PREA AUDIT REPORT ☐ INTERIM x FINAL

JUVENILE FACILITIES

Date of report: August 22, 2016

Auditor Information			
Auditor name: Nate Parker			
Address: 7555 4th Ave Lino Lakes, MN 55014			
Email: nate.parker@co.anoka.mn.us			
Telephone number: 651-783-7528			
Date of facility visit: July 25-29, 2016			
Facility Information			
Facility name: Four Oaks			
Facility physical address: 5400 Kirkwood Blvd SW, Cedar Rapids, Iowa 52404			
Facility mailing address: *(if different from above)* Click here to enter text.			
Facility telephone number: 319-364-0259			
The facility is:	☐ Federal	☐ State	☐ County
	☐ Military	☐ Municipal	☐ Private for profit
	x Private not for profit		
Facility type:	☐ Correctional	☐ Detention	x Other
Name of facility's Chief Executive Officer: Anne Gruenewald			
Number of staff assigned to the facility in the last 12 months: 400			
Designed facility capacity: 130			
Current population of facility: 109			
Facility security levels/inmate custody levels: 7 unlocked units/1 locked unit			
Age range of the population: 12-17			
Name of PREA Compliance Manager: Travis Meiborg		**Title:** Program Manager	
Email address: tmeiborg@fouroaks.org		**Telephone number:** 319-784-1400	
Agency Information			
Name of agency: Four Oaks			
Governing authority or parent agency: *(if applicable)* Click here to enter text.			
Physical address: 5400 Kirkwood Blvd SW, Cedar Rapids, Iowa 52404			
Mailing address: *(if different from above)* Click here to enter text.			
Telephone number: 319-364-0259			
Agency Chief Executive Officer			
Name: Anne Gruenewald		**Title:** President/CEO	
Email address: agruenewald@fouroaks.org		**Telephone number:** 319-364-2142	
Agency-Wide PREA Coordinator			
Name: Chad Prior		**Title:** Quality & Performance Improvement Manager	
Email address: cprior@fouroaks.org		**Telephone number:** 319-364-2050	

AUDIT FINDINGS

NARRATIVE

On Monday, July 25, 2016, an entrance meeting was held at the Four Oaks campus, Cedar Rapids, IA, with the Agency PREA Coordinator, three Program Managers, Training Manager and Manager of the Quality Improvement Department. This meeting detailed the scope of the audit, a review of the four distinct programs operated by Four Oaks and an audit plan for the next five days. At the completion of the meeting, the PREA Coordinator guided the auditor on a tour of the Smith Center Program and made introductions to various staff. Time was spent reviewing physical layout and placement of PREA educational posters and PREA audit announcements placed in the housing units.

Population of the Smith Center Program is 40 beds with 34 placements at the time of the audit. Of the 34 residents placed, 20 were male and 14 females. This program is comprised of two houses each of 10 beds for male residents and one living unit for female residents with a maximum capacity of 20 residents. The auditor completed 14 resident interviews, 10 random staff interviews, 3 PREA Compliance Manager interviews, 2 Program Coordinator interviews, 1 Therapist Interview, Agency Head Designee interview and PREA Coordinator/Investigative staff interview at this program location.

On Tuesday, July 26, 2016, the audit continued at the STOP program. This program can house up to 38 residents and had 34 residents at the time of the audit. The STOP program has three housing units to include one locked unit. PREA Coordinator led a tour of the individual housing units and time was spent viewing education posters and PREA Audit announcements placed in each housing location. The auditor completed 10 resident interviews, 6 random staff interviews, 2 PREA Compliance Manager interviews, 1 Therapist interview, 1 Case Manager interview and 1 Program Manager interview.

On Wednesday, July 27, 2016, the audit moved to the Marion program, a 27 bed program that at the time of the audit had 24 males housed in the program. Program manager led a tour of this program to include placement of educational posters and PREA audit announcements. The auditor completed 10 resident interviews, 6 random staff interviews, 1 Therapist interview, 1 Case Manager interview, 1 PREA Compliance Manager interview and 1 Program Manager interview at this location.

On Thursday, July 28, 2016, the audit moved to the JMRT program, a 25 bed female program that had 16 residents at the time of the audit. The Program Coordinator led the auditor on a tour of the program and time was spent viewing educational posters and PREA audit announcements. The auditor completed 8 resident interviews, 3 staff interviews, 1 Therapist interview, 1 Case Manager interview, 1 Program Coordinator interview, 1 PREA Compliance Manager interview, 1 Program Manager interview and 1 Program officer interview.

On Friday, July 29, 2016, the auditor and PREA Coordinator spent time reviewing training records, investigative report documents, Coordinated Response plans and facility policy. An exit interview was completed at the end of the day to review audit results.

It should be noted that prior to the on-site audit, the auditor had telephone conversations with Waypoint, a local provider.

Currently there are no cameras in any of the program locations.

The auditor would like to thank all of the Four Oaks staff for their hospitality, cooperation and thorough commitment during the audit process.

DESCRIPTION OF FACILITY CHARACTERISTICS

Four Oaks manages four distinct programs specializing in group residential foster care. The Smith Center program houses both male and female residents between the ages of 12-17 with the average length of stay 6-9 months. The STOP program is a residential program for male residents specializing in programming for sexually inappropriate behaviors in the community. Residents in this program typically have longer stays based on programming needs up to 18 months if needed. The Marion program is a male only program for youth between the ages of 12-17 who have been placed by the courts for programming needs. The JMRT program specializes in female residents between the ages of 12-17 in need of programming services.

Each program offers clients therapeutic services from the time they enter the program until the time of their transition back into the community often times ensuring that residents have a continuation of care once they reach the community. Every client at Four Oaks is assigned a therapist, case manager and an advocate to ensure seamless service delivery during a youth's stay in their particular program. The therapy team will create an individualized treatment plan for each client so that therapeutic needs are met during a youth's stay. Program staff also create and implement behavioral health plans and safety plans for clients to ensure a holistic approach is used when incorporating program modalities.

Four Oaks takes a family-based approach when incorporating cognitive behavioral interventions, coping skills, social skills and personal accountability into daily programming.

Four Oaks is comprised of 8 housing units in the four distinct program areas with a licensed capacity of 130 residents. Of the 8 units, 6 can be characterized as a dorm setting while 2 units are converted houses with a more group home feel to the setting. As previously noted, Four Oaks does not have cameras in any of their program locations. This dynamic was reviewed with the Agency Head designee and PREA Coordinator at the time of the audit.

SUMMARY OF AUDIT FINDINGS

Four Oaks is found to be in compliance with the PREA Standards.

Number of standards exceeded: 0

Number of standards met: 39

Number of standards not met: 0

Number of standards not applicable: 2

Standard 115.311 Zero tolerance of sexual abuse and sexual harassment; PREA Coordinator

☐ Exceeds Standard (substantially exceeds requirement of standard)

x Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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

The agency has a detailed, written policy that mandates zero tolerance toward all forms of sexual abuse and sexual harassment. The policy also outlines the agency's approach to prevention, detection, and responding to such conduct if it occurs. The agency has identified and designated an upper-level, agency wide PREA coordinator who has sufficient time and authority to develop, implement, and oversee agency efforts to comply with PREA standards. The agency has identified eight PREA Compliance Managers based on the four program locations. The PREA Compliance Managers have sufficient time and authority to coordinate compliance with PREA standards.

Standard 115.312 Contracting with other entities for the confinement of residents

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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The agency currently does not contract for the confinement of residents. N/A

Standard 115.313 Supervision and monitoring

☐ Exceeds Standard (substantially exceeds requirement of standard)

x Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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The agency provided documentation of a staffing plan for each program location. The staffing plan takes into consideration the eleven criteria as outlined in standard 115.313 (a). The facility had no documented deviations from the staffing plan in the last twelve months. Random facility schedules were reviewed to verify compliance with the staffing plan. Each program location maintains at a minimum a 1:5

staff to resident ratio based on state licensing rules during wake hours. Staff to resident ratios during sleep hours are 1:12 based on state licensing standards. At the time of the report, the agency has yet to complete their annual review of the staffing plan based on the PREA implementation timeline of the first quarter of 2016. The PREA Coordinator has implemented a system for completing unannounced rounds in each program location covering all facility shifts. A system has also been created for tracking unannounced rounds in each location.

Standard 115.315 Limits to cross-gender viewing and searches

☐ Exceeds Standard (substantially exceeds requirement of standard)

x Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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

Agency policy prohibits the practice of strip searches and pat-down searches. All residents complete a self search: pull pockets, remove shoes, and waistband check. None of the program locations had logged cross-gender searches based on agency policy. Each program location requires residents to change clothing in the bathroom area which is private and behind a closed door. All staff use a knock and announce procedure for completing room checks and employ the same practice if needing to check on a resident that is in the bathroom area. Agency procedure calls for staff of the same sex to be the staff that conducts the check if a resident is unresponsive behind a closed door. Agency policy and procedure was verified through resident interviews and staff interviews. All staff were aware of the policy and procedure and were able to articulate the process. All residents interviewed felt they had privacy to complete showering, hygiene, changing of clothing, and perform bodily functions. The agency had no residents at the time of the audit that identified as transgender or intersex.

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

☐ Exceeds Standard (substantially exceeds requirement of standard)

x Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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

The agency has policy and procedure in place to ensure clients with disabilities and clients with limited English language skills are aware of the zero tolerance for any form of sexual abuse or sexual harassment. The agency has a network of interpreter services available to meet the needs of all clients and their families. During the pre-audit phase, the agency created resident education materials for residents and their families that may have limited English proficiency. These materials were provided to the auditor at the time of the on-site inspection. Agency policy allows for customized education for residents that may have cognitive disabilities or limited sight or vision. Agency policy also mandates that resident interpreters will not be used except in limited circumstances. The facility has no documented cases of resident interpreter use. At the time of the audit, there were no clients with disability or limited English proficiency. After interviewing a random sample of staff, all staff were able to review the process of accessing interpreter services if needed.

Standard 115.317 Hiring and promotion decisions

☐ Exceeds Standard (substantially exceeds requirement of standard)

x Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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

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 has engaged in sexual abuse in any type of confinement setting, has been convicted of engaging or attempting to engage in sexual activity in the community facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse; or has been civilly or administratively adjudicated to have engaged in the activity described above. Per agency policy, any incident of sexual harassment will be considered when hiring or promoting anyone. Before hiring new employees, the agency will perform a criminal background check, consult any child abuse registry maintained by the State of Iowa and 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 sexual abuse. The agency policy also prescribes the same process prior to enlisting the services of any contractor who may have contact with residents. At the time of the audit, there was no defined time frame per state licensing standards regarding frequency of background checks. At the completion of the on-site audit, the agency made the decision to conduct a background check of current employees every five years. Agency policy requires that all applicants who may have contact with residents be screened for previous conduct related to sexual abuse or sexual harassment as part of the application process. The agency also imposes upon its employees a continuing affirmative duty to disclose any such conduct. The agency will 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.

Standard 115.318 Upgrades to facilities and technologies

☐ Exceeds Standard (substantially exceeds requirement of standard)

x Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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Since August 20, 2012, the agency relocated one of its male only programs to a modern building. The new program location allows for better sight lines, minimizes blind spots and all program space is on one level. The agency currently has no camera technology in any of its programs.

Standard 115.321 Evidence protocol and forensic medical examinations

☐ Exceeds Standard (substantially exceeds requirement of standard)

x Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion

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

The agency trains all staff who have contact with residents as first responders. This training includes the importance of scene safety, evidence integrity and separation of alleged perpetrator and alleged victim. Local law enforcement agencies are responsible for the collection of evidence at all program locations. The agency has attempted to enter into a memo of understanding with the local law enforcement agencies to ensure a uniform evidence protocol is followed and also developmentally appropriate for youth. The agency provided proof of these attempts to secure memos of understanding. The agency has a policy that all cases requiring medical examinations will be performed by a Sexual Assault Forensic Examiner (SAFE) or Sexual Assault Nurse Examiner (SANE). While the investigating agency will set this up, the agency will ensure that examinations are performed by qualified entities at no cost to the resident victim. In the past twelve months, the agency has had no referrals for forensic medical examinations. The agency will offer advocacy services from a sexual assault service provider to the client victim. If none are available, the agency will provide support services from a community based organization or a qualified agency staff member. The agency has established relationships with multiple community based providers to provide support and advocacy services for resident victims to include the Rape Victim Advocacy Program in Iowa City, Family Resources Crisis Line in Davenport Iowa, Waypoint Crisis Line in Cedar Rapids and St Lukes Child Protection Center in Cedar Rapids, Iowa. As previously noted, local law enforcement agencies will be completing all criminal investigations of alleged sexual abuse. St Lukes Hospital in Cedar Rapids, Iowa will be conducting all SAFE/SANE examinations. Attempted memos of understanding have been made to all agencies that conduct criminal investigations of sexual abuse and forensic examinations.

Standard 115.322 Policies to ensure referrals of allegations for investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

x Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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

The agency has a policy in place that ensures an administrative or criminal investigation is completed for all allegations of sexual abuse and sexual harassment. In the past twelve months, the agency has received a total of five allegations: two of the allegations were investigated administratively and three of the allegations were referred for investigation externally. A thorough investigation was completed in all cases. Agency policy also requires that allegations be referred for investigation to an agency with the legal authority to conduct criminal investigations. The agency's policy is published on their public website in regards to investigative responsibilities for each type of investigation. Procedure and investigative reports were reviewed with the PREA Coordinator and process was confirmed with agency head designee.

Standard 115.331 Employee training

☐ Exceeds Standard (substantially exceeds requirement of standard)

x Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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

The agency has trained all employees who may have contact with residents on the eleven prescribed training components as described in 115.331 (a). The agency provided copies of training curriculum and employee training records. All training is documented in an electronic training management system. A random sample of staff were interviewed and all staff verified completion and understanding of the various training components. Staff training has been tailored to the unique needs and attributes of each program. Agency policy describes staff training that will be completed when refresher training is not completed to include current sexual abuse and sexual harassment policies. The agency has established a client safety training package that employees need to complete annually. The PREA Coordinator provided copies of targeted training reminders that are sent to staff as a means of providing refresher training on key concepts such as first responder duties.

Standard 115.332 Volunteer and contractor training

☐ Exceeds Standard (substantially exceeds requirement of standard)

x Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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

Agency policy requires all volunteers and contractors who have contact with residents to be trained on their responsibilities under the agency's sexual abuse and sexual harassment prevention, detection, and response policies and procedures. The agency provided training curriculum and training records for all volunteers. Volunteer training focused on the agency's zero tolerance policy on sexual abuse and sexual harassment as well as how to report such incidents. The agency maintains training records electronically. Each training module includes a test portion to ensure the trainee understands the information. No volunteers were interviewed at the time of the audit.

Standard 115.333 Resident education

☐ Exceeds Standard (substantially exceeds requirement of standard)

x Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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

The agency has a unique system for completing resident education. At the time of intake, each resident meets with their assigned therapist and completes an intake assessment. The intake assessment includes initial and comprehensive PREA education for the residents regarding their rights to be free from sexual abuse and sexual harassment and to be free from retaliation for reporting such incidents. Resident education also focuses on agency policies and procedures for responding to such incidents. All residents currently placed have completed comprehensive education and random youth files were spot checked for verification. The auditor interviewed four therapists from the agency who articulated a very thorough intake and education process for residents. The auditor interviewed 42 residents who were able to articulate the education they received quite well. The facility provided a copy of the education material that is reviewed with each resident and given to them as a client safety manual. The facility has alternative formats available to residents based on disability or limited English proficiency. The agency provides residents access to ongoing education through posters, resident handbooks and ongoing small group discussions on resident safety.

Standard 115.334 Specialized training: Investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

x Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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Agency policy requires that investigators be trained in conducting sexual abuse investigations in confinement settings. The agency PREA Coordinator is the lone investigative staff in the agency. The PREA coordinator only conducts administrative investigations. All criminal investigations are referred to local law enforcement. The PREA Coordinator provided proof of completed training.

Standard 115.335 Specialized training: Medical and mental health care

☐ Exceeds Standard (substantially exceeds requirement of standard)

x Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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The agency has a policy to ensure all medical and mental health care practitioners who work regularly in its programs have been trained on the four areas as outlined in 115.335 (a). The agency provided training records for all specialized staff. The auditor interviewed agency therapists who were able to articulate the training they received. These staff also received training on the agency zero tolerance policy and how to prevent, detect and report allegations of sexual abuse and sexual harassment.

Standard 115.341 Screening for risk of victimization and abusiveness

☐ Exceeds Standard (substantially exceeds requirement of standard)

x Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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

Agency policy requires each resident to be screened for risk of sexual abuse victimization or sexual abusiveness within 72 hours of intake. While conducting interviews with random residents, all indicated that the screening questions were asked of them at the time of intake by their assigned therapist. Risk level is assessed ongoing by the treatment team that has weekly consultation to review resident treatment plans,

behavioral health plans, and safety plans. A random sample of resident files were reviewed to ensure agency policy and procedure were being met. All were in compliance. The agency provided a copy of their screening instrument used for all residents. The screening instrument includes all areas identified in 115.341 (c). Information is gathered from residents during the intake process and collateral information provided is reviewed to include court records, case files, behavioral records from other facilities, and other relevant documentation from the resident's file. Sensitive information is controlled through settings in the resident information management system. Policy and procedure were verified in great detail through interviews with therapists that conduct initial assessment interviews with residents.

Standard 115.342 Use of screening information

☐ Exceeds Standard (substantially exceeds requirement of standard)

x Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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The agency has a policy to ensure intake screening risk factors are taken into consideration when making decisions on housing, bed, program, education, and work assignments for all residents. The agency incorporates all risk factors into the resident's primary treatment plan, behavioral health plan and safety plan. Risk areas are re-assessed on an ongoing basis to ensure resident and staff safety. The agency provided copies of behavioral health plans and safety plans for auditor review and standard compliance. This process was reviewed with program PREA Compliance Managers and therapist staff that complete risk screening of residents. Information regarding risk factors is sent to staff in a timely manner to ensure resident safety. Per agency policy, isolation is not used for any reason. The agency policy prohibits the placement of lesbian, gay, bisexual, transgender or intersex residents solely on the basis of such identification or status. This identification or status is also not considered as an indicator or likelihood of being sexually abusive. The agency policy considers on a case-by-case basis whether a placement would ensure the client's health and safety in regards to assigning housing and programming transgender or intersex residents. Management and security problems are also reviewed as part of the process. Agency policy also requires placement and programming assignments for each transgender or intersex resident be reviewed at least twice per year. A transgender or intersex resident's own views with respect to his or her safety will be given serious consideration. Each program has individual showers for all residents. At the time of the audit there were no transgender or intersex residents placed. The auditor interviewed PREA Compliance Managers, Case Managers and Therapists at each program location to ensure compliance with policy and procedure. All staff interviewed were able to discuss the components of this standard.

Standard 115.351 Resident reporting

☐ Exceeds Standard (substantially exceeds requirement of standard)

x Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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

The agency has developed a policy providing multiple internal ways for residents to privately report sexual abuse and sexual harassment, retaliation by other residents or staff for reporting sexual abuse and sexual harassment, and staff neglect or violation of responsibilities that may have contributed to such incidents. Through interviews with random staff and residents, all were able to articulate the avenues available

to report including resident's therapist, program manager, advocate, shift leader, teacher, medical provider or any staff member the resident may trust. Each program also has drop boxes available to residents for anonymous reporting. The agency also provides residents with access to a third party reporting center that is able to receive and immediately forward resident reports of sexual abuse and sexual harassment to agency officials. The agency has provided proof of agreement with Waypoint, a 24-hour crisis line. Resident access to external reporting is noted on educational posters in each program as well as the resident handbook. Each staff interviewed was able to review the process used when handling a verbal report to include documentation and review with program management staff to include PREA Compliance Manager and PREA Coordinator. Each program makes the necessary tools available to residents in order to effectively make a report. Staff were also able to articulate the different means available to them in order to make a private report regarding sexual abuse and sexual harassment of residents.

Standard 115.352 Exhaustion of administrative remedies

☐ Exceeds Standard (substantially exceeds requirement of standard)

x Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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The agency has a clear policy and procedure for dealing with resident grievances regarding sexual abuse. In review of the resident handbook, residents are informed of their right to file a grievance if needed. Agency policy includes four criteria as established in 115.352 (b). Agency policy also does not require the resident to submit the grievance to a staff member who is the subject of the complaint and the grievance is not referred to a staff member who is the subject of the complaint. Agency policy requires that a decision on the merits of any grievance alleging sexual abuse be made within 90 days of the filing of the grievance. Agency policy also allows for third parties, including fellow residents, staff members, family members, attorneys, and outside advocates to be permitted to assist residents in filing requests for administrative remedies in relation to allegations of sexual abuse and are permitted to file requests on behalf of residents. Agency policy also has a clear process to handle emergency grievances which are defined with eminent danger to the client. Timeline for emergency grievance procedures is 48 hours for initial response and a final agency decision in five days. All grievance procedures will be documented per agency policy. Agency policy calls for no resident discipline for a false report.

Standard 115.353 Resident access to outside confidential support services

☐ Exceeds Standard (substantially exceeds requirement of standard)

x Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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

Each agency program provides residents with access to outside victim advocates for emotional support services related to sexual abuse. Contact information for these services was posted on educational posters in each housing unit and provided to each resident in their client safety guide. Each agency program provides access to these support agencies in as confidential a manner as possible. Through resident interviews, each youth was able to articulate the availability of outside resources and the extent to which those conversations would be confidential based on mandatory reporting laws in the state of Iowa. The agency has attempted to enter into a memo of understanding with a community service provider who will provide emotional support services. Currently, there are four providers available for residents to

contact. All residents interviewed described daily contact with attorneys and parents/legal guardians if needed.

Standard 115.354 Third-party reporting

☐ Exceeds Standard (substantially exceeds requirement of standard)

x Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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The agency has established a policy and procedure on receiving third party reports. Third party reporting is listed on the agency website giving interested parties means of filing a report if needed.

Standard 115.361 Staff and agency reporting duties

☐ Exceeds Standard (substantially exceeds requirement of standard)

x Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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

Agency policy requires 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 an agency program; retaliation against residents or staff who reported such an incident; or any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation. All staff are trained on State of Iowa mandatory reporting laws. Staff are trained on data privacy in relation to sexual abuse and sexual harassment allegations and are prohibited from disclosing any information to anyone other than to make treatment, investigation, and other security and management decisions. Per policy, medical and mental health practitioners are required to report to designated supervisors as well as state or local service agencies based on mandatory reporting laws. Such practitioners are also obligated per policy to inform residents at the initiation of services the limitations on confidentiality. Upon receiving a complaint, per policy, the program manager or designee will report the allegation to the appropriate agency office, residents parent/legal guardian, placing worker and assigned attorney or legal representative such as guardian ad litem. All allegations of sexual abuse and sexual harassment are reported to the agency PREA Coordinator for administrative review. Policy and procedure was reviewed with Program Officer designee, PREA Compliance Managers, PREA Coordinator and random staff. All interviewed were well versed on process and their individual responsibilities in regards to responding to a resident report.

Standard 115.362 Agency protection duties

☐ Exceeds Standard (substantially exceeds requirement of standard)

x Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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

Agency protocol is to respond to risks of imminent sexual abuse immediately. Staff interviewed all articulated the same response: separate the potential victim from the potential perpetrator immediately, engage supervision, document the incident and re-locate the resident to a different housing unit if available. Agency head designee and Program Officer designee confirmed the process in their interviews. The agency had no documented cases of imminent risk reported in the past 12 months.

Standard 115.363 Reporting to other confinement facilities

☐ Exceeds Standard (substantially exceeds requirement of standard)

x Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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

Agency policy requires that an allegation that a resident was sexually abused while confined at another facility will be reported to the head of the facility where the alleged abuse occurred or the appropriate office of the agency where the alleged abuse occurred and shall also notify the appropriate investigative agency. In the past 12 months, the agency has received no such complaints. Notification will be completed as soon as possible but no later than 72 hours after receiving the allegation. Per policy, the agency will document that it has provided the notification. Interviews of agency head designee and Program Officer designee affirmed policy and procedure.

Standard 115.364 Staff first responder duties

☐ Exceeds Standard (substantially exceeds requirement of standard)

x Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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

Agency has developed a policy and trained all staff who have contact with residents on first responder duties. The policy includes separating the alleged victim and perpetrator as well as the steps needed for evidence preservation. All staff interviewed were well versed on first responder duties and were able to articulate the process they would take step by step when posed with a scenario by the auditor.

Standard 115.365 Coordinated response

☐ Exceeds Standard (substantially exceeds requirement of standard)

x Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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

The agency has developed a coordinated response plan for each program to deal effectively with an incident of sexual abuse. The flow chart details responsibilities of staff first responders, medical and mental health practitioners, investigators, and facility leadership. This plan was reviewed with the PREA Coordinator.

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

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The agency currently does not have any collective bargaining units.

Standard 115.367 Agency protection against retaliation

☐ Exceeds Standard (substantially exceeds requirement of standard)

x Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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

The agency has established a policy to protect all residents and staff who report sexual abuse or sexual harassment or cooperate with a sexual abuse or sexual harassment investigation. Immediately following a report, a staff member or outside department will be assigned to monitor for retaliation based on the nature of the incident. The agency has employed multiple measures to protect from retaliation to include; housing transfers or program removal for resident victims or resident abusers, removal of alleged staff or resident abusers from contact with resident victims and emotional support services for residents or staff that fear retaliation. The agency will monitor for at least 90 days the conduct and treatment of residents or staff who have reported sexual abuse and sexual harassment. The agency will also monitor for at least 90 days resident victims who were reported to have suffered sexual abuse to see if there are changes that may suggest possible retaliation. Items the agency will monitor include client disciplinary reports, housing or program changes, or negative performance reviews or reassignments of

staff. The agency will extend the 90-day monitoring period if deemed necessary. In the case of residents, the monitoring period will include period status checks. The agency provided five documented cases where retaliation periods were documented.

Standard 115.368 Post-allegation protective custody

☐ Exceeds Standard (substantially exceeds requirement of standard)

x Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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

The agency does not use isolation of residents for any reason. This practice was confirmed during the interview with the Program Officer designee.

Standard 115.371 Criminal and administrative agency investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

x Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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

The agency policy regarding investigations calls for prompt, thorough, and objective response including third party and anonymous reports. The agency uses a trained investigator to complete administrative investigations and refers all criminal investigations to local law enforcement agencies. Law enforcement agencies responsible for criminal investigations will collect evidence based on their agency protocols. The agency will not terminate an investigation because the source of the allegation recants the allegation. The credibility of an alleged victim, suspect, or witness shall be assessed on an individual basis and shall not be determined by the person's status as resident or staff. The agency shall not require a resident who alleges sexual abuse to submit to a polygraph examination as a condition of proceeding with the investigation. Per policy. administrative investigations will include an effort to determine whether staff actions or failures to act contributed to the abuse and shall be documented in written reports that include a description of the physical and testimonial evidence, reasoning behind credibility assessments, and investigative facts and findings. The agency will retain all written reports related to criminal and administrative investigations. Investigative process was reviewed with the PREA Coordinator, the staff responsible for conducting all administrative investigations. Due to law enforcement conducting criminal investigations, the agency will stay informed about the progress of the investigation. This process was confirmed with the Program Officer designee and PREA Coordinator.

Standard 115.372 Evidentiary standard for administrative investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

x Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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

Agency policy has established a standard no higher than a preponderance of the evidence in determining whether allegations of sexual abuse or sexual harassment are substantiated. This was confirmed during the interview with the PREA Coordinator.

Standard 115.373 Reporting to residents

☐ Exceeds Standard (substantially exceeds requirement of standard)

x Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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

Agency policy requires that any resident who makes an allegation of sexual abuse will be 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 or outside investigative agency. In the past 12 months the agency has had four allegations of sexual abuse. Findings were communicated to all residents who made an allegation. This policy and procedure was confirmed in interviews with the Program Officer designee and PREA Coordinator. If the agency did not conduct the investigation, it will request the relevant information from the investigative agency in order to inform the resident. Per agency policy, following a resident's allegation that a staff member has committed sexual abuse against a resident, the agency will report to the resident based on 115.373 (c). If the alleged abuser is a resident, the agency policy calls for notification to the victim if the alleged abuser has been indicted on a charge related to sexual abuse or the agency learns that the alleged abuser has been adjudicated on a charge related to sexual assault within the facility. All notifications were documented per policy and provided to the auditor.

Standard 115.376 Disciplinary sanctions for staff

☐ Exceeds Standard (substantially exceeds requirement of standard)

x Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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

Per agency policy, staff are subject to disciplinary sanctions up to and including termination for violating agency sexual abuse or sexual harassment policies. Termination is presumptive for staff who have engaged in sexual abuse. Per policy, disciplinary action that results in termination for criminal behavior, or a resignation preceding termination, will be reported to law enforcement and any relevant licensing bodies. In the past 12 months, the agency has had no staff related investigations that would fit the circumstances of this policy.

Standard 115.377 Corrective action for contractors and volunteers

☐ Exceeds Standard (substantially exceeds requirement of standard)

x Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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

Per agency policy, any contractor or volunteer who engages in sexual abuse or sexual harassment will be prohibited from contact with clients and will be reported to law enforcement, unless the activity was clearly not criminal, and to relevant licensing bodies. The agency will take remedial measures, and will consider whether to prohibit further contact with clients, in the case of any other violation of agency sexual abuse or sexual harassment policies by a contractor or volunteer. The agency has no documented cases in the past 12 months. This was confirmed with the Program Officer designee.

Standard 115.378 Disciplinary sanctions for residents

☐ Exceeds Standard (substantially exceeds requirement of standard)

x Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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

The agency has a policy in place that will subject residents to disciplinary sanctions only pursuant to a formal disciplinary process following an administrative finding that the resident engaged in resident-on-resident sexual abuse or following a criminal finding of guilt for resident-on-resident sexual abuse. There have been no findings either administratively or criminally in the past 12 months of resident-on-resident sexual abuse. Per policy, any disciplinary sanction shall be commensurate with the nature and circumstances of the abuse committed, the resident's disciplinary history, and the sanctions imposed for comparable offenses. The agency does not use isolation in any of its programs per state licensing standards. The discipline process considers whether a resident's mental disabilities, mental illness or trauma contributed to the behavior. The agency may offer therapy, counseling, or other interventions to address and correct underling reasons or motivations for the abuse. The agency may discipline a resident for sexual contact with staff only upon finding that the staff member did not consent to such contact. There are no such cases documented. For the purpose of disciplinary action, a report made in good faith will not constitute a false report even if the outcome of the investigation finds the action to be unfounded. Agency policy prohibits all sexual activity between residents and may discipline for such activity.

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

☐ Exceeds Standard (substantially exceeds requirement of standard)

x Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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

Agency policy requires that all residents who indicated prior sexual victimization or prior sexual abuse perpetration during intake screening be offered follow up services. Due to the nature of programming at all programs, each resident is assigned a therapist during their stay. Prior victimization or perpetration is incorporated into each resident's treatment plan and is reviewed regularly by the treatment team in weekly consultation meetings. This practice was confirmed with therapists at each program location. Information related to sexual victimization or abusiveness that occurred in an institutional setting will limited to medical and mental health practitioners and other staff, as necessary, to inform treatment plans, and security and management decisions, including housing, bed, work, education, and program assignments. Informed consent does not apply as all residents placed are 12-17 years of age.

Standard 115.382 Access to emergency medical and mental health services

☐ Exceeds Standard (substantially exceeds requirement of standard)

x Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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

Agency policy calls for victims of sexual abuse to receive timely, unimpeded access to emergency medical treatment and crisis intervention services provided by the investigative agency. The agency relies on law enforcement and community based medical providers to triage emergency care needed for victims of sexual abuse. Treatment services will be provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident.

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

☐ Exceeds Standard (substantially exceeds requirement of standard)

x Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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

The agency will offer medical and mental health evaluation and, as appropriate, treatment to all clients who have been victimized by sexual abuse. The evaluation and treatment includes follow-up services, treatment plans, and, when necessary, referrals for continued care following discharge from the program. Each program provides victims with medical and mental health services consistent with the community level of care to include pregnancy tests for victims of sexually abusive vaginal penetration and for those residents who have resulting pregnancy, timely and comprehensive information about and timely access to all lawful pregnancy-related medical services. Resident victims of sexual abuse will be offered tests for sexually transmitted infections as medically appropriate. All treatment services will be provided to the client victim without financial cost and regardless of whether the client victim names the abuser or cooperates with any investigation arising out of the incident. The agency will attempt to conduct a mental health evaluation of all known client-on-client abusers

within 60 days of learning of such abuse and offer treatment when deemed appropriate by mental health practitioners.

Standard 115.386 Sexual abuse incident reviews

☐ Exceeds Standard (substantially exceeds requirement of standard)

x Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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

The agency has created a sexual abuse incident review team that includes management officials, supervisors, investigators, and medical or mental health practitioners. Agency provided documentation of completed investigations. The agency had one incident meeting the criteria for review and it was completed within 30 days of the incident being reported. The review team considers all areas as defined in 115.386 (d). As part of the process, the agency will implement recommendations from the review team or document its reasons for not doing so. Incident review process was confirmed during interviews with PREA Coordinator and Program Officer designee.

Standard 115.387 Data collection

☐ Exceeds Standard (substantially exceeds requirement of standard)

x Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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

The agency has established a policy to collect accurate, uniform data for every allegation of sexual abuse using a standardized instrument and set of definitions. The agency is aggregating its data annually and will provide it to the U.S. Department of Justice upon request. The agency will maintain, review, and collect data as needed from all available incident based documents, including reports, investigation files, and sexual abuse incident reviews.

Standard 115.388 Data review for corrective action

☐ Exceeds Standard (substantially exceeds requirement of standard)

x Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These

recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Per agency policy, data will be reviewed by the PREA Coordinator to identify problem areas and take corrective action. Problem areas and corrective action will be documented in an annual report. The report will include a comparison of current year's data with those from prior years and will provide an assessment of the agency's progress in addressing sexual abuse. The agency report will be approved by the Four Oaks President/CEO or designee and made readily available to the public through its website. The agency may redact specific material from the report when publication would present a clear threat to the safety and security of Four Oaks. This data review process was confirmed with the Agency Head designee and PREA Coordinator. Due to implementation timeline, 2016 will be the first year of data collection.

Standard 115.389 Data storage, publication, and destruction

☐ Exceeds Standard (substantially exceeds requirement of standard)

x Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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

The agency has developed a policy for data storage, publication and destruction. The policy ensures that all data will be securely retained. All aggregated sexual abuse data will be readily available to the public at least annually through its website. All personal identifiers will be removed from aggregated data prior to publication. All sexual abuse data will be maintained for at least 10 years after the date of the initial collection.

AUDITOR CERTIFICATION

I certify that:

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

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

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

Nate Parker August 27, 2016

Auditor Signature Date