Prison Rape Elimination Act (PREA) Audit Report
Juvenile Facilities

☐ **Interim** ☒ **Final**

Date of Report 07/26/2019

Auditor Information

Name: Elaine Bridschge	**Email:** elaine@preaauditing.com
Company Name: PREA Auditors of America, LLC	
Mailing Address: 14506 Lakeside View Way	**City, State, Zip:** Cypress, TX 77429
Telephone: 713-818-9098	**Date of Facility Visit:** June 27-28, 2019

Agency Information

Name of Agency Rite of Passage, Meadowlark Academy	**Governing Authority or Parent Agency** *(If Applicable)* Rite of Passage, Inc.
Physical Address: 2560 Business Parkway	**City, State, Zip:** Minden, NV 89423
Mailing Address: Click or tap here to enter text.	**City, State, Zip:** Click or tap here to enter text.
Telephone: 775-267-9411	**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: Rite of Passage is a cognitive-behavioral, strengths-based program based on restorative justice principles dedicated to providing the best level of care and the most effective treatment program for youth within a normalized milieu.

Agency Website with PREA Information: www.riteofpassage.com

Agency Chief Executive Officer

Name: Ski James Broman	**Title:** President/Owner/CEO
Email: ski.broman@rop.com	**Telephone:** 775-267-9411

Agency-Wide PREA Coordinator

Name: Karen Murray	**Title:** Regional PREA Coordinator

Email: karen.murray@rop.com	**Telephone:** 303-882-0052
PREA Coordinator Reports to: James Berger	**Number of Compliance Managers who report to the PREA Coordinator** 5

Facility Information

Name of Facility:	Meadowlark Academy			
Physical Address:	3304 East I80 Service Road, Cheyenne, WY 82009			
Mailing Address (if different than above):	Click or tap here to enter text.			
Telephone Number:	307-829-7355			
The Facility Is:	☐ Military	☒ Private for Profit	☐ Private not for Profit	
☐ Municipal	☐ County	☐ State	☐ Federal	
Facility Type:	☐ Detention	☐ Correction	☐ Intake	☒ Other

Facility Mission: Rite of Passage is a cognitive-behavioral, strengths-based program based on restorative justice principles dedicated to providing the best level of care and the most effective treatment program for youth within a normalized milieu.

Facility Website with PREA Information: www.meadowlark-academy.com

Is this facility accredited by any other organization? ☒ Yes ☐ No

Facility Administrator/Superintendent

Name: Cary Reed	**Title:** Program Director
Email: cary.reed@rop.com	**Telephone:** 307-829-7356

Facility PREA Compliance Manager

Name: Shelby Andrews	**Title:** PREA Manager
Email: Shelby.andrews@rop.com	**Telephone:** 970-376-5913

Facility Health Service Administrator

Name: N/A	**Title:** Click or tap here to enter text.
Email: Click or tap here to enter text.	**Telephone:** Click or tap here to enter text.

Facility Characteristics

Designated Facility Capacity: 62		**Current Population of Facility:** 27	
Number of residents admitted to facility during the past 12 months			54
Number of residents admitted to facility during the past 12 months whose length of stay in the facility was for 10 days or more:			54
Number of residents admitted to facility during the past 12 months whose length of stay in the facility was for 72 hours or more:			54
Number of residents on date of audit who were admitted to facility prior to August 20, 2012:			0
Age Range of Population:	No minimum age. Students leave at 18th birthday		
Average length of stay or time under supervision:			6.7 months
Facility Security Level:			Staff secure
Resident Custody Levels:			Probation; Child Protective Services
Number of staff currently employed by the facility who may have contact with residents:			39
Number of staff hired by the facility during the past 12 months who may have contact with residents:			73
Number of contracts in the past 12 months for services with contractors who may have contact with residents:			16

Physical Plant

Number of Buildings: 1		**Number of Single Cell Housing Units:** 0	
Number of Multiple Occupancy Cell Housing Units:			4
Number of Open Bay/Dorm Housing Units:			0
Number of Segregation Cells (Administrative and Disciplinary:			0

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.):

Video monitoring is located throughout the main level in the interior of the facility. Control room is in the intake/main lobby area. Video has recording capability that can be archived. Lower level houses the medical department. There is are no cameras installed downstairs.

Medical

Type of Medical Facility:	Hospital – off-site; Clinic – on-site
Forensic sexual assault medical exams are conducted at:	Cheyenne Medical Center

Other

Number of volunteers and individual contractors, who may have contact with residents, currently authorized to enter the facility:	0
Number of investigators the agency currently employs to investigate allegations of sexual abuse:	40+ (2 at MLA)

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.

The PREA onsite audit of the Rite of Passage Meadowlark Academy in Cheyenne Wyoming was conducted on June 27-28, 2019 by Elaine Bridschge, from Valley Farms, Arizona, a U.S. Department of Justice Certified PREA Auditor for Juvenile Facilities. The purpose of the audit was to determine the degree of compliance with the Federal Rape Elimination Act (PREA) standards.

Approximately Six weeks in advance of the onsite audit, the Auditor provided the PREA Compliance Manager with a flyer to be posted throughout the facility announcing the upcoming audit. The flyer explained the purpose of the audit and provided residents and staff with the Auditors contact information. The flyer was written in English and in Spanish. The Facility dated the flyer with the date it was posted, and the Auditor has photos of the displayed flyers.

Pre-audit preparation included a thorough evaluation of all documentation and materials electronically submitted by the facility along with the data included in the pre-audit questionnaire. The documentation reviewed include agency policies, procedures, forms, education materials, training curriculum and rosters, organizational chart, posters, brochures, and other relevant materials that were provided to determine compliance with the PREA standards. This review prompted questions that were submitted to the PREA Coordinator and Compliance Manager for review and clarification. Responses were submitted to the Auditor in a timely manner and prior to the onsite audit. Additional documentation was also requested by the Auditor and submitted by the facility.

The onsite portion of the audit was conducted over a two-day period. During this time, the Auditor conducted interviews with facility leadership, staff, and residents. The interviews were conducted consistent with Department of Justice PREA auditing expectations in content and approach utilizing the PREA Compliance Audit Instrument Interview Guides, as well as individuals selected for interviews (i.e. Facility Director, PREA Coordinator, Agency Head, Superintendent, Compliance Manager, specialized staff, random staff, Medical and Mental Health staff, Human Resource staff, Investigators, and residents.). The Auditor was able to ask additional questions to personnel and residents to gain more information about certain practices of the facility. In addition, the Auditor was able to verify through interviews specific protocols and clarify documentation submitted.

An extensive facility tour was conducted which included observation of facility configuration, staff supervision of residents, housing, intake, classrooms, medical unit, visitation area, central control, recreation areas, dining area, kitchen, and administration areas. There are two levels of the facility and the Auditor was able to tour both levels. Additionally, the Auditor was able to tour the horse barn located in the back of the property. The Auditor was able to view camera locations, showering areas, toilet facilities, and sleeping rooms. The Auditor was able to informally talk to the residents and staff. While on the tour, the Auditor was permitted full access to all areas of the facility. Notices of the PREA audit was observed posted in each housing unit. The Auditor was escorted by facility staff.

The residents were selected randomly to interview by the Auditor using a current roster of residents. The Auditor selected residents from the two occupied housing units, to include interviews with eight male and five female residents. At the time of the onsite visit, there were twenty-seven residents listed on the daily roster, of which one exited the program before the Auditor arrived and the other was off-site. There were no residents to interview that met the criteria for residents held in isolation, or residents who were transgendered or intersex. Residents were interviewed using the recommended DOJ PREA Compliance Audit Instrument Interview Guides that question their knowledge of a variety of PREA protections generally and specifically their knowledge of reporting mechanisms available to residents to report abuse and harassment. The Auditor was able to ask additional questions to residents to gain more information about certain practices of the facility. In addition, the Auditor was able to gather information through interviews regarding facility practices that occur in the environment.

Thirteen random staff members were interviewed representing all shifts, including night shift staff, and group leaders. The Auditor selected staff randomly and by specialty using a current staff roster. The Auditor randomly selected staff per each shift, position assignment, and gender. Four security staff who has acted as first responders, two intake staff, three group leaders/supervisors, and two non-security staff who had acted as a first responders were also interviewed. Selected staff were interviewed using both random and specialty area interview questions. Staff were questioned using the recommended DOJ PREA Compliance Audit Instrument Interview Guides that question their PREA training and overall knowledge of the agency's zero tolerance policy, reporting mechanisms available to residents and staff, the response protocols when a resident alleges abuse, and first responder duties. The Auditor also interviewed specialty staff to include medical staff, mental health staff, human resources staff, staff that oversee retaliation, investigators, and staff who perform risk assessments. The Compliance Manager, PREA Coordinator, Superintendent, Agency Head, and Sexual Abuse Response Team Members were also interviewed. The facility's leadership accommodated the Auditor's request to interview specific staff and covered resident supervision while staff were participating in the interview process.

While at the facility, the Auditor reviewed thirteen resident case records randomly selected by the Auditor utilizing a resident roster provided to the Auditor by the facility to evaluate screening and intake procedures, resident education, and other general programmatic areas.

The Auditor randomly selected and reviewed eleven employee files and employee training logs to determine compliance with training mandates and background check procedures. All documents reviewed by the Auditor was within a one-year period from date of audit. To obtain information about the rape crisis center and advocacy services, an online review of local services was conducted.

On the final day of the onsite audit, a debriefing was held with the facility's leadership staff. The purpose of the meeting was to summarize preliminary audit findings, next steps of the audit process, and to provide specific feedback to include strengths and areas of improvement as it relates to PREA standards.

Facility Characteristics

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

The Rite of Passage Meadowlark Academy in Cheyenne Wyoming is a private-for-profit facility with a designed capacity of sixty-two. There is a total of four units, of which two are currently being occupied, one for male residents and the other for female residents. The male unit has seven rooms with 20 beds with a single use, private shower and restroom. The female unit has 6 rooms with 14 beds with a private shower and restroom.

The facility has two separate buildings, the main facility and a barn that horses occupy. The facility has a large intake/control/lobby area, a library, a kitchen, and a dining room. Also, the facility has an indoor gym with an upstairs lounge and an outdoor recreation area with a running track and ample space for large outdoor activities. Each unit has their own programming space and each of the four classrooms are located within each unit. The medical department including the exam room is located downstairs, along with the tornado shelter.

The Rite of Passage Meadowlark Academy houses residents up to their eighteenth birthday. There is no minimum age limit. No residents older than 18 years of age were detained at time of audit. The facility security level is considered staff secure.

The building contains an administration area which is accessible only to employees and controlled by locking doors. The medical unit contains one medical exam room that is utilized for residents, a small area for pharmaceuticals, a restroom/changing area, clothing storage area, property room, and an office space. The medical department is available Monday through Friday from 7:00am to 4:00pm.

The facility is large and has private rooms for intake and processing. The facility implements direct podular supervision, where staff can visually supervise residents. Programming is conducted daily, and residents have access to onsite medical and mental health services. Visitation is available weekly and with special visits for parents and guardians as needed. Attorneys and counselors can visit residents at any time.

The average length of stay for a resident in the Rite of Passage Meadowlark Academy is 6.7 months. The facility currently has thirty-nine staff employed that have contact with residents. Currently, the facility does not have any contractors or volunteers.

The facility is equipped with a video monitoring system internally which is not monitored round the clock. Meals are prepared onsite in an approved kitchen and residents eat meals in the dining room.

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: 5

115.317, 115.331, 115.364, 115.367, 115.388

Number of Standards Met: 38

115.311, 115.312, 115.313, 115.315, 115.316, 115.318, 115.321, 115.322, 115.332, 115.313, 115.334, 115.335, 115.341, 115.342, 115.351, 115.352, 115.353, 115.354, 115.361, 115.362, 115.363, 115.364, 115.365, 115.366, 115.368, 115.371, 115.372, 115.373, 115.376, 115.377, 115.378, 115.381, 115.382, 115.383, 115.386, 115.387, 115.389, 115.401, 115.403

Number of Standards Not Met: 0

Summary of Corrective Action (if any)

In the interim report four standards were found to be non-compliant. Those standards were 115.313; 115.333; 115.351; and 115.364. A corrective action period began on July 14, 2019 and was completed on July 26, 2019. During the corrective action period, the Auditor had a telephonic meeting with the PREA Coordinator and the Compliance Manager on July 22, 2019 to review the interim report, discuss standards not met, and determine the corrective action needed for each standard to become compliant.

The PREA Coordinator and the Compliance Manager submitted the appropriate documentation to the Auditor. The Auditor verified that all submitted documentation supported the corrective action required for the four standards and concluded that the facility is in compliance with all PREA standards.

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

The agency employs an upper-level, agency-wide PREA Coordinator, Karen Murray. The PREA Coordinator has sufficient time and authority to develop, implement, and oversee agency efforts to comply with the PREA standards in all of its facilities. The position of the PREA Coordinator is specified in the agency's organizational structure.

The facility has designated a PREA Compliance Manager, Shelby Andrews. The PREA Compliance Manager has sufficient time and authority to coordinate the facility's efforts to comply with the PREA standards. The position of the PREA Compliance Manager is specified in the agency's organizational

structure. The PREA Compliance Manager reports to the Regional Improvement Imbedded PREA Coordinator, Karen Murray, and the Site Director, Cary Reed.

Observations of the facility during the guided tour revealed that PREA posters are in all units and lobby and are in English and in Spanish. The facility provided to the Auditor a facility map/layout of poster locations.

Interviews were conducted with the PREA Compliance Manager, PREA Coordinator, and the Agency Head. Policy changes are made by a committee and the PREA Coordinator takes lead for implementation of the PREA Standards. The Agency Head reviews and approves changes to all policies. The facility staff stated that there is an upper level staff member in each region (Eastern, Western, Mountain, and Southern) of Rite of Passage, and is the Regional Improvement Imbedded PREA Coordinator (RIIP), Karen Murray. The RIIP reports directly to the Director of Quality Assurance and works with each site's Program Director and PREA Compliance Manager. The Regional PREA Coordinator oversees PREA compliance in six facilities located within three states. Each facility has one Compliance Manager. The PREA Coordinator creates systems, monthly regional meetings, and works closely with the Compliance Managers. The PREA Coordinator conducts quality assurance assessments to track PREA compliance. The Compliance Manager has sufficient time to perform all aspects of her position and PREA compliance is a standing agenda item during the weekly management meetings. As issues arise between the meetings, the Compliance Manager uses email to communicate issues. The Compliance Manager has authority to correct issues as they arise.

The facility submitted the following policy and/or documentation to the Auditor for review:

ROP Policy 600.600 (PREA Policy Statement)
Safe Environmental Standards Policy
Employee Position Control Roster
Regional Improvement Imbedded PREA Coordinator Job Description
ROP Organizational Chart (revised)
Signed Zero-Tolerance Acknowledgement Forms
Site PREA Compliance Manager Job Description
Site Organizational Chart

Based on the evidence discussed, the facility has demonstrated 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 not entered into or renewed a contract for the confinement of residents on or after August 20, 2012.

Based on the evidence discussed, the facility has demonstrated compliance with this standard.

Standard 115.313: Supervision and monitoring

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

115.313 (a)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

115.313 (b)

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

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

115.313 (c)

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

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

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

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

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

115.313 (d)

- In the past 12 months, has the facility, in consultation with the agency PREA 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 agency requires each facility it operates to develop, document, and make its best efforts to comply on a regular basis with a staffing plan that provides for adequate levels of staffing, and, where applicable, video monitoring, to protect residents against abuse.

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

During the facility tour, the Auditor did not observe unannounced rounds being completed. Surveillance video of rounds was reviewed by Auditor. The Compliance Manager stated that employee's received training on how to conduct unannounced rounds. Observations of the facility during the tour revealed that ratios at time of audit were maintained.

Interviews were conducted with Intermediate or higher-level staff, Superintendent, PREA Compliance Manager, and the PREA Coordinator. The facility staff states that since August 2017, the average daily number of residents is thirty. The facility also stated that since August 2017, the average daily number of residents on which the staffing plan was predicated is thirty. Since May 11, 2019, each time the staffing plan is not complied with, the facility documents and justifies all deviations from the staffing plan. The facility states that staff on personal time off is the most common reason for deviating from the staffing plan in the past 12 months. Prior to May 11, 2019, deviations were not being recorded.

When out of ratio, the Compliance Manager will notify PREA Coordinator. The facility is obligated by law, regulation, or judicial consent decree to maintain staffing ratios of a minimum of 1:6 with those staff physically being in the building, but not in the presence of residents. The facility reports that in the past

12 months, the facility has deviated one time from the staffing ratios of 1:8 security staff during resident waking hours and zero times during resident sleeping hours.

At least once every year the facility, in collaboration with the agency's PREA Coordinator, reviews the staffing plan. The staffing plan is revised as needed. There are no cameras or monitoring system down stairs in the medial department or on the exterior of the facility where residents have access. All other areas are covered by surveillance monitoring or mirrors. Video is reviewed quarterly to verify checks being conducted. Facility states that the first Staffing Plan was completed June 2018. Documentation of unannounced rounds are kept with the Compliance Manager. Reviews are completed as changes occur or at minimum semiannually.

PREA compliance issues are discussed weekly during management meetings. Blind spots are identified, and cameras or mirrors are utilized. The Facility Director maintains presence on the floor and receives weekly reports. When ratio is not met due to call off's or no call, no shows, the Director and the Compliance Manager is added into the ratio and placed on the floor. The facility also has a part-time on call registry and offers over-time to their employees when needed. The State of WY has set ratio to be 1:6 in waking hours and 1:10 at night. Shift supervisors conduct unannounced rounds one to two times per shift. Unannounced rounds are completed randomly and documented on a form to include ratios and any findings. Supervisors state that rounds are not announced. Compliance Manager maintains forms and provides feedback when needed.

The facility submitted the following policy and/or documentation to the Auditor for review:

ROP Safe Environmental Standards Policy
Daily Site Unannounced Rounds
Site Staff Schedule
Site Student Roster
2019 Annual Review of Staffing Assignments and Video Monitoring dated June 10, 2019
Log of deviations with reason, corrective action, and outcome were reviewed by the Auditor

Based on the need for additional monitoring downstairs, the Auditor recommended that corrective action be taken. The facility revised the annual staffing plan to speak to measures taken in areas without cameras. The plan includes having two staff present at all times when residents are downstairs.

Based on the evidence discussed, the facility has demonstrated compliance 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.

The facility does not conduct cross gender strip or cross gender visual body cavity searches of residents. The facility reports that zero of such searches have been conducted in the past 12 months. The facility does not permit cross gender pat down searches of residents, absent exigent circumstances. The facility reports that there was zero cross gender pat down searches within the past 12 months. Facility policy requires that all cross-gender strip searches and cross-gender visual body cavity searches be documented and justified.

The facility has implemented policies and procedures that enable residents to shower, perform bodily functions, and change clothing without non-medical staff of the opposite gender viewing their breasts, buttocks, or genitalia, except in exigent circumstances or when such viewing is incidental to routine cell checks (this includes viewing via video camera). Policies and procedures require staff of the opposite gender to announce their presence when entering a resident's housing unit/areas where residents are likely to be showering, performing bodily functions, or changing clothing.

The facility has a policy prohibiting staff from searching or physically examining a transgender or intersex resident for the sole purpose of determining the resident's genital status. The facility reports that no searches of this type have occurred in the past 12 months. The facility reports that 100% of security staff received training on conducting cross gender pat down searches and searches of transgender and intersex residents in a professional and respectful manner, consistent with security needs.

Observations of facility during tour revealed that there are single use showers, restrooms, and changing areas in each unit that are private. There are signs on each unit door reminding staff to announce themselves. Announcements are made by staff prior to entering the units. Video cameras do not reach into student rooms.

Interviews were conducted with random residents, LBGTI residents, and random staff. All stated that cross gender searches are prohibited. Staff announce themselves by stating "female" or "male" on unit and is repeated several times. Residents regularly respond back to the staff member that they are changing, using the restroom, etc.

The facility submitted the following policy and/or documentation to the Auditor for review:

ROP Safe Environmental Standards Policy
Pre-service Staff Training and Development Documentation
Staff Training and Development Documentation of PREA training
PREA Training Lesson Plan

Based on the evidence discussed, the facility has demonstrated compliance with this standard.

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

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

115.316 (a)

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

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

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

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

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

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

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

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

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

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

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

115.316 (b)

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

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

115.316 (c)

- Does the agency always refrain from relying on resident interpreters, resident readers, or other types of resident assistants except in limited circumstances where an extended delay in obtaining an effective interpreter could compromise the resident's safety, the performance of first-response duties under §115.364, or the investigation of the resident's allegations? ☒ Yes ☐ No

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the Auditor's analysis and reasoning, and the Auditor's conclusions. This discussion must also include corrective action recommendations where the facility does

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

The agency has established procedures to provide disabled residents equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment. The agency has established procedures to provide residents with limited English proficiency equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment. Agency policy prohibits use of resident interpreters, resident readers, or other types of resident assistants except in limited circumstances where an extended delay in obtaining an effective interpreter could compromise the resident's safety, the performance of first-response duties under 115.364, or the investigation of the resident's allegations.

The facility reports that in the past 12 months, there have been zero instances where resident interpreters, readers, or other types of resident assistants have been used and it was not the case that an extended delay in obtaining another interpreter could compromise the resident's safety, the performance of first-response duties under 115.364, or the investigation of the resident's allegations.

The facility submitted the following policy and/or documentation to the Auditor for review:

ROP Safe Environmental Standards Policy
PREA Training Lesson Plan
ROP Training Sign-In Sheets
Language Line Solutions language lists
A Student Guide to Rights, Protections, and Reporting of Sexual Abuse – English
A Student Guide to Rights, Protections, and Reporting of Sexual Abuse – Spanish
Observations of Facility during tour revealed that 2 ADA bathrooms. Bilingual staff

Based on the evidence discussed, the facility has demonstrated compliance with this standard.

Standard 115.317: Hiring and promotion decisions

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

115.317 (a)

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

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

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

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

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

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

115.317 (b)

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

115.317 (c)

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

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

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

Agency policy prohibits hiring or promoting anyone who may have contact with residents, and prohibits enlisting the services of any contractor who may have contact with residents, who (1) has engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility, or other institution; (2) has been convicted of engaging or attempting to engage in sexual activity in the community facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse; or (3) has been civilly or administratively adjudicated to have engaged in the activity described in this paragraph. 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.

Agency policy requires that before it hires any new employees who may have contact with residents, it (a) conducts criminal background record checks, (b) consults any child abuse registry maintained by the state or locality in which the employee would work; and (c) consistent with Federal, State, and local law, makes its best efforts to contact all prior institutional employers for information on substantiated allegations of sexual abuse or any resignation during a pending investigation of an allegation of sexual abuse.

Agency policy requires that a criminal background record check be completed, and applicable child abuse registries consulted before enlisting the services of any contractor who may have contact with residents. Agency policy requires that either criminal background record checks be conducted at least every five years of current employees and contractors who may have contact with residents or that a system is in place for otherwise capturing such information for current employees. Agency policy states that material omissions regarding such misconduct, or the provision of materially false information, shall be grounds for termination.

A review of eleven employee files indicate that criminal history checks, and child abuse registry checks are being completed and an administrative adjudication check (questions on employment application) are being completed for all employees. Institutional reference checks when applicable are being completed. Employees were given a PREA knowledge assessment test and that is also located in the employees file. The facility provides 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.

During interview with the Human Resource staff, all employees have background checks ran every five years on the employment anniversary. The facility gives out service awards to employees every five years. This list is utilized to determine when a background check must be completed for all current employees. The Child Abuse Registry is not re-consulted due to the automatic notifications received from the Department of Public Safety. All new hires receive background check verifications. WY Department of Human Services conducts the background checks. WY Bureau of Investigations and the FBI databases are checked. WY Department of Family Services conducts the child abuse registry checks.

The facility has each applicant complete a fingerprint clearance card. Applicants are also asked to sign a disclosure form to conduct extended checks in other states. Currently, Meadowlark Academy does not have any contractors. Should they in the future, all contractors would go through the background verification checks. There is a reporting process for all employees to run a background check. Rite of Passage is notified automatically for all charges of current employees. An employment verification form is completed on all applicants. Current employees are expected to follow the Employee Conduct and Performance Policy (code of ethics). The facility will provide another facility with applicant information

upon receipt of a written request. The facility reports that in the past 12 months, seventy-three persons have been hired who may have contact with residents who have had criminal background record checks.

The facility submitted the following policy and/or documentation to the Auditor for review:

ROP Safe Environmental Standards Policy
Site Background Attestation Form Policy
Application for Child and Adult Abuse/Neglect Central Registry Screen
Authorization to Release from
Employment Reference Verification form
PREA Verification for Employment form
PREA Attestation from Employment Application
ROP Policy 100.205 Employee References and Information Request
Policy 600.100 ROP Code of Ethics

Based on the evidence discussed, the facility has exceeded compliance with this standard.

Standard 115.318: Upgrades to facilities and technologies

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

115.318 (a)

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

115.318 (b)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

The Agency has acquired a new facility or made a substantial expansion or modification to existing facilities since August 20, 2012. The facility was purchased November 2016, with occupancy in 2017. Several modifications and improvements were made to the facility prior to occupancy.

Observations of facility during tour revealed that additional cameras (main floor), carpet, and open spaces were incorporated into the modification. There are not any cameras downstairs in medical or on the exterior of the facility. No cameras are placed in view of or in bathrooms, sleeping areas, changing rooms, showers, or cells were observed. Control has a video monitoring system that is not manned consistently. Video is recorded for playback and can be saved to a CD and archived.

Interviews were conducted with Superintendent and Agency Head. Supervision has been made easier due to removing blind spots by taking out walls and creating more open space. The facility uses mirrors and cameras to cover blind spots. The facility has implemented an interactive supervision policy. The Agency Head stated he is the front edge of PREA implementation. The agency takes a line of site supervision approach. The agency completed audits of all buildings and in turn, closed some buildings due to design and safety issues. Cameras have been installed at Meadowlark Academy on the main floor. Additional staff have been added to ensure safety of residents. A facility plant team is in place to evaluate facilities. First line supervisors review and identify systems that are broke down.

The facility submitted the following policy and/or documentation to the Auditor for review:

List of facility modifications and improvements
ROP Safe Environmental Standards Policy

Based on the evidence discussed, the facility has demonstrated compliance with this standard.

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 agency/facility is responsible for conducting administrative sexual abuse investigations including staff sexual misconduct. Criminal investigations are completed by the local law enforcement agency. When conducting a sexual abuse investigation, the local law enforcement agency investigators follow a uniform evidence protocol. The protocol is developmentally appropriate for youth. The protocol was adopted from or otherwise based on the most recent edition of the DOJ'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.

The facility offers to all residents who experience sexual abuse access to forensic medical examinations through an outside facility. Forensic medical examinations are offered without financial cost to the victim. Where possible, examinations are conducted by Sexual Assault Forensic Examiners (SAFE’s) or Sexual Assault Nurse Examiners (SANE’s). When SAFE’s or SANE’s are not available, a qualified medical practitioner performs forensic medical examinations. The facility documents efforts to provide SANE’s or SAFEs. The facility reports that in the past 12 months, zero forensic medical exams were conducted.

Documentation of good faith attempts to obtain MOU’s with Cheyenne Regional Medical Center, Laramie County Sheriff’s Department, and Cheyenne Police Department were reviewed by the Auditor. The Auditor was able to view services provided at Cheyenne Regional Medical Center regarding the sexual assault nurse examination that they provide. The hospital states that the Sexual Assault Nurses strive to provide safe, compassionate and confidential care to anyone who has been affected by sexual assault or sexual violence and that there is no charge for any of the services required for a forensic medical examination.

The facility attempts to make a victim advocate from a rape crisis center available to the victim, in person or by other means. These efforts are documented. When a rape crisis center is not available to provide victim advocate services, the facility provides a qualified staff member from a community-based organization, such as the hotline or police department advocate. An MOU with Safe House was developed but remains unsigned as Safe House will not sign an MOU at this time. Efforts to obtain MOU are well documented. The facility should continue efforts toward obtaining a signed MOU.

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

Interviews were conducted with residents who reported sexual abuse, Agency Head, PREA Compliance Manager, and random staff. The Agency Head identified difficulty establishing a MOU with victim advocacy services through Safe House. Residents are instructed to utilize the national hotline number. The County Sheriff Department has victim advocates; however, they also have refused to sign an MOU. The facility has Mental Health clinicians on staff who will accompany the victim to forensic services. Random staff stated that they would notify the Compliance Manager. A resident who reported sexual abuse while in the facility stated that staff separated her from another girl and placed them on a different unit. Facility states they use National Hotline. The Laramie County Sheriff’s Department has a victim advocacy unit (Safe House) available for residents.

The facility submitted the following policy and/or documentation to the Auditor for review:

ROP Safe Environmental Standards Policy
Uniform Evidence Protocol
Documentation of efforts made to obtain MOU

Based on the evidence discussed, the facility has demonstrated compliance with this standard.

Standard 115.322: Policies to ensure referrals of allegations for investigations

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

115.322 (a)

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

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

115.322 (b)

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

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

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

115.322 (c)

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

115.322 (d)

- Auditor is not required to audit this provision.

115.322 (e)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

The agency ensures that an administrative or criminal investigation is completed for all allegations of sexual abuse and sexual harassment. The facility reports that in the past 12 months, five allegations of sexual abuse and sexual harassment were received and investigated. One of which was referred for criminal investigation.

The agency has a policy that requires allegations of sexual abuse or sexual harassment be referred for investigation to an agency with the legal authority to conduct criminal investigations, including the agency if it conducts its own investigations, unless the allegation does not involve criminal behavior. The agency's policy regarding the referral of allegations of sexual abuse or sexual harassment for a criminal investigation is published on the agency's website or made publicly available via other means. The agency documents all referrals of allegations of sexual abuse or sexual harassment for criminal investigation.

Attempts to obtain MOU with Laramie County Sheriff's Department and Cheyenne Police Department are well documented. The Auditor was able to review investigative files. The facility website contains the sexual abuse and sexual harassment investigations policy. Records of referrals of allegations for criminal investigations within past 12 months are maintained.

Interviews were conducted with Investigators and Agency Head. Laramie County Sheriff Office conducts sexual abuse investigations for the facility, although they refuse to sign an MOU. The Agency Head stated that the Local Compliance Manager with Regional PREA Coordinator would conduct internal investigations.

The facility submitted the following policy and/or documentation to the Auditor for review:

ROP Safe Environmental Standards Policy
Records of allegations during the past 12 months
Records of Administrative and Criminal investigations completed during the past 12 months

Based on the evidence discussed, the facility has demonstrated 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 agency's zero tolerance policy; how to fulfill their responsibilities with PREA; residents right to be free from sexual abuse and sexual harassment; the right to be free from retaliation; dynamics of sexual abuse and sexual harassment; common reactions; how to detect and respond; avoiding inappropriate relationships; how to communicate effectively; complying with relevant laws; and age of consent. Training is tailored to the unique needs and attributes, and gender of the residents at the facility. Employees who are reassigned from facilities housing opposite gender are given additional training.

The agency documents that all employees understand the training they have received through employee signature or electronic verification. A review of eleven employee files indicate that PREA acknowledgement forms are signed by each employee and documentation of PREA training is in the file.

Interviews were conducted with random staff. All staff report they received PREA training covering all areas during annual preservice and refreshers every six months. The facility reports that thirty-eight staff that are currently employed by the facility that may have contact with residents have been trained or retrained in PREA. Between annual trainings, the agency provides employees who may have contact with residents with refresher information about current policies regarding sexual abuse and harassment. The facility reports that all employees receive refresher training on PREA requirements every six months.

The facility submitted the following policy and/or documentation to the Auditor for review:

ROP Safe Environmental Standards Policy
ROP PREA Training Lesson Plan
ROP PREA Training PowerPoint with notes
Site employee training logs with signatures
Employee signed zero tolerance acknowledgement forms
Pre-service records for PREA training of staff that were reassigned

Based on the evidence discussed, the facility has exceeded compliance with this standard.

Standard 115.332: Volunteer and contractor training

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

115.332 (a)

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

115.332 (b)

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

115.332 (c)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

All volunteers and contractors who have contact with residents will be trained on their responsibilities under 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 based on the services they provide and level of contact they have with residents.

All volunteers and contractors who have contact with residents will be notified of the agency's zero tolerance policy regarding sexual abuse and sexual harassment and informed how to report such incidents. The agency will maintain documentation confirming that the volunteers and contractors understand the training they have received.

Interviews were conducted with the PREA Coordinator. Currently, the facility does not have any volunteers or contractors.

The facility submitted the following policy and/or documentation to the Auditor for review:

ROP Safe Environmental Standards Policy
ROP PREA Training Independent Contractor Lesson Plan
ROP PREA Training PowerPoint Independent Contractor with notes
Signed independent contractor training documents

Based on the evidence discussed, the facility has demonstrated compliance with this standard.

Standard 115.333: Resident education

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

115.333 (a)

- During intake, do residents receive information explaining the agency's zero-tolerance policy regarding sexual abuse and sexual harassment? ☒ Yes ☐ No
- During intake, do residents receive information explaining how to report incidents or suspicions of sexual abuse or sexual harassment? ☒ Yes ☐ No
- Is this information presented in an age-appropriate fashion? ☒ Yes ☐ No

115.333 (b)

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

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

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

115.333 (c)

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

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

115.333 (d)

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

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

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

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

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

115.333 (e)

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

115.333 (f)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

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. Facility reports that fifty-four residents admitted in past 12 months were given this information at intake. This information provided in an age appropriate fashion. Agency policy requires that residents who are transferred from one facility to another be educated regarding their rights to be free from sexual abuse and sexual harassment and to be free from retaliation for reporting such incidents, and regarding agency policies and procedures for responding to such incidents to the extent that the policies and procedures of the new facility differ from those of the previous facility. 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.

Observations of facility during tour revealed that the PREA Resource Center video in English and Spanish is utilized as comprehensive education. Resident PREA education is available in accessible formats for all residents including those who are limited English proficient, deaf, visually impaired, otherwise disabled, or have limited reading skills.

Documentation of PREA Comprehensive education within 10 days of intake was not found in two files and the Auditor was unable to verify if it was consistently being provided. A review of thirteen resident files indicates that PREA information was reviewed at time of intake with each resident. Files contain PREA Acknowledgement statements signed by the resident. Resident Intake records in the past 12 months indicate that all residents received PREA information at time of intake. However, comprehensive education within 10 days for all residents reviewed was unable to be verified by the Auditor. Data sheets submitted by facility at time of audit were insufficient as the Auditor was unable to tell if the education was received within 10 days of intake. The data sheets were not dated and unable to be verified. The agency maintains documentation of resident participation in PREA education sessions.

Interviews were conducted with random residents and intake staff. Staff state that the Case Manager's complete resident intakes. PREA information is given both verbally and written. Residents also watch a PREA video within 10 days. The PREA brochure is explained to residents verbally. Residents are asked if they would like a copy of the materials.

Residents stated that they receive PREA information verbally, in writing, and a video. Some residents stated that they were told about PREA after one month of intake. Residents stated that they are asked to sign a PREA paper after they watch a video. The residents did not know if the video was watched within 10 days of intake. Two residents stated that staff did not tell them about PREA, but other kids did. Facility reports that fifty-four residents admitted in the past 12 months received comprehensive age-appropriate education on their rights to be free from sexual abuse and sexual harassment, from retaliation for reporting such incidents, and on agency policies and procedures for responding to such incidents within 10 days of intake.

The facility submitted the following policy and/or documentation to the Auditor for review:

ROP Safe Environmental Standards Policy

ROP Safe Environmental Standards Student Brochure

ROP Safe Environmental Standards Student Video (weblink)

Intake records from past 12 months and intake training data

Pictures of posters

Diagram of where posters are located

Student handbook

Student training documents

Student zero tolerance acknowledgement forms

Based on comprehensive education documentation not found in two resident files and that the Auditor was unable to verify the timeframes based on the spreadsheet that was provided, the Auditor recommended that corrective action be taken. The facility submitted the revised Master Student Spreadsheet to include dates of comprehensive education. Case Managers will show the PREA video every Friday during weeks when new students arrive.

Based on the evidence discussed, the facility has demonstrated compliance with this standard.

Standard 115.334: Specialized training: Investigations

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

115.334 (a)

- In addition to the general training provided to all employees pursuant to §115.331, does the agency ensure that, to the extent the agency itself conducts sexual abuse investigations, its investigators have received training in conducting such investigations in confinement settings?

[N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.321(a).] ☒ Yes ☐ No ☐ NA

115.334 (b)

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

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

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

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

115.334 (c)

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

115.334 (d)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the Auditor's analysis and reasoning, and the Auditor's conclusions. This discussion must also include corrective action recommendations where the facility does

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

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

Documentation of training was submitted by the facility and verified by the Auditor. The agency maintains documentation showing that investigators have completed the required training. The facility employs two investigators who have completed the required training.

Interviews were conducted with Investigators. Investigators state that the Compliance Manager investigates internally. Training was received through the National Institute Training Program.

The facility submitted the following policy and/or documentation to the Auditor for review:

ROP Safe Environmental Standards Policy
ROP Safe Environmental Standards/PREA Training Specialized Training for Administrative Investigators Curriculum
Signed Training documentation of Administrative Investigators

Based on the evidence discussed, the facility has demonstrated 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. One hundred percent of all medical and mental health care practitioners who work regularly at this facility received the training required by agency policy.

Interviews were conducted with Medical and Mental Health staff. Medical and Mental Health staff complete PREA training annually with refreshers as needed. Specialty training was completed online. Rite of Passage also has PREA training they must take. Documentation of training was in the employee's training file and able to be verified. Agency medical staff at this facility does not conduct forensic medical exams. The agency maintains documentation showing that medical and mental health practitioners have completed the required training.

The facility submitted the following policy and/or documentation to the Auditor for review:

ROP Safe Environmental Standards Policy
Signed training rosters
Specialized curriculum

Based on the evidence discussed, the facility has demonstrated compliance with this standard.

SCREENING FOR RISK OF SEXUAL VICTIMIZATION AND ABUSIVENESS

Standard 115.341: Screening for risk of victimization and abusiveness

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

115.341 (a)

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

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

115.341 (b)

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

115.341 (c)

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

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

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

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

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

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

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

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

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

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

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

115.341 (d)

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

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

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

115.341 (e)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

The agency has a policy that requires screening (upon admission to a facility or transfer to another facility) for risk of sexual abuse victimization or sexual abusiveness toward other residents. The policy requires that residents be screened for risk of sexual victimization or risk of sexually abusing other residents within 72 hours of their intake. The policy requires that the resident's risk level be reassessed periodically throughout their confinement.

Observations of facility during tour revealed that risk screenings are completed by Case Manager's and located in Case Manager's office. A review of thirteen resident files indicates that Intake Screenings were completed within 72 hours of admission. Periodic reassessment documentation was found in file for one resident who has resided there for over a year. This documentation for reassessments is maintained electronically by the Case Manager. Risk assessment screenings are conducted using an objective screening instrument.

Interviews were conducted with random residents, staff who conduct risk screenings, Compliance Manager, and the PREA Coordinator. It was stated that the Intake Case Manager's complete assessments and they are maintained in the residents file located in the Case Manager's office. Case Managers maintain the confidentiality of the file and keep them locked. Information is given to staff on a need to know basis. Staff are given scores (higher the score the greater the risk) and general information from the risk assessment but are not shown the entire assessment. There is a risk assessment packet that is completed during intake to include a vulnerability assessment. Management team is notified by email with any issues. Intakes are prescheduled, so a Case Manager is always available. A MAYSI is also given to residents. Therapists and Case Managers can view the risk assessment at any time.

Referrals are made immediately to counselors or the head therapist if the risk assessment indicates the need for follow-up. All residents recall being asked all the questions noted in this standard. Facility reports that fifty-four residents entering the facility within the past 12 months (either through intake or transfer) whose length of stay in the facility was for 72 hours or more who were screened for risk of sexual victimization or risk of sexually abusing other residents within 72 hours of their entry into the facility.

The facility submitted the following policy and/or documentation to the Auditor for review:

ROP Safe Environmental Standards Policy
Student Vulnerability Assessment Instrument: Risk of Victimization and/or Sexually Aggressive Behavior/Overall Risk

Based on the evidence discussed, the facility has demonstrated 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.

The agency or facility uses information from the risk screening required by §115.341 to inform housing, bed, work, education, and program assignments with the goal of keeping all residents safe and free from sexual abuse. The facility has a policy that residents at risk of sexual victimization may only be placed in isolation as a last resort if less restrictive measures are inadequate to keep them and other residents safe, and only until an alternative means of keeping all residents safe can be arranged. The facility policy requires that residents at risk of sexual victimization who are placed in isolation have access to legally required educational programming, special education services, and daily large-muscle exercise. The agency or facility makes housing and program assignments for transgender or intersex residents in a facility on a case-by-case basis. The facility prohibits placing lesbian, gay, bisexual, transgender, or intersex residents in particular housing, bed, or other assignments solely on the basis of such identification or status. The facility prohibits considering lesbian, gay, bisexual, transgender, or intersex identification or status as an indicator of likelihood of being sexually abusive.

Observations of facility during tour revealed that there are private single use showers in each unit available to residents. The Auditor did not observe any isolation areas.

The facility submitted samples of completed Vulnerability Assessment Team Site Visit Reporting Forms. The forms assess all locations of the facility for potential vulnerabilities and provides recommendations. This is normally completed by the PREA Coordinator.

Interviews were conducted with LBGTI residents, Medical and Mental Health Staff, staff who conduct risk screenings, Superintendent, Compliance Manager, and the PREA Coordinator. All stated that the facility does not use isolation at any time for any reason. Residents are not separated by LGBTI. Meadowlark Academy has four units, two male units and two female units. Residents are housed by gender only. Risk assessments determine what unit, roommates, seating assignments, and programming are needed. Risk levels are coded on bed rosters for staff use. Resident sleeping room doors remain open to allow for sight and sound observations during sleeping hours. Fifteen-minute welfare checks are conducted during sleeping hours. Residents stated that private sleeping rooms are available when needed and that their requests are taken into consideration. Risk assessments are reviewed every six months or as often as needed by Case Managers. All bathrooms and showers are private, single use rooms. Facility reports that isolation is not used and that no residents at risk of sexual victimization who were placed in isolation in the past 12 months and that no residents at risk of sexual victimization who were placed in isolation who have been denied daily access to large muscle exercise, and/or legally required education or special education services in the past 12 months. The facility also reports that no residents at risk of sexual victimization were held in isolation to protect them from sexual victimization in the past 12 months.

The facility submitted the following policy and/or documentation to the Auditor for review:

ROP Safe Environmental Standards Policy
Student Vulnerability Assessment Instrument: Risk of Victimization and/or Sexually Aggressive Behavior/Overall Risk

Based on the evidence discussed, the facility has demonstrated 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.

The agency has established procedures allowing for multiple internal ways for residents to report privately to agency officials about sexual abuse and sexual harassment; retaliation by other residents or staff for reporting sexual abuse and sexual harassment; and staff neglect or violation of responsibilities that may have contributed to such incidents. The agency has a policy mandating that staff accept

reports of sexual abuse and sexual harassment made verbally, in writing, anonymously and from third parties. The facility provides residents with access to tools to make written reports of sexual abuse or sexual harassment, and retaliation by other residents or staff for reporting sexual abuse and sexual harassment.

Observations of facility during tour revealed that posters are in each housing unit are written in English and Spanish, as well as in the dining room and lobby. 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. A toll-free hotline number and a telephone is available for confidential reporting. Phones are available in each unit, along with grievance forms and boxes. Grievance forms are available in English. Third party reporting forms are located in the lobby.

Interviews were conducted with random residents, residents who reported sexual abuse, Compliance Manager, and random staff. PREA grievance boxes are located throughout the facility for residents to submit written reports of sexual harassment and sexual abuse. Third party reporting forms are in the facility visitor entrance for public use. Hotline numbers are posted throughout facility and phones are available for resident usage. Random staff stated that they could talk to the Director or call the hotline if they needed to report anonymously. They also stated that they could report to the PREA Coordinator and they can write a grievance if necessary. Staff are required to document verbal reports (internal notice) by end of shift. Staff stated that residents must submit a grievance form to report PREA incidents. The agency has established procedures for staff to privately report sexual abuse and sexual harassment of residents. Staff are informed of these procedures via pre-service and refresher training. Residents reported that they can call the hotline, make private calls to family, report to staff, write a grievance, call Department of Family Services, and tell a counselor or probation officer.

The facility submitted the following policy and/or documentation to the Auditor for review:

ROP Safe Environmental Standards Policy
ROP Safe Environmental Standards Student Brochure
Third-party reporting forms
ROP Safe Environmental Standards Lesson Plan
ROP Safe Environmental Standards Training on Staff Reporting
ROP Policy 600.364 Incident Reporting
Incident report documentation of verbal reports received
MOU with outside agency responsible for taking reports from students
ROP Policy 600.402 Student Grievance Policy

Based on the lack of understanding in regards to student written PREA reporting, the Auditor recommended that corrective action be taken. The facility submitted a staff training roster verifying that staff received training in student written reports of sexual harassment or sexual abuse.

Based on the evidence discussed, the facility has demonstrated compliance with this standard.

Standard 115.352: Exhaustion of administrative remedies

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

115.352 (a)

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

115.352 (b)

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

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

115.352 (c)

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

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

115.352 (d)

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

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

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

115.352 (e)

- Are third parties, including fellow residents, staff members, family members, attorneys, and outside advocates, permitted to assist residents in filing requests for administrative remedies

relating to allegations of sexual abuse? (N/A if agency is exempt from this standard.)
☒ Yes ☐ No ☐ NA

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

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

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

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

115.352 (f)

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

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

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

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

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

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

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

115.352 (g)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

The agency has an administrative procedure for dealing with resident grievances regarding sexual abuse. Agency policy or procedure allows a resident to submit a grievance regarding an allegation of sexual abuse at any time regardless of when the incident is alleged to have occurred. Agency policy does not require a resident to use an informal grievance process, or otherwise to attempt to resolve with staff, an alleged incident of sexual abuse. The agency's policy and procedure allow a resident to submit a grievance alleging sexual abuse without submitting it to the staff member who is the subject of the complaint.

The agency's policy and procedure require that a resident grievance alleging sexual abuse not be referred to the staff member who is the subject of the complaint. The agency's policy and procedures that require that a decision on the merits of any grievance or portion of a grievance alleging sexual abuse be made within 72 hours of the filing of the grievance. Agency policy and procedure permits third parties, including fellow residents, staff members, family members, attorneys, and outside advocates, to assist residents in filing requests for administrative remedies relating to allegations of sexual abuse, and to file such requests on behalf of residents. Agency policy and procedure require that if the resident declines to have third-party assistance in filing a grievance alleging sexual abuse, the agency documents the resident's decision to decline. Agency policy allows parents or legal guardians of residents to file a grievance alleging sexual abuse, including appeals, on behalf of such resident, regardless of whether the resident agrees to having the grievance filed on their behalf.

The agency has a policy and established procedures for filing an emergency grievance alleging that a resident is subject to a substantial risk of imminent sexual abuse. The agency's policy and procedures

for emergency grievances alleging substantial risk of imminent sexual abuse require an initial response within 48 hours. The agency's policy and procedure for emergency grievances alleging substantial risk of imminent sexual abuse require that a final agency decision be issued within 5 days. The agency has a written policy that limits its ability to discipline a resident for filing a grievance alleging sexual abuse to occasions where the agency demonstrates that the resident filed the grievance in bad faith.

Interviews were conducted with residents who reported sexual abuse. Residents felt they were treated fairly and were not disciplined. During staff interviews, they report that in the past 12 months, zero grievances that were filed alleging sexual abuse and that there were zero grievances alleging sexual abuse that reached final decision within 90 days after being filed. Also, in the past 12 months, there were zero grievances alleging sexual abuse that involved extensions because final decision was not reached within 90 days. Zero emergency grievances alleging substantial risk of imminent sexual abuse were filed in the past 12 months.

The agency would always notify the resident in writing when the agency files for an extension, including notice of the date by which a decision will be made. Zero grievances alleging sexual abuse were filed by residents in the past 12 months in which the resident declined third-party assistance, containing documentation of the resident's decision to decline. In the past 12 months, no resident grievances alleging sexual abuse that resulted in disciplinary action by the agency against the resident for having filed the grievance in bad faith were filed.

The facility submitted the following policy and/or documentation to the Auditor for review:

ROP Safe Environmental Standards Policy
Data report of grievances where student declined 3rd party assistance
Grievance data reports

Based on the evidence discussed, the facility has demonstrated compliance with this standard.

Standard 115.353: Resident access to outside confidential support services and legal representation

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

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

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 provides residents with access to outside victim advocates for emotional support services related to sexual abuse by giving residents (by providing, posting, or otherwise making accessible) mailing addresses and telephone numbers (including toll-free hotline numbers where available) of local, State, or national victim advocacy or rape crisis organizations; and by enabling reasonable communication between residents and these organizations, in as confidential a manner as possible.

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

The agency or facility does not maintain memorandum of understanding or other agreements with community service providers that are able to provide residents with emotional support services related to sexual abuse. The agency or facility has attempted to enter into MOUs or other agreements with community service providers that are able to provide such services. The agency maintains documentation of good faith attempts to enter into such agreements.

The Auditor was able to review documentation of good faith efforts made by the facility in an attempt to have a written agreement with outside support services.

Interviews were conducted with random residents, residents who reported sexual abuse, Superintendent, Compliance Manager. Residents can request a phone call in a private room to allow for confidentiality. Residents stated that there are posters with hotline numbers available to call, calls are unmonitored, and they can call or video chat with attorney or family. The facility provides residents with reasonable and confidential access to their attorneys or other legal representation. The facility provides residents with reasonable access to parents or legal guardians. Family phone calls can be made twice per week with weekend visitations. Family therapy sessions are also held weekly.

The facility submitted the following policy and/or documentation to the Auditor for review:

ROP Safe Environmental Standards Policy
Site Student handbook
Pictures of postings of outside support services

Based on the evidence discussed, the facility has demonstrated compliance with this standard.

Standard 115.354: Third-party reporting

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

115.354 (a)

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

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

The agency or facility provides a method to receive third-party reports of resident sexual abuse or sexual harassment. The agency or facility publicly distributes information on how to report resident sexual abuse or sexual harassment on behalf of residents via the facility's website.

The Auditor observed that third party reporting forms are available at the lobby, reception, and control center desk. Posters explaining third party reporting for sexual abuse and sexual harassment are posted in the lobby, reception, control center areas and visitation area.

The facility submitted the following policy and/or documentation to the Auditor for review:

ROP Safe Environmental Standards Policy
ROP Third Party Reporting Form
Pictures of postings
Website www.riteofpassage.com explaining third party reporting

Based on the evidence discussed, the facility has demonstrated compliance with this standard.

OFFICIAL RESPONSE FOLLOWING A RESIDENT REPORT

Standard 115.361: Staff and agency reporting duties

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

115.361 (a)

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

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

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

115.361 (b)

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

115.361 (c)

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

115.361 (d)

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

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

115.361 (e)

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

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

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

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

115.361 (f)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

The agency requires all staff to report immediately and according to agency policy any knowledge, suspicion, or information they receive regarding an incident of sexual abuse or sexual harassment that occurred in a facility, whether or not it is part of the agency. The agency requires all staff to report immediately and according to agency policy any retaliation against residents or staff who reported such an incident. The agency also requires all staff to report immediately and according to agency policy 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. Apart from reporting to the 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.

Interviews were conducted with Medical and Mental Health Staff, Superintendent, Compliance Manager, and random staff. Therapists advise residents that they have a duty to disclose and report and notifications are made by the therapists to the PREA Coordinator, Case Manager, Director, outside entities, parents and guardians. The Program Director reports verbally to licensing within 24 hours and an incident report is sent within 48 hours. Probation Case Workers complete notifications to court and attorneys. Random staff stated that they will notify Case Manager, Director, or the PREA Manager, and/or report externally.

The facility submitted the following policy and/or documentation to the Auditor for review:

ROP Safe Environmental Standards Policy
ROP Policy 100.407 Child Abuse Reporting Policy

Based on the evidence discussed, the facility has demonstrated compliance with this standard.

Standard 115.362: Agency protection duties

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

115.362 (a)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

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

Interviews were conducted with Superintendent, Agency Head, and random staff. Department of Family Services is notified if necessary and administrative staff would take immediate action to ensure safety of residents. The Agency Head stated that protocols are established for immediate action. Random staff stated that they would remove the resident from the situation and notify the supervisor. The Compliance Manager would conduct the investigation.

The facility submitted the following policy and/or documentation to the Auditor for review:

ROP Safe Environmental Standards Policy
Site PREA Incident Response Flowchart and Checklist
Documentation of substantial Risk of Imminent Domain
Documentation of response and timeframe

Based on the evidence discussed, the facility has demonstrated compliance with this standard.

Standard 115.363: Reporting to other confinement facilities

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

115.363 (a)

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

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

115.363 (b)

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

115.363 (c)

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

115.363 (d)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

The agency has a policy requiring that, upon receiving an allegation that a resident was sexually abused while confined at another facility, the head of the facility must notify the head of the facility or appropriate office of the agency or facility where sexual abuse is alleged to have occurred. The agency's policy also requires that the head of the facility notify the appropriate investigative agency.

Agency policy requires that the facility head provide such notification as soon as possible, but no later than 72 hours after receiving the allegation. The agency or facility documents that it has provided such

notification within 72 hours of receiving the allegation. Agency or facility policy requires that allegations received from other agencies or facilities are investigated in accordance with the PREA standards.

Interviews were conducted with Superintendent and the Agency Head. Both stated a full investigation will be conducted immediately and appropriate notifications made.

The facility submitted the following policy and/or documentation to the Auditor for review:

ROP Safe Environmental Standards Policy
Records of allegations
Case notes of abused students

Based on the evidence discussed, the facility has demonstrated compliance with this standard.

Standard 115.364: Staff first responder duties

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

115.364 (a)

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

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

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

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

115.364 (b)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

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

Rite of Passage does not have specific security staff. All staff are trained in standards 115.364 and 115.365.

Training documentation of personnel was reviewed and verified by the Auditor.

Interviews were conducted with residents who reported sexual abuse, first responders, and random staff. First responder protocols were inconsistent among staff as to what their expectations are, should they be the first responder to a situation of sexual abuse/sexual assault. Additional training or direction is needed in this area. Less than half of the first responder's stated that they would separate residents and stay with the victim, the other half stated that they would tell a supervisor and have them handle it. Residents who reported sexual abuse said that action was taken right away. Staff report that in the past 12 months, two allegations that a resident was sexually abused were made.

The facility submitted the following policy and/or documentation to the Auditor for review:

ROP Safe Environmental Standards Policy
Site specific PREA Incident Response Flowchart and Checklist
Records on the number of allegations and first responders in the past 12 months

Based on staff unclear as to their first responder duties, the Auditor recommended that corrective action be taken. The facility submitted a PREA first responder badge that will be given to each staff member to attach to their lanyard.

Based on the evidence discussed, the facility has exceeded compliance with this standard.

Standard 115.365: Coordinated response

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

115.365 (a)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

The facility developed a written institutional plan to coordinate actions taken in response to an incident of sexual abuse among staff first responders, medical and mental health practitioners, investigators, and facility leadership.

Interviews were conducted with the Superintendent. The facility has an incident response flowchart that is used for reporting purposes.

The facility submitted the following policy and/or documentation to the Auditor for review:

ROP Safe Environmental Standards Policy
PREA Incident Response Flowchart and Checklist/MLA Communication Tree

Based on the evidence discussed, the facility has demonstrated compliance with this standard.

Standard 115.366: Preservation of ability to protect residents from contact with abusers

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

115.366 (a)

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

115.366 (b)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

Rite of Passage does not have collective bargaining agreements and is an at-will employer.

An interview was conducted with the Agency Head. Wyoming is a right to work state and is not a collective bargaining state.

Based on the evidence discussed, the facility has demonstrated compliance with this standard.

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.

The agency has a policy to protect all residents and staff who report sexual abuse or sexual harassment or cooperate with sexual abuse or sexual harassment investigations from retaliation by other residents or staff. The agency designates staff member(s) or charges department(s) with monitoring for possible retaliation.

The agency and/or facility monitors the conduct or treatment of residents or staff who reported sexual abuse and of residents who were reported to have suffered sexual abuse to see if there are any changes that may suggest possible retaliation by residents or staff for at least 90 days. The agency/facility acts promptly to remedy any such retaliation. The agency/facility continues such monitoring beyond 90 days if the initial monitoring indicates a continuing need.

Interviews were conducted with residents who reported sexual abuse, Superintendent, and the Agency Head. The Compliance Manager monitors all disciplinary actions. If staff are involved, they would be removed from units and/or the facility if needed. Victim and alleged abuser are immediately separated. Residents are reminded how to report sexual abuse and sexual harassment incidents. Minimum weekly check-in's with residents would be provided by the Compliance Manager. Residents can use grievance boxes to report any retaliation. Retaliation is monitored at least 90 days or until the residents leave the facility. Monitoring will continue until Compliance Manager determines it is no longer needed. Staff environmental standards are in place to investigate and report immediately. Human Resources would assist the Compliance Manager with investigations should staff be involved. Residents who reported sexual abuse or sexual harassment felt that they are protected from retaliation.

The facility submitted the following policy and/or documentation to the Auditor for review:

ROP Safe Environmental Standards Policy
ROP Policy 600.402 Student Problem Solving and Grievance Procedure
ROP Policy 100.402 Staff Protection (Whistleblower)

Based on the evidence discussed, the facility has exceeded compliance with this standard.

Standard 115.368: Post-allegation protective custody

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

115.368 (a)

- Is any and all use of segregated housing to protect a resident who is alleged to have suffered sexual abuse subject to the requirements of § 115.342? ☒ Yes ☐ No

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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 that residents who allege to have suffered sexual abuse may only be placed in isolation as a last resort if less restrictive measures are inadequate to keep them and other residents safe, and only until an alternative means of keeping all residents safe can be arranged. The facility policy requires that residents who are placed in isolation because they allege to have suffered sexual abuse have access to legally required educational programming, special education services, and daily large-muscle exercise.

Observations of Facility during tour revealed that there were not any isolation areas or segregated areas.

Interviews were conducted with Medical and Mental Health staff and the Superintendent. All state that isolation is not utilized. Residents stated that they have not been isolated and are not aware that other residents have been isolated.

The facility submitted the following policy and/or documentation to the Auditor for review:
ROP Safe Environmental Standards Policy

Based on the evidence discussed, the facility has demonstrated compliance with this standard.

INVESTIGATIONS

Standard 115.371: Criminal and administrative agency investigations

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

115.371 (a)

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

- Does the agency conduct such investigations for all allegations, including third party and anonymous reports? [N/A if the agency/facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations. See 115.321(a).]
  ☒ Yes ☐ No ☐ NA

115.371 (b)

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

115.371 (c)

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

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

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

115.371 (d)

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

115.371 (e)

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

115.371 (f)

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

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

115.371 (g)

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

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

115.371 (h)

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

115.371 (i)

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

115.371 (j)

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

115.371 (k)

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

115.371 (l)

- Auditor is not required to audit this provision.

115.371 (m)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

The agency/facility has a policy related to criminal and administrative agency investigations. The agency does not terminate an investigation solely because the source of the allegation recants the allegation. Substantiated allegations of conduct that appear to be criminal are referred for prosecution.

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

Interviews were conducted with residents who reported sexual abuse, Investigators, Superintendent, Compliance Manager, and the PREA Coordinator. PREA Coordinator stated that this has not occurred due to constant communication. The Compliance Manager will follow up regularly with Laramie County Sheriff Department on all criminal cases. Internal notice is given within 48 hours. Investigation begins immediately after. For sexual assaults, Laramie County Sheriff Office is called immediately, and they will conduct the investigation. For internal investigations, residents and staff are interviewed, and cameras are reviewed. Ratio and policies are reviewed as well. This investigation is due in 30 days; however, is usually completed within two-to-three weeks. Any evidence is preserved. Resident and staff files are reviewed including previous history. All allegations are treated as valid until proven otherwise. Should an employee leave during an ongoing investigation, the investigation will continue.

The facility submitted the following policy and/or documentation to the Auditor for review:

ROP Safe Environmental Standards Policy

Based on the evidence discussed, the facility has demonstrated 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.

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

The facility submitted the following policy and/or documentation to the Auditor for review:

ROP Safe Environmental Standards Policy

Based on the evidence discussed, the facility has demonstrated compliance with this standard.

Standard 115.373: Reporting to residents

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

115.373 (a)

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

115.373 (b)

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

115.373 (c)

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

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

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

- Following a resident's allegation that a staff member has committed sexual abuse against the resident, unless the agency has determined that the allegation is unfounded, or unless the resident has been released from custody, does the agency subsequently inform the resident

whenever: The agency learns that the staff member has been convicted on a charge related to sexual abuse within the facility? ☒ Yes ☐ No

115.373 (d)

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

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

115.373 (e)

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

115.373 (f)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

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

Following a resident's allegation that a staff member has committed sexual abuse against the resident, the agency/facility subsequently informs the resident (unless the agency has determined that the allegation is unfounded) whenever the staff member is no longer posted within the resident's unit; the staff member is no longer employed at the facility; the agency learns that the staff member has been

indicted on a charge related to sexual abuse within the facility; or the agency learns that the staff member has been convicted on a charge related to sexual abuse within the facility.

Following a resident's allegation that he or she has been sexually abused by another resident in an agency facility, the agency subsequently informs the alleged victim whenever the agency learns that the alleged abuser has been indicted on a charge related to sexual abuse within the facility; or the agency learns that the alleged abuser has been convicted on a charge related to sexual abuse within the facility.

Interviews were conducted with residents who reported sexual abuse, Investigators, and the Superintendent. Status of Investigation Notification to victims are provided in writing by the Compliance Manager. If an outside entity conducts such investigations, the agency requests the relevant information from the investigative entity in order to inform the resident as to the outcome of the investigation. There has not been a substantiated or unsubstantiated complaint (i.e. not unfounded) of sexual abuse committed by a staff member against a resident in an agency facility in the past 12 months.

The facility submitted the following policy and/or documentation to the Auditor for review:

ROP Safe Environmental Standards Policy
Sample of alleged sexual abuse investigations completed by agency
Post Allegation Student Notification Response Form
Sample documentation of notification of students of alleged student abuser's outcome
Records of documented notifications made
Sample documentation of substantiated or unsubstantiated complaints
Samples of alleged sexual abuse investigations completed by outside agency
Records of completed outside investigations

Based on the evidence discussed, the facility has demonstrated compliance with this standard.

DISCIPLINE

Standard 115.376: Disciplinary sanctions for staff

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

115.376 (a)

- Are 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.

Policy states that staff are subject to disciplinary sanctions up to and including termination for violating agency sexual abuse or sexual harassment policies. Disciplinary sanctions for violations of agency policies relating to sexual abuse or sexual harassment (other than engaging in sexual abuse) are commensurate with the nature and circumstances of the acts committed, the staff member's disciplinary history, and the sanctions imposed for comparable offenses by other staff with similar histories. All terminations for violations of agency sexual abuse or sexual harassment policies, or resignations by staff who would have been terminated if not for their resignation, are reported to law enforcement agencies, unless the activity was clearly not criminal, and to any relevant licensing bodies.

The facility submitted the following policy and/or documentation to the Auditor for review:

ROP Safe Environmental Standards Policy
Reports of the number of staff that have violated agency sexual abuse or sexual harassment policies
Reports of the number of staff that have been disciplined
Reports of staff that have been reported to law enforcement

Disciplinary Action forms

Based on the evidence discussed, the facility has demonstrated 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.

Agency policy requires that any contractor or volunteer who engages in sexual abuse be reported to law enforcement agencies, unless the activity was clearly not criminal, and to relevant licensing bodies. Agency policy requires that any contractor or volunteer who engages in sexual abuse be prohibited from contact with residents. 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.

Interviews were conducted with Superintendent. The Superintendent stated that contractors and volunteers would be removed from the facility and reported to Law Enforcement should an allegation arise. At this time, the facility does not have any volunteers or contractors.

The facility submitted the following policy and/or documentation to the Auditor for review:

ROP Safe Environmental Standards Policy

Based on the evidence discussed, the facility has demonstrated compliance with this standard.

Standard 115.378: Interventions and disciplinary sanctions for residents

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

115.378 (a)

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

115.378 (b)

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

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

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

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

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

115.378 (c)

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

115.378 (d)

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

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

115.378 (e)

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

115.378 (f)

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

115.378 (g)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

Policy states that residents are subject to disciplinary sanctions only pursuant to a formal disciplinary process following an administrative finding that the resident engaged in resident-on-resident sexual abuse. Residents are subject to disciplinary sanctions only pursuant to a formal disciplinary process following a criminal finding of guilt for resident-on-resident sexual abuse. In the event a disciplinary sanction for resident-on resident sexual abuse results in the isolation of a resident, the facility policy requires that residents in isolation have daily access to large muscle exercise, legally required educational programming, and special education services. In the event a disciplinary sanction for resident-on resident sexual abuse results in the isolation of a resident, residents in isolation receive daily visits from a medical or mental health care clinician. In the event a disciplinary sanction for resident-on resident sexual abuse results in the isolation of a resident, residents in isolation have access to other programs and work opportunities to the extent possible.

The facility offers therapy, counseling, or other interventions designed to address and correct the underlying reasons or motivations for abuse. The facility considers whether to require the offending resident to participate in such interventions as a condition of access to any rewards-based behavior management system or other behavior-based incentives. Access to general programming or education is not conditional on participation in such interventions. The agency disciplines residents for sexual contact with staff only upon finding that the staff member did not consent to such contact.

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

The facility reports that isolation is not used. During a tour of the facility the Auditor did not observe any isolation areas or isolation rooms.

Interviews were conducted with Medical and Mental Health Staff and the Superintendent. Case Managers complete a Sexual Offender Tip Evaluation. Therapy interventions are held regularly with victims and all therapy sessions are voluntary for residents. Psychosexual evaluations are completed by an outside psychologist as needed. Resident sleeping rooms do not lock. The facility can take residents into the sensory therapy room or the therapist office if needed. One-on-one observations can be used as well.

The facility submitted the following policy and/or documentation to the Auditor for review:

ROP Safe Environmental Standards Policy
Records of disciplinary actions

Based on the evidence discussed, the facility has demonstrated compliance with this standard.

MEDICAL AND MENTAL CARE

Standard 115.381: Medical and mental health screenings; history of sexual abuse

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

115.381 (a)

- If the screening pursuant to § 115.341 indicates that a resident has experienced prior sexual victimization, whether it occurred in an institutional setting or in the community, do staff ensure that the resident is offered a follow-up meeting with a medical or mental health practitioner within 14 days of the intake screening? ☒ Yes ☐ No

115.381 (b)

- If the screening pursuant to § 115.341 indicates that a resident has previously perpetrated sexual abuse, whether it occurred in an institutional setting or in the community, do staff ensure that the resident is offered a follow-up meeting with a mental health practitioner within 14 days of the intake screening? ☒ Yes ☐ No

115.381 (c)

- Is any information related to sexual victimization or abusiveness that occurred in an institutional setting strictly limited to medical and mental health practitioners and other staff as necessary to inform treatment plans and security management decisions, including housing, bed, work, education, and program assignments, or as otherwise required by Federal, State, or local law? ☒ Yes ☐ No

115.381 (d)

- Do medical and mental health practitioners obtain informed consent from residents before reporting information about prior sexual victimization that did not occur in an institutional setting, unless the resident is under the age of 18? ☒ Yes ☐ No

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

Policy states that all residents at this facility who have disclosed any prior sexual victimization during a screening pursuant to §115.341 are offered a follow-up meeting with a medical or mental health practitioner within 14 days of the intake screening. Case Managers complete the risk assessment.

Medical and mental health staff maintain secondary materials (e.g., form, log) documenting compliance with the above required services. All residents who have previously perpetrated sexual abuse, as indicated during the screening pursuant to § 115.341, are offered a follow-up meeting with a mental health practitioner within 14 days. Mental health staff maintain secondary materials (e.g., form, log) documenting compliance with the above required services. The information shared with other staff is strictly limited to informing security and management decisions, including treatment plans, housing, bed, work, education, and program assignments, or as otherwise required by federal, state, or local law.

Observations of facility during tour revealed that medical records are kept locked in the medical office and mental health records are kept locked in the Case Manager's office. Medical and mental health practitioners do not obtain informed consent from residents before reporting information about prior sexual victimization that did not occur in an institutional setting due to the resident being under the age of 18. Residents exit the facility on their 18th birthday. Observations of facility during tour revealed that resident files were kept locked in the Case Manager's office.

A review of nine resident files indicate that three were potential victims and two were potential aggressors according to the risk screening.

Interviews were conducted with residents who disclosed prior sexual abuse, Medical and Mental Health Staff, and staff that perform risk screenings stated that consent is not needed for residents under 18 years but is required for residents over 18 years. All residents sign a consent to treat during intake regardless of age. Should a previous sexual incident be reported during intake, Case Managers will report the incident and follow-up and services will be provided. All staff are mandatory reporters. Residents stated that they are informed of this also. One resident stated that she was placed in a trauma group.

The facility submitted the following policy and/or documentation to the Auditor for review:

ROP Safe Environmental Standards Policy

Based on the evidence discussed, the facility has demonstrated compliance with this standard.

Standard 115.382: Access to emergency medical and mental health services

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

115.382 (a)

- Do resident victims of sexual abuse receive timely, unimpeded access to emergency medical treatment and crisis intervention services, the nature and scope of which are determined by medical and mental health practitioners according to their professional judgment? ☒ Yes ☐ No

115.382 (b)

- If no qualified medical or mental health practitioners are on duty at the time a report of recent sexual abuse is made, do staff first responders take preliminary steps to protect the victim pursuant to § 115.362? ☒ Yes ☐ No

- Do staff first responders immediately notify the appropriate medical and mental health practitioners? ☒ Yes ☐ No

115.382 (c)

- Are resident victims of sexual abuse offered timely information about and timely access to emergency contraception and sexually transmitted infections prophylaxis, in accordance with professionally accepted standards of care, where medically appropriate? ☒ Yes ☐ No

115.382 (d)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

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

Resident victims of sexual abuse while incarcerated are offered timely information about and timely access to emergency contraception and sexually transmitted infections prophylaxis, in accordance with professionally accepted standards of care, where medically appropriate. Treatment services are

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

Observations of facility during tour revealed that a medical exam room is downstairs and available to residents.

Interviews were conducted with Medical and Mental Health Staff, and staff first responders. Staff stated that reports are made within 24 hours and data is provided to Rite of Passage and posted on the webpage. Medical will transport residents immediately to the hospital.

The facility submitted the following policy and/or documentation to the Auditor for review:

ROP Safe Environmental Standards Policy

Based on the evidence discussed, the facility has demonstrated compliance with this standard.

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

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

115.383 (a)

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

115.383 (b)

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

115.383 (c)

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

115.383 (d)

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

115.383 (e)

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

115.383 (f)

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

115.383 (g)

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

115.383 (h)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

According to policy, 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. Female victims of sexually abusive vaginal penetration while incarcerated are offered pregnancy tests. If pregnancy results from sexual abuse while incarcerated, victims receive timely and comprehensive information about, and timely access to, all lawful pregnancy related medical services. Resident victims of sexual abuse while incarcerated are offered tests for sexually transmitted infections as medically appropriate. The facility attempts to conduct a mental health evaluation of all known resident-on-resident abusers within 60 days of learning of such abuse history and offers treatment when deemed appropriate by mental health practitioners.

Observations of facility during tour revealed that a medical exam room is downstairs and available to residents.

Interviews were conducted with Medical and Mental Health Staff. Mental Health staff ask residents how they are feeling but do not ask for details. Therapists assist to connect resident to resources. Facility is very interactive with the residents. Therapy is offered weekdays with groups daily. Should a resident upon entering the facility already have a therapist assigned, the facility will attempt to keep that connection to assist with consistency and transition. All residents receive assessments at intake and throughout their stay. Therapists treat mental health issues while residents are at the facility. As needs arise, treatment plans are modified. Victim advocacy is through the Sheriff Office. Medical staff will refer residents to an OB GYN and a pregnancy treatment plan will be put in place.

The facility submitted the following policy and/or documentation to the Auditor for review:

ROP Safe Environmental Standards Policy
ROP Student Vulnerability Assessment Instrument: Risk of Victimization and/or Sexually Aggressive Behavior/Overall Risk
Pregnancy Treatment Plan (safety plan)

Based on the evidence discussed, the facility has demonstrated compliance with this standard.

DATA COLLECTION AND REVIEW

Standard 115.386: Sexual abuse incident reviews

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

115.386 (a)

- Does the facility conduct a sexual abuse incident review at the conclusion of every sexual abuse investigation, including where the allegation has not been substantiated, unless the allegation has been determined to be unfounded? ☒ Yes ☐ No

115.386 (b)

- Does such review ordinarily occur within 30 days of the conclusion of the investigation? ☒ Yes ☐ No

115.386 (c)

- Does the review team include upper-level management officials, with input from line supervisors, investigators, and medical or mental health practitioners? ☒ Yes ☐ No

115.386 (d)

- Does the review team: Consider whether the allegation or investigation indicates a need to change policy or practice to better prevent, detect, or respond to sexual abuse? ☒ Yes ☐ No

- Does the review team: Consider whether the incident or allegation was motivated by race; ethnicity; gender identity; lesbian, gay, bisexual, transgender, or intersex identification, status, or perceived status; gang affiliation; or other group dynamics at the facility? ☒ Yes ☐ No

- Does the review team: Examine the area in the facility where the incident allegedly occurred to assess whether physical barriers in the area may enable abuse? ☒ Yes ☐ No

- Does the review team: Assess the adequacy of staffing levels in that area during different shifts? ☒ Yes ☐ No

- Does the review team: Assess whether monitoring technology should be deployed or augmented to supplement supervision by staff? ☒ Yes ☐ No

- Does the review team: Prepare a report of its findings, including but not necessarily limited to determinations made pursuant to §§ 115.386(d)(1) - (d)(5), and any recommendations for improvement and submit such report to the facility head and PREA compliance manager? ☒ Yes ☐ No

115.386 (e)

- Does the facility implement the recommendations for improvement, or document its reasons for not doing so? ☒ Yes ☐ No

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

Policy states that the facility conducts a sexual abuse incident review at the end of every criminal or administrative sexual abuse investigation, unless the allegation has been determined to be unfounded. Sexual abuse incident reviews are ordinarily conducted within 30 days of concluding the criminal or administrative investigation. The sexual abuse incident review team includes upper-level management officials and allows for input from line supervisors, investigators, and medical or mental health practitioners. The facility conducts internal investigations on all criminal allegations, regardless of the outside findings. Investigations are completed when they are unfounded by law enforcement.

The facility prepares a report of its findings from sexual abuse incident reviews, including but not necessarily limited to determinations made pursuant to paragraphs (d)(1)-(d)(5) of this section, and any recommendations for improvement and submits such report to the Facility Head and Compliance Manager. The facility implements the recommendations for improvement or documents its reasons for not doing so.

Interviews were conducted with Sexual Assault Response Team (SART) members, Superintendent, and the Compliance Manager. Staff's direct supervisor or the Program Director writes the disciplinary actions. Most outcomes are due to lack of supervision and staff being slow to report. Changes are also made to the physical environment when needed. Mirrors are used in areas of blind spots where cameras are unable to view or are not present. The Facility Director, who is part of the SART, stated that all areas are discussed, reviewed, and analyzed and the physical environment is also assessed.

The facility submitted the following policy and/or documentation to the Auditor for review:

ROP Safe Environmental Standards Policy
ROP Form – Safe Environmental Standards Administrative Response Review
Documentation of Incident Reviews
Records regarding implementation of recommendations or reasons for not implementing recommendations
Records of administrative investigations

Based on the evidence discussed, the facility has demonstrated compliance with this standard.

Standard 115.387: Data collection

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

115.387 (a)

- Does the agency collect accurate, uniform data for every allegation of sexual abuse at facilities under its direct control using a standardized instrument and set of definitions? ☒ Yes ☐ No

115.387 (b)

- Does the agency aggregate the incident-based sexual abuse data at least annually? ☒ Yes ☐ No

115.387 (c)

- Does the incident-based data include, at a minimum, the data necessary to answer all questions from the most recent version of the Survey of Sexual Violence conducted by the Department of Justice? ☒ Yes ☐ No

115.387 (d)

- Does the agency maintain, review, and collect data as needed from all available incident-based documents, including reports, investigation files, and sexual abuse incident reviews?
  ☒ Yes ☐ No

115.387 (e)

- Does the agency also obtain incident-based and aggregated data from every private facility with which it contracts for the confinement of its residents? (N/A if agency does not contract for the confinement of its residents.) ☐ Yes ☐ No ☒ NA

115.387 (f)

- Does the agency, upon request, provide all such data from the previous calendar year to the Department of Justice no later than June 30? (N/A if DOJ has not requested agency data.)
  ☒ Yes ☐ No ☐ NA

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

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

The agency aggregates 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.

The agency does not contract for the confinement of its residents. The agency provided the Department of Justice (DOJ) with data from the previous calendar year upon request.

The facility submitted the following policy and/or documentation to the Auditor for review:

ROP Safe Environmental Standards Policy
DOJ Survey of Sexual Violence

Student Vulnerability Assessment Instrument: Risk of Victimization and/or Sexually Aggressive Behavior/Overall Risk

Based on the evidence discussed, the facility has demonstrated compliance with this standard.

Standard 115.388: Data review for corrective action

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

115.388 (a)

- Does the agency review data collected and aggregated pursuant to § 115.387 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training, including by: Identifying problem areas? ☒ Yes ☐ No

- Does the agency review data collected and aggregated pursuant to § 115.387 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training, including by: Taking corrective action on an ongoing basis? ☒ Yes ☐ No

- Does the agency review data collected and aggregated pursuant to § 115.387 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training, including by: Preparing an annual report of its findings and corrective actions for each facility, as well as the agency as a whole? ☒ Yes ☐ No

115.388 (b)

- Does the agency's annual report include a comparison of the current year's data and corrective actions with those from prior years and provide an assessment of the agency's progress in addressing sexual abuse ☒ Yes ☐ No

115.388 (c)

- Is the agency's annual report approved by the agency head and made readily available to the public through its website or, if it does not have one, through other means? ☒ Yes ☐ No

115.388 (d)

- Does the agency indicate the nature of the material redacted where it redacts specific material from the reports when publication would present a clear and specific threat to the safety and security of a facility? ☒ Yes ☐ No

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

The agency reviews data collected and aggregated pursuant to §115.387 to assess and improve the effectiveness of its 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 its findings from its 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 to those from prior years. The annual report provides an assessment of the agency's progress in addressing sexual abuse. The agency makes its annual report readily available to the public, at least annually, through its website: Riteofpassage.com/safe-environmental-standards. The annual reports are approved by the Agency Head before being publicly shared.

When the agency redacts material from an annual report for publication, the redactions are limited to specific materials where publication would present a clear and specific threat to the safety and security of the facility. The agency indicates the nature of material redacted.

Interviews were conducted with Agency Head, PREA Compliance Manager, and the PREA Coordinator. Reports are developed annually and information is redacted to avoid personal identifiers. Agency Head conducts a review of the annual report before it is published and the PREA Coordinator reviews the report monthly after it has been published and reviews investigations on a quarterly basis. Annual reports contain SSV information. The agency is hiring a National Director of Compliance to analyze data on a regular basis, to conduct annual reviews of site by site trends, and quality assurance reviews.

The facility submitted the following policy and/or documentation to the Auditor for review:

ROP Safe Environmental Standards Policy
2017 PREA Annual Report Agency Report

Based on the evidence discussed, the facility has exceeded compliance with this standard.

Standard 115.389: Data storage, publication, and destruction

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

115.389 (a)

- Does the agency ensure that data collected pursuant to § 115.387 are securely retained? ☒ Yes ☐ No

115.389 (b)

- Does the agency make all aggregated sexual abuse data, from facilities under its direct control and private facilities with which it contracts, readily available to the public at least annually through its website or, if it does not have one, through other means? ☒ Yes ☐ No

115.389 (c)

- Does the agency remove all personal identifiers before making aggregated sexual abuse data publicly available? ☒ Yes ☐ No

115.389 (d)

- Does the agency maintain sexual abuse data collected pursuant to § 115.387 for at least 10 years after the date of the initial collection, unless Federal, State, or local law requires otherwise? ☒ Yes ☐ No

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

The agency ensures that incident-based and aggregate data are securely retained. Agency policy requires that aggregated sexual abuse data from facilities under its direct control and private facilities with which it contracts with, be made readily available to the public at least annually through its website.

Before making aggregated sexual abuse data publicly available, the agency removes all personal identifiers. The agency maintains sexual abuse data collected pursuant to §115.387 for at least 10 years after the date of initial collection, unless Federal, State or local law requires otherwise.

An interview was conducted with the PREA Coordinator. PREA Coordinator reviews monthly to determine root cause. Investigations are reviewed quarterly. Annual report contains required SSV information.

The facility submitted the following policy and/or documentation to the Auditor for review:

ROP Safe Environmental Standards Policy
MLA 2017 PREA Incident Data
MLA 2018 PREA Incident Data
MLA 2019 PREA Incident Data
2017 PREA Annual Report Agency Report
Agency's record retention schedule

Based on the evidence discussed, the facility has demonstrated compliance with this standard.

AUDITING AND CORRECTIVE ACTION

Standard 115.401: Frequency and scope of audits

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

115.401 (a)

- During the prior three-year audit period, did the agency ensure that each facility operated by the agency, or by a private organization on behalf of the agency, was audited at least once? (*Note: The response here is purely informational. A "no" response does not impact overall compliance with this standard.*) ☒ Yes ☐ No

115.401 (b)

- Is this the first year of the current audit cycle? (*Note: a "no" response does not impact overall compliance with this standard*.) ☒ Yes ☐ No

- If this is the second year of the current audit cycle, did the agency ensure that at least one-third of each facility type operated by the agency, or by a private organization on behalf of the agency, was audited during the first year of the current audit cycle? (N/A if this is **not** the *second* year of the current audit cycle.) ☐ Yes ☐ No ☒ NA

- If this is the third year of the current audit cycle, did the agency ensure that at least two-thirds of each facility type operated by the agency, or by a private organization on behalf of the agency, were audited during the first two years of the current audit cycle? (N/A if this is **not** the *third* year of the current audit cycle.) ☐ Yes ☐ No ☒ NA

115.401 (h)

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

115.401 (i)

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

115.401 (m)

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

115.401 (n)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

This is the facility's first audit. The Auditor was given full access to the facility, staff, residents, and documentation.

Observations of facility during tour revealed that dated notice of audits were posted in all housing areas and other locations throughout the facility with the Auditor's name and mailing address clearly visible.

Based on the evidence discussed, the facility has demonstrated compliance with this standard.

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.

This is the facility's first audit. The Auditor was given full access to the facility, staff, residents, and documentation.

Based on the evidence discussed, the facility has demonstrated compliance with this standard.

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.

Elaine Bridschge 07/14/2019

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.