medical and mental health services consistent with the community level of care? ☒ Yes ☐ No

115.383 (d)

- Are resident victims of sexually abusive vaginal penetration while incarcerated offered pregnancy tests? (N/A if all-male facility.) ☐ Yes ☐ No ☒ NA

115.383 (e)

- If pregnancy results from the conduct described in paragraph § 115.383(d), do such victims receive timely and comprehensive information about and timely access to all lawful pregnancy-related medical services? (N/A if all-male facility.) ☐ Yes ☐ No ☒ NA

115.383 (f)

- Are resident victims of sexual abuse while incarcerated offered tests for sexually transmitted infections as medically appropriate? ☒ Yes ☐ No

115.383 (g)

- Are treatment services provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident? ☒ Yes ☐ No

115.383 (h)

- Does the facility attempt to conduct a mental health evaluation of all known resident-on-resident abusers within 60 days of learning of such abuse history and offer treatment when deemed appropriate by mental health practitioners? ☒ Yes ☐ No

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

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, as required by this PREA standard. Resident victims of sexual abuse while incarcerated are offered tests for sexually transmitted infections as medically appropriate. 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. The facility attempts to conduct a mental health evaluation of all known resident-on-resident abusers within 60 days of learning of such history. The evaluation and treatment of such victims includes, 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 facility provides such victims with medical and mental health services consistent with the community level of care. The audit team reviewed documentation and conducted interviews which confirmed compliance with this standard. Also, the auditor reviewed the Washington State Juvenile Justice and Rehabilitation Administration Policy 5.90 (49) Applying the PREA Juvenile Standards in JR.

Analysis:
The information available to the auditor at the time of the PREA Audit Interim Report indicated that the facility had shown compliance with this standard. No corrective action was required. No information obtained since the time that report was completed has contradicted the finding of "Meets Standard."

Finding:
The facility has shown compliance with this standard in all material ways for the relevant review period.

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.

According to the documentation provided to the audit team, the facility did not have any investigations, during the 12 months prior to the Pre-Audit Questionnaire, that required a sexual abuse incident review, referred to as a Post-Incident Review in policy. Washington State Juvenile Justice and Rehabilitation Administration Policy 5.90 (49) Applying the PREA Juvenile Standards in JR was reviewed by the auditor. This policy, which was approved 02-11-2015, requires these reviews on page 10 (policy section 47). In addition, the PREA Administrator, PREA Compliance Manager, and Investigators interviewed all stated that the policy is practiced. The PREA Audit Interim Report for Naselle Youth Center found the facility in compliance with this standard even though no Post-Incident Reviews had been reviewed. While standard 115.386 was not explicitly and officially part of the CAP, there were investigations completed during the CAP period, and these investigations were subject to the CAP. One of these investigations was an unsubstantiated allegation of sexual abuse, so it required a Post-Incident Review be completed, and this documentation was provided to the auditor for review. The Post-Incident Review contained all the minimum requirements of this standard, and agency policy, so the auditor continues to believe the facility has shown compliance with this standard. On May 17, 2018, PREA Administrator Eric Crawford stated in an email, "To address issues associated with investigations (CAP items 115.322, 334, 371, 373 and 376) our management team has determined that myself and Brian Harlow, HQ PREA Compliance Manager, will be the designated investigators for all facilities. . . ." Although the audit team has been provided of no verification of this new determination being in practice, and therefore cannot attest to whether the agency is following their policies regarding investigations, the audit team has received no indication that any superseding policy or directives undermines compliance, as verified in practice, with 115.386.

Analysis:
The information available to the auditor at the time of the PREA Audit Interim Report indicated that the facility had shown compliance with this standard. No corrective action was required. No information obtained since the time that report was completed has contradicted the finding of "Meets Standard."

Finding:
The facility has shown compliance with this standard in all material ways for the relevant review period.

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 agency collects accurate, uniform data for every allegation of sexual abuse at facilities, 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 Violence conducted by the Department of Justice. The agency aggregates the incident-based sexual abuse data at least annually. The agency maintains, reviews, and collects data as needed from all available incident-based documents, including reports, investigation files, and sexual abuse incident reviews. Washington State Juvenile Justice and Rehabilitation Administration Policy 5.90 (49) Applying the PREA Juvenile Standards in JR was reviewed by the auditor. Section 49 of this policy deals with the requirements of this standard. In addition, the audit team reviewed data collected by the agency in the past, other documentation tracking that data, and interviewed the PREA Administrator, to determine that the facility has shown compliance with this standard.

Analysis:
The information available to the auditor at the time of the PREA Audit Interim Report indicated that the facility had shown compliance with this standard. No corrective action was required. No information obtained since the time that report was completed has contradicted the finding of "Meets Standard."

Finding:
The facility has shown compliance with this standard in all material ways for the relevant review period.

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.

Washington State Juvenile Justice and Rehabilitation Administration Policy 5.90 (49) Applying the PREA Juvenile Standards in JR was reviewed by the auditor. Section 49 of this policy deals with the requirements of this standard. The facility and agency review data collected and aggregated pursuant to ß115.387 in order to assess and improve the effectiveness of the agency's sexual abuse prevention, detection, and response policies, and training, including: identifying problem areas; taking corrective action on an ongoing basis; and preparing an annual report of findings from data review and any corrective actions for each facility, as well as the agency as a whole. The annual report includes a comparison of the current year's data and corrective actions with those from prior years and provides an assessment of the agency's progress in addressing sexual abuse. The Annual Report is made readily available to the public through the agency website, as approved by the agency head. Currently, the agency's JR PREA Activities Report: Overview of 2017-18 Federal Audits appears to be a working document verifying some efforts being made toward ongoing compliance with this standard.

Analysis:
The information available to the auditor at the time of the PREA Audit Interim Report indicated that the facility had shown compliance with this standard. No corrective action was required. No information obtained since the time that report was completed has contradicted the finding of "Meets Standard."

Finding:
The facility has shown compliance with this standard in all material ways for the relevant review period.

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 agency ensures that incident-based and aggregate data are securely retained. The database has limited access, but it is shared with the leadership group, which is charged with utilizing the information to protect information and to protect residents. 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.
https://www.dshs.wa.gov/sites/default/files/JJRA/jr/documents/PREA/2017%20Annual%20Data-Compliance%20Report.pdf

Analysis:
The information available to the auditor at the time of the PREA Audit Interim Report indicated that the facility had shown compliance with this standard. No corrective action was required. No information obtained since the time that report was completed has contradicted the finding of "Meets Standard."

Finding:
The facility has shown compliance with this standard in all material ways for the relevant review period.

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 three-year period starting on August 20, 2013, and during each three-year period thereafter, 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? (N/A before August 20, 2016.)
  ☒ Yes ☐ No ☐ NA

115.401 (b)

- During each one-year period starting on August 20, 2013, 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? ☐ Yes ☒ No

115.401 (h)

- Did the auditor have access to, and the ability to observe, all areas of the audited facility?
  ☒ Yes ☐ No

115.401 (i)

- Was the auditor permitted to request and receive copies of any relevant documents (including electronically stored information)? ☐ Yes ☒ No

115.401 (m)

- Was the auditor permitted to conduct private interviews with inmates, residents, and detainees? ☒ Yes ☐ No

115.401 (n)

- Were residents permitted to send confidential information or correspondence to the auditor in the same manner as if they were communicating with legal counsel? ☒ Yes ☐ No

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

During the Pre-Audit phase, the auditor was provided with policies that were out of date in a "Common Documents" folder. Also, the Pre-Audit Questionnaire (PAQ), even after a revision, included information that did not seem accurate. For example, the number given for the number of residents admitted during the past 12 months that stayed more than 72 hours was much greater than the total number of residents admitted in the past 12 months. In addition, significant sections of the PAQ were left blank.

Corrective Action Needed:
On February 5, 2018, the PREA Administrator provided the first draft of the Corrective Action Plan (CAP) which required that the agency re-do the PAQ with a due date of 02-28-2018 listed for that particular task. In the section for 115.401, the CAP stated,
"1. Notify auditors of any new policies established during the CAP
2. Confirm which policy versions are actually in place (2.10 & 4.30)
3. Submit a revised and complete pre-audit questionnaire to ensure all questions are answered and numbers are accurate."
Although the wording of other sections of the CAP were revised in the weeks that followed, this section of the CAP retained this original language without revision throughout the process of negotiation and collaboration regarding the wording of the CAP, indicating there was no expressed confusion or conflict regarding how to show compliance with standard 115.401. Despite the 02-28-2018 due date, the audit team received nothing regarding this standard until June when a flash drive arrived in the mail with an incomplete PAQ, essentially the same as the versions provided during the Pre-Audit process. DOJ guidance requires the PAQ information be provided well in advance of the on-site audit so that auditors can review information regarding all the standards and start working with the agency and/or facility regarding any compliance issues. The official DOJ recommended auditing process could not be fully followed regarding NYC since the audit team never, at any point, had all the information required.

As quoted above, the CAP required the auditor to be notified of all new policies. A new proposal for investigations was provided to the auditor, however no policy was provided. Additionally, a memo referred to a new policy #4.60, but the new policy was not provided. For policies to be in practice, implementation processes, such as employee notification and training of the contents of policies must be completed. The audit team received no verification regarding any implementation processes being practiced. As noted previously in this report, the confusion regarding investigations had the effect of nullifying the efforts, already verified, regarding compliance with several standards regarding investigative practices, because the new proposal implied that all the verified investigative practices were a thing of the past. Yet, there was no verification provided regarding any new system so that the audit team could review the new system for compliance.

The CAP required clarification of a policies 2.10 and 4.30. The PREA Administrator had provided the auditor with an old policy, which he indicated would have exempted the agency from the grievance reporting requirements. A previous PREA Auditor had exempted the agency from 115.352 (Exhaustion of Administrative Remedies). However, Mr. Weir found new policy on the agency website which was specific to PREA which had superseded the old policy. Requests for verification of which policy was in place went unanswered. The auditor did reach a facility administrator (from a different agency facility) who verified the correct policy currently in place. The PREA Administrator states that he sits on the agency's policy review team. It is difficult to understand why he argued, numerous times, against the contents of the PREA compliant policy and why the old policy was provided. The explanation of an old folder being erroneously attached is contradicted by the repeated opposition of the PREA Administrator to this standard being applied to the agency and facility, indicating he prefers and/or follows the outdated policy which he provided with first version of the PAQ. The last and final version of the PAQ continues to indicate, in contradiction to the wording of the practiced policy, that 115.352 does not apply to the agency or facility.

The Contract for Services between PREA America LLC and the agency required the PAQ be sent to the auditors 3 weeks prior to the on-site audit. It was late and incomplete. After it was resubmitted it still had omissions and errors. By agreement, it was added to the CAP. When received, the belated CAP PAQ still had omissions and errors. The agency failed to meet its repeated agreements to provide basic documentation for compliance with 115.401.

Analysis:
At the conclusion of the corrective action period, the audited facility should have taken all the steps agreed upon with the auditor, according to the PREA Auditor's Handbook. This was not done, so the Interim Report's finding of "Does Not Meet Standard" still stands. The PREA Auditor Handbook States, "It is not appropriate to focus only or primarily on written policies and procedures when conducting a PREA audit. The importance of auditors' observations, interviews with staff and inmates, and review of facility documentation is reflected in Standard 115.401(e), which states, 'The agency shall bear the burden of demonstrating compliance with the standards.' Therefore, an agency must be compliant not only in policy but must also demonstrate institutionalization of the Standards in its day-to-day practices. An agency or facility that is unable to provide sufficient evidence of compliance, or provides substantially conflicting information or evidence regarding compliance, has failed to meet its burden. Significantly, the unavailability of documentation or information required to adequately evaluate and demonstrate compliance requires a finding of 'Does Not Meet Standard' for Standard 115.401(e)." The PREA Auditor Handbook also states, "Auditors should remember that the PREA audit is not an audit of policies and procedures only. It is primarily an audit of practice. The objective for the auditor is to examine enough evidence to make a compliance determination regarding the audited facility's actual practice. Policies and procedures do not demonstrate actual practice, although they are the essential baseline for establishing practice and should be reviewed carefully. Some facility practices may be reflected in documents, which should be sampled and reviewed appropriately. However, in order to

gather sufficient evidence to make a compliance determination, documentation must be reviewed in tandem with observations made during the site review and with information obtained during interviews with inmates and staff. Each of these sources of information—interviews, observations, and documentation—should be used to corroborate the others."

Finding:
The facility has not shown compliance in all material ways with this standard, as required by the U.S. Department of Justice in the PREA Auditor's Handbook.

Standard 115.403: Audit contents and findings

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

115.403 (f)

- The agency has published on its agency website, if it has one, or has otherwise made publicly available, all Final Audit Reports within 90 days of issuance by auditor. The review period is for prior audits completed during the past three years PRECEDING THIS AGENCY AUDIT. In the case of single facility agencies, the auditor shall ensure that the facility's last audit report was published. The pendency of any agency appeal pursuant to 28 C.F.R. § 115.405 does not excuse noncompliance with this provision. (N/A if there have been no Final Audit Reports issued in the past three years, or in the case of single facility agencies that there has never been a Final Audit Report issued.) ☒ Yes ☐ No ☐ NA

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

The agency makes Final Audit Reports available to the public and complies in material ways with this standard. The reports can be viewed at: https://www.dshs.wa.gov/ra/juvenile-rehabilitation/prison-rape-elimination-act-compliance

The previous NYC report is located at:
https://www.dshs.wa.gov/sites/default/files/JJRA/jr/documents/PREA/Audit/Washington%20State_Naselle%20Youth%20Camp_Year%202%20Cycle%201.pdf

Analysis:
The information available to the auditor at the time of the PREA Audit Interim Report indicated that the facility had shown compliance with this standard. No corrective action was required. No information obtained since the time that report was completed has contradicted the finding of "Meets Standard."

Finding:
The facility has shown compliance with this standard in all material ways for the relevant review period.

AUDITOR CERTIFICATION

I certify that:

☒ The contents of this report are accurate to the best of my knowledge.

☒ No conflict of interest exists with respect to my ability to conduct an audit of the agency under review, and

☒ I have not included in the final report any personally identifiable information (PII) about any resident or staff member, except where the names of administrative personnel are specifically requested in the report template.

Auditor Instructions:

Type your full name in the text box below for Auditor Signature. This will function as your official electronic signature. Auditors must deliver their final report to the PREA Resource Center as a searchable PDF format to ensure accessibility to people with disabilities. Save this report document into a PDF format prior to submission.[1] Auditors are not permitted to submit audit reports that have been scanned.[2] See the PREA Auditor Handbook for a full discussion of audit report formatting requirements.

D. Will Weir 08-12-2018

Auditor Signature **Date**

[1] See additional instructions here: https://support.office.com/en-us/article/Save-or-convert-to-PDF-d85416c5-7d77-4fd6-a216-6f4bf7c7c110 .

[2] See *PREA Auditor Handbook*, Version 1.0, August 2017; Pages 68-69.