PREA AUDIT REPORT ☐ INTERIM ☒ FINAL
JUVENILE FACILITIES

Date of report: May 26, 2016

Auditor Information			
Auditor name: Jeff Rogers			
Address: P.O. Box 1628 Frankfort, Kentucky 40602			
Email: jamraat02@gmail.com			
Telephone number: 502-320-4769			
Date of facility visit: May 17-18, 2016			
Facility Information			
Facility name: Oklahoma Juvenile Center for Girls			
Facility physical address: 310 12th Street, N.E., Norman, Oklahoma 73071			
Facility mailing address: *(if different from above)* same			
Facility telephone number: 405-329-1163			
The facility is:	☐ Federal	☒ State	☐ County
	☐ Military	☐ Municipal	☐ Private for profit
	☐ Private not for profit		
Facility type:	☒ Correctional	☐ Detention	☐ Other
Name of facility's Chief Executive Officer: Todd Anderson			
Number of staff assigned to the facility in the last 12 months: 53			
Designed facility capacity: 22			
Current population of facility: 18			
Facility security levels/inmate custody levels: medium secure			
Age range of the population: 13-19			
Name of PREA Compliance Manager: Sally Davis		**Title:** Psych Clinician	
Email address: sally.davis@oja.ok.gov		**Telephone number:** 405-329-1163	
Agency Information			
Name of agency: Office of Juvenile Affairs			
Governing authority or parent agency: *(if applicable)* state			
Physical address: 3812 N. Santa Fe, Suite 400, Oklahoma City, Oklahoma 73118			
Mailing address: *(if different from above)* same			
Telephone number: 405-530-2800			
Agency Chief Executive Officer			
Name: Steven Buck		**Title:** Executive Director	
Email address: steven.buck@oja.ok.gov		**Telephone number:** 405-530-2800	
Agency-Wide PREA Coordinator			
Name: Cathy McLean		**Title:** PREA Coordinator	
Email address: cathy.mclean@oja.ok.gov		**Telephone number:** 405-530-2877	

AUDIT FINDINGS

NARRATIVE

The Prison Rape Elimination Act (PREA) on-site audit of the Oklahoma Juvenile Center for Girls (OJC4G) was conducted on May 17-18, 2016 by Jeff Rogers, from Frankfort, Kentucky who is a U.S. Department of Justice Certified PREA Auditor for juvenile facilities. Pre-audit preparation included a thorough review of all documentation and materials submitted by the facility along with the data included in the completed Pre-Audit Questionnaire. The documentation reviewed included agency policies, procedures, forms, education materials, training curriculum, organizational charts, posters, brochures and other PREA related materials that were provided to demonstrate compliance with the PREA standards. The review prompted two questions by the auditor that were sent via email and discussed on the telephone prior to the on-site audit. All concerns were addressed to the satisfaction of the auditor prior to his arrival.
During the on-site audit, the auditor was provided a private conference room in the facility from which to work and conduct confidential interviews with facility staff, residents and contractors. The auditor interviewed six (6) residents from the three housing units, two from each housing unit with varying lengths of stay. Eight (8) facility staff members were interviewed representing all shifts utilizing the DOJ provided Random Staff Questionnaire. Residents were interviewed using the recommended DOJ protocols that question their knowledge of a variety of PREA protections; generally and specifically, their knowledge of reporting mechanisms available to residents to report abuse or harassment. Staff were questioned using the DOJ protocols 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 following specialty staff/resident questionnaires were utlized during this review including:

The Agency Head (interviewed by this auditor in August 2015 during another PREA audit in OJA)
The Facility Director
Agency PREA Coordinator (previously interviewed by this auditor in August 2015 during a previous OJA PREA Audit)
PREA Compliance Manager (Sally Davis was off on medical leave during this audit, her backup Stephen Grayson was interviewed)
Designated Staff Charged with Monitoring Retaliation
Incident Review Team
Staff that preform Screening For Risk or Victimization and Abusiveness
Intake Staff
Volunteers and Contractor Who May Have Contact with Residents (2)
Medical and Mental Health Staff (2)
Administrative (Human Resources) Staff
Intermediate or Higher Level Facility Staff (2)
Staff First Responder (2)
Investigator
Resident Who Reported Sexual Abuse

The auditor reviewed five (5) staff personnel records to determine compliance with training mandates and background check procedures. Case records of five (5) residents were reviewed to evaluate screening and intake procedures, resident education and other general programmatic areas. In addition to examining the five (5) case records the auditor also interviewed one resident who had reported sexual abuse. The auditor also reviewed and read four investigations out of a possible six (6) available. During the past 12 months there has been six (6) allegations of sexual harassment.

The auditor toured the facility escorted by the Agency Head and PREA Compliance Manager and observed among other things the facility configuration, location of cameras, staff supervision of residents, housing unit layout including shower/toilet areas, placement of posters and PREA informational resources, security monitoring, resident entrance and search procedures, and resident programming. The auditor noted that shower areas allow residents to shower separately and shower stalls have plastic curtains for additional privacy (residents shower one at a time). Notices of the PREA audit were posted throughout the facility in common areas on April 4, 2016.

DESCRIPTION OF FACILITY CHARACTERISTICS

The Oklahoma Juvenile Center for Girls (OJC4G) provides care, guidance, discipline, education, rehabilitation and reintegration services for 22 female youth between the ages of 14-19. The facility is located in Norman, Oklahoma adjacient to additional social service facilities and programs. Residents of OJC4G have been adjudicated by the court as a Delinquent or Youthful Offender, are in the custody of the Office of Juvenile Affairs and meet the requirements for placement in a medium-secure facility. The purpose of Oklahoma Juvenile Center for Girls is to provide temporary residential care, offer effective intervention into the resident's delinquent behaviors, provide for the safety of the public and hold residents accountable for their behaviors.

The physical plant is a one story structure. All pedestrian traffic enters at a single entry point that requires staff assistance to open. Once inside the building all staff and visitors are searched as are carry in items such as a briefcase or a purse. Each visitor signs in to a log at the entry point. The facility is comprised of three housing units. Two housing units have seven (7) beds each and a third housing unit has eight (8) beds. Each sleeping room is a dry room necessitating each resident to ask staff permission at night to access the toilets. Each housing unit has toilets, wash basins and showers. Each housing unit also has a washer and dryer. Residents shower one a time with staff supervision outside of the shower area. There is a dining/multipurpose room however, food is delivered to the facility from another OJA facility approximately 30 miles away. Food is delivered in temperature controlled containers. The facility also has a large training/conference room and administrative offices, a medical room, and staff offices. There is also an outside recreation area surrounded by fencing with razor ribbon at the top. There are 32 surveillance cameras that are viewed as part of the supervision of residents. The cameras can be monitored from in the facility's control center which is near the single entry point into the facility. The control center is manned 24 hours each day. The average length of staff is 496 days. The OJC4G is the only girls secure treatment facility in Oklahoma in Oklahoma.

The Education Department is part of the Norman School District. The District provides two (2) teachers (considered contract employees) whom teach an aray of educational topics including Math, Science, Social Studies, and English. Other programming at the facility consists of GED Preperation, Chemical Dependency Groups, Individual and Group Counseling, Issues group, anger management group. Social Skills Group, Gender Specific Group (Girls Circle and Seeking Safety), Parenting, and Girl Scouts. The facility staffing is concentrated in the following departments:

Social Services

The Social Services Department consists of Juvenile Justice Specialists (JJS). They are professional staff providing case management and therapeutic services to the residents. Case management includes monthly reviews of the resident's progress, reports to the courts and contact with the resident's family and community service providers. Available therapeutic services include treatment plan development, crisis intervention, individual counseling, family counseling and hosting cognitive/behavioral groups.

Psychology

Psychological Clinicians and a contract psychologist provide the following services and duties; individual and family therapy, resident treatment consultation, assessment of assault and suicidal risks, assessment for intake, crisis intervention, screening recommendations for medications, special assessments for certification studies, and mental health evaluations. The Psychology Department directs the sex offender treatment program and develops focal treatment groups as needed to meet the needs of the residents. They also oversee the facility's Drug and Alcohol program. This program provides substance abuse treatment for residents with chemical dependency issues.

Security

The Security Department is comprised of Juvenile Security Officers (JSO) whose primary objective is to ensure the safety and security of residents and staff at the facility. JSOs regularly complete safety and security checks including inside the living units, around the grounds, and the facility's perimeter. They are also responsible for transporting residents outside of the facility for court and other appointments. They respond to all crisis incidents and regularly assist Youth Guidance Specialists in the de-escalation of disturbances. They also investigate incidents and assist in resident crisis counseling.

Youth Guidance

Youth Guidance Specialists (YGS) are responsible for the care and safety of the resident population. They are the first and most constant role models for the residents. While projecting a positive example, they encourage the youth to engage in the treatment programs. The YGS staff is responsible for documenting the progress of the residents during each eight-hour shift. They keep a visual and documented count of each resident with a fifteen to thirty minute frequency. They maintain a log of all incidents and complete reports. Driven by safety and security, they perform routine and non-routine inspections of assigned living areas and items within the living units. YGS staff care for the daily needs of the residents and direct the movement of the residents between various activities.

Nursing

The medical department is dedicated to providing quality medical care to the residents at OJC4G. The staff provide a variety of health service's needs. A medical doctor and dentist provide routine services for residents. The department works with other medical professionals when specialty services are needed. Ongoing education courses are provided to the nursing staff and facility-wide to keep up with the ever-changing medical and psychiatric needs of the resident population.

Recreation

The Recreation Department is committed to promoting social interaction between the residents at OJC4G, to improve quality of life, and to provide opportunities to learn new skills. .The staff offers opportunities for the residents to learn appropriate leisure time activities and self-expression and to enhance their self-image and self-esteem. The goals of the department are to assist the residents in reducing their anxiety and stress, promote community re-integration, decrease social isolation, and improve their overall fitness level.

Volunteer Services

Volunteer Services is the liaison between OJC4G and community members that willingly offer their talents and abilities to enhance the services provided and meet the needs of residents at OJC4G.

Building and Grounds Maintenance

The Building and Grounds Maintenance Department works tirelessly to maintain the facility. This includes electrical, plumbing, construction and housekeeping. The department has staff available 24-hours a day to address maintenance needs of the facility

SUMMARY OF AUDIT FINDINGS

Overall, the interviews of residents reflected that they were aware of and understood the PREA protections and the agency's zero tolerance policy. Residents receive written materials at intake that provide detailed information about PREA protections, the multiple ways to report sexual abuse or harassment and ways to protect themselves from abuse. Subsequent to intake, residents are provided more comprehensive education on PREA that includes personal instruction in addition to a video titled "PREA", a Juvenile Orientation video prepared by Phoenix Associates LLC . There are also PREA posters, guides, and pamphlets in English and Spanish to assist in educating residents about PREA. Residents indicated they understand the various ways to report abuse and discussed the posters throughout the facility with the telephone number to call to report sexual abuse or harassment. Residents were able to articulate to the auditor what they would do and who they would tell if they were sexually abused. Residents reported they could tell a trusted staff member, a therapist , the Victim Advocate or call the hotline telephone number. Residents consistently indicated to the auditor that they felt safe in the facility. Residents were also aware that outside services were available including counseling for sexual abuse and harassment.

There were eight (8) allegations involving six (6) incidents of sexual harassment made to the facility in the past 12 months. Of the eight (8), three (3) were unsubstantiated, two (2) were unfounded, and three (3) were substantiated.

All facility staff interviewed indicated they had received detailed PREA training and could articulate the meaning of the agency's zero tolerance policy. Staff was knowledgeable about their roles and responsibilities in the prevention, reporting and response to sexual abuse and sexual harassment. Staff consistently articulated the variety of reporting mechanisms for residents and staff to use to report sexual abuse or sexual harassment. Additionally, staff were well trained on the PREA first responder's protocol for any PREA related allegation and could clearly articulate exactly the steps they would follow if they were the first responder to an incident.

During the audit, the auditor toured the Women's Wellness Center that is the rape crises center in Norman and met with the program's service coordinator. Discussions with the coordinator centered around the Center's operations. In addition to providing SAFE/SANE services, the Center's staff also provide training for OJC4G staff relating to how clients react to sexual abuse and how it affects lives, In turn the PREA Coordinator provide training about the PREA.

In summary, after reviewing all pertinent information and after conducting resident and staff interviews, the auditor found that department and agency leadership have clearly made PREA compliance a high priority and have devoted a significant amount of time and resources to policy development, training of staff and education of residents on all the key aspects of PREA.

Number of standards exceeded: 0

Number of standards met: 38

Number of standards not met: 0

Number of standards not applicable: 3

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

☐ 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.

This standard directs the agency to adopt a zero tolerance policy for sexual abuse and harassment.

An agency shall have a written policy mandating zero tolerance toward all forms of sexual abuse and sexual harassment and outlining the agency's approach to preventing, detecting, and responding to such conduct. An agency shall employ or designate an upper-level, agency-wide PREA coordinator with sufficient time and authority to develop, implement, and oversee agency efforts to comply with the PREA standards in all of its facilities. Where an agency operates more than one facility, each facility shall designate a PREA compliance manager with sufficient time and authority to coordinate the facility's efforts to comply with the PREA standards.

The Oklahoma Office of Juvenile Affairs has developed and implemented a Zero Tolorence Policy (P-03-20-01) that includes all requirements of the PREA of 2003. The policy mirrors the language of the standards and spells out procedures for implementing this law. The agency has adopted the definitions contained in 115.5 and 115.6 relating to definitions involving sexual assault. The OJA has a PREA Coordinator that operates from its Central Office. She is included in the Agency's Organizational Chart and reports to the Chief of Programs. In addition to this there are PREA Compliance Managers at each of the three facilities operated by the OJA and are shown in the facility's organization charts. Each has expressed to the auditor that they have enough time to perform their duties.

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)

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.

This standard directs the agency who has facilities for the housing of youth at other locations.

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

The OJA does not contract for the confinement of residents in private facilities. Therefore this standard is Non Applicable.

Standard 115.313 Supervision and monitoring

☐ 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.

This standard directs the facility in how it monitors and supervises residents.

The agency shall ensure that each facility it operates shall develop, implement, and document a staffing plan that provides for adequate levels of staffing, and, where applicable, video monitoring, to protect residents against sexual abuse. In calculating adequate staffing levels and determining the need for video monitoring, facilities shall take into consideration:
(1) Generally accepted juvenile detention and correctional/secure residential practices;
(2) Any judicial findings of inadequacy;
(3) Any findings of inadequacy from Federal investigative agencies;
(4) Any findings of inadequacy from internal or external oversight bodies;
(5) All components of the facility's physical plant (including "blind spots" or areas where staff or residents may be isolated);
(6) The composition of the resident population;
(7) The number and placement of supervisory staff;
(8) Institution programs occurring on a particular shift;
(9) Any applicable State or local laws, regulations, or standards;
(10) The prevalence of substantiated and unsubstantiated incidents of sexual abuse; and
(11) Any other relevant factors.
The agency shall comply with the staffing plan except during limited and discrete exigent circumstances, and shall fully document deviations from the plan during such circumstances. Each secure juvenile facility shall maintain staff ratios of a minimum of 1:8 during resident waking hours and 1:16 during resident sleeping hours, except during limited and discrete exigent circumstances, which shall be fully documented. Only security staff shall be included in these ratios. Any facility that, as of the date of publication of this final rule, is not already obligated by law, regulation, or judicial consent decree to maintain the staffing ratios set forth in this paragraph shall have until October 1, 2017, to achieve compliance. Whenever necessary, but no less frequently than once each year, for each facility the agency operates, in consultation with the PREA coordinator required by § 115.311, the agency shall assess, determine, and document whether adjustments are needed to:
(1) The staffing plan established pursuant to paragraph (a) of this section;
(2) Prevailing staffing patterns;
(3) The facility's deployment of video monitoring systems and other monitoring technologies; and
(4) The resources the facility has available to commit to ensure adherence to the staffing plan.
Each secure facility shall implement a policy and practice of having intermediate-level or higher level supervisors conduct and document unannounced rounds to identify and deter staff sexual abuse and sexual harassment. Such policy and practice shall be implemented for night shifts as well as day shifts. Each secure facility shall have a policy to prohibit staff from alerting other staff members that these supervisory rounds are occurring, unless such announcement is related to the legitimate operational functions of the facility.

Compliance Documents
(a)(c)(d) P-03-20-01 - Prison Rape Elimination Act – Zero Tolerance Policy
OJC4G – 4G30500.01 - PREA Procedure with Staffing Plan
OJC4G – OPI License to Operate Facility with OPI Audit Report Findings
OJC4G – OCCY Audit Report Findings
(b) OJC4G – Note: There has been No Occurrence of any Deviations from Staffing Plan
(e) P-35-03-01 - Security and Control Policy
OJC4G - Documentation of Unannounced Rounds on All Shifts

The agency develops a staffing plan and has not deviated from it during the past 12 months. The plan is reviewed annually and updated as needed. Population reports were examined to ensure there was no times when the population exceeded the rating of the facility's 22 beds and those same reports listed the staffings at the time. The agency has 32 surveillance cameras that assist with supervising residents and any PREA related incidents are available for viewing at least 30 days after they are recorded. The OJC4G operates with a staffing pattern that is 1:8 during waking hours and 1:8 during sleeping hours. The facility uses shift supervisors to conduct unannounced rounds each shift and document those rounds in the log book. The unannounced rounds are not announced over staff radios. These documented rounds were viewed by the auditor and found acceptable. The staffing plan is reviewed and updated annually. The staffing plan considers requirements listed in this standard (# 1-11) when developing this plan according to the facility superintendent and with assistance of the PREA Compliance Manager and the PREA Coordinator.

Standard 115.315 Limits to cross-gender viewing and searches

☐ 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.

This standard directs the facility about how it treats transgendered and intersex residents in regards to cross-gender strip searchs or cross-gender body cavity searches.

The facility shall not conduct cross-gender strip searches or cross-gender visual body cavity searches (meaning a search of the anal or genital opening) except in exigent circumstances or when performed by medical practitioners. The agency shall not conduct cross-gender pat-down searches except in exigent circumstances. The facility shall document and justify all cross-gender strip searches, cross-gender visual body cavity searches, and cross-gender pat-down searches. The facility shall implement policies and procedures that enable residents to shower, perform bodily functions, and change clothing without nonmedical staff of the opposite gender viewing their breasts, buttocks, or genitalia, except in exigent circumstances or when such viewing is incidental to routine cell checks. Such policies and procedures shall require staff of the opposite gender to announce their presence when entering a resident housing unit. In facilities (such as group homes) that do not contain discrete housing units, staff of the opposite gender shall be required to announce their presence when entering an area where residents are likely to be showering, performing bodily functions, or changing clothing. The facility shall not search or physically examine a transgender or intersex resident for the sole purpose of determining the resident's genital status. If the resident's genital status is unknown, it may be determined during conversations with the resident, by reviewing medical records, or, if necessary, by learning that information as part of a broader medical examination conducted in private by a medical practitioner. The agency shall train security staff in how to conduct cross-gender pat-down searches, and searches of transgender and intersex residents, in a professional and respectful manner, and in the least intrusive manner possible, consistent with security needs.

Compliance Documents
(a)(b)(c) P-35-03-08 - Search Policy
OJC4G – Logs: Pat-Down Search
Disrobement Search
Cavity Search (if applicable) (Progress Notes from Hospital)
(d) P-35-03-01 - Security and Control Policy
Cross-Gender Supervision Announcement – Sign For Housing Units
Cross-Gender Supervision – Male Presence – Sign For Housing Units
(e) P-35-13-01 - Reception, Classification and Transfer – Admissions Policy
(f) P-03-20-01 - Prison Rape Elimination Act – Zero Tolerance Policy
Cross-Gender Search – Training Curriculum
OJC4G - Cross-Gender Search – Training Records
Note: There has been NO Occurrence of any visual body cavity searches conducted on a resident at OJC4G.

The OJC4G has not conducted any visual body cavity searches since opening the facility two years ago. Whenever male staff enter into areas where residents may be showering, dressing, or using the toilet they announce themselves accoring to resident interviews. Staff indicated during random staff interviews that they are aware of the policy that they are not allowed to physically examine a transgender or intersex resident for purposes of determining that resident's genital status. All staff have been trained in how to conduct cross-gender pat down searches and searches of transgender and intersex residents. Residents indicated in interviews that no male staff had ever conducted a pat down search of their bodies. There has been no transgender or intersex residents at this facility. Agency policy requires any cross gender strip searches to be conducted by medical personnel outside of the facility at the local hospital in Norman.

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

☐ 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.

This standard directs the facility to ensure that residents who are limited English proficient and residents with disabilities be afforded the same equal opportunities to participate in or benefit from the facility's efforts to prevent, detect, and respond to sexual abuse or harassment.

The agency shall take appropriate steps to ensure that residents with disabilities (including, for example, residents who are deaf or hard of hearing, those who are blind or have low vision, or those who have intellectual, psychiatric, or speech disabilities), have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment. Such steps shall include, when necessary to ensure effective communication with residents who are deaf or hard of hearing, providing access to interpreters who can interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary. In addition, the agency shall ensure that written materials are provided in formats or through methods that ensure effective communication with residents with disabilities, including residents who have intellectual disabilities, limited reading skills, or who are blind or have low vision. An agency is not required to take actions that it can demonstrate would result in a fundamental alteration in the nature of a service, program, or activity, or in undue financial and administrative burdens, as those terms are used in regulations promulgated under title II of the Americans With Disabilities Act, 28 CFR 35.164. The agency shall take reasonable steps to ensure meaningful access to all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment to residents who are limited English proficient, including steps to provide interpreters who can interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary. The agency shall not rely on resident interpreters, resident readers, or other types of resident assistants except in limited circumstances where an extended delay in obtaining an effective interpreter could compromise the resident's safety, the performance of first-response duties under § 115.364, or the investigation of the resident's allegations.

Compliance Documents
(a)(b)(c) P-03-20-01 Prison Rape Elimination Act (PREA) – Zero Tolerance Policy
P-35-13-01 Reception, Classification, and Transfers – Admissions Policy
Juvenile's PREA Guide (English)
Juvenile's PREA Guide (Spanish)
PREA Brochure (English)
PREA Brochure (Spanish)
PREA Posters (English)
PREA Posters (Spanish)
OJC4G – Intake Orientation, PREA Acknowledgement and Risk Assessment
OJC4G – Interpreter's List
Note: During this audit period, there has been no occurrence of a resident with disabilities or a resident who is limited English proficient at OJC4G.

There has been no occurrence of a resident with disabilities or a resident who is limited English proficent housed at the OJC4G. However, agency and facility policy spells out the action that will be taken should such a resident be placed at the OJC4G. Currently the facility has five (5) translators who can speak Spanish and there is one (1) staff who can read and use sign language for those residents with hearing issues. All PREA material such as posters, quidelines and brochures for girls are printed in both Spanish and English. If a resident is unable because of low reading and comprehension skills, a staff member will read to the resident in a manner that will educate the resident about PREA. In summation every effort will be made by the agency/facility to ensure that each resident is capable of knowing and understanding PREA.

Standard 115.317 Hiring and promotion decisions

☐ 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 standard directs the facility in hiring and promotional practices in regards to PREA.

The agency shall not hire or promote anyone who may have contact with residents, and shall not enlist the services of any contractor who may have contact with residents, who—
(1) Has engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility, or other institution (as defined in 42

U.S.C. 1997);
(2) Has been convicted of engaging or attempting to engage in sexual activity in the community facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse; or
(3) Has been civilly or administratively adjudicated to have engaged in the activity described in paragraph (a)(2) of this section.
The agency shall consider any incidents of sexual harassment in determining whether to hire or promote anyone, or to enlist the services of any contractor, who may have contact with residents. Before hiring new employees who may have contact with residents, the agency shall:
(1) Perform a criminal background records check;
(2) Consult any child abuse registry maintained by the State or locality in which the employee would work; and
(3) Consistent with Federal, State, and local law, make its best efforts to contact all prior institutional employers for information on substantiated allegations of sexual abuse or any resignation during a pending investigation of an allegation of sexual abuse.
The agency shall also perform a criminal background records check, and consult applicable child abuse registries, before enlisting the services of any contractor who may have contact with residents. The agency shall either conduct criminal background records checks at least every five years of current employees and contractors who may have contact with residents or have in place a system for otherwise capturing such information for current employees.

Compliance Documents
(a) – (g) P-03-05-106 - Agency Selection Procedures
HR Form - Employment Application
HR Form - Pre-Hire Checklist
OJC4G – New Employee Background Check
OJC4G - OSBI Rap Back Notification
Contractor Background Check – Medical/Mental Health Licensure Information
(h) No Occurrence – There has been no requests from any institutional employer to provide information on substantiated allegations of sexual abuse or sexual harassment involving any former employee.
Note: The Oklahoma Board of Medical Licensure and the Oklahoma Board of Behavioral Health conducts an “Extended Background Check” on our contract doctors as a requirement for their medical and/or behavioral health licensure.

An examination of the Agency Selection Process ensures that no staff person or contractor can be hired if they have violated any laws related to sexual abuse and harassment either in the community or a confinement setting. There have been no requests from any institutional employer to provide information on substantiated allegations of sexual anbuse or harassment involving any former employee. The agency has guidelines for the hiring and promotional opportunties for staff and contractors. Each job be it an agency employee or a contract employee, goes through criminal background checks and child abuse registry checks before being hired. In addition to this the facility's Physician is subjected to an extended background check. Each employee is thoroughly screend prior to hire and the state of Oklahoma or more specifically the Oklahoma Bureau of Investigation has a program called RAP that will report to any agency that one of their employees has been cited for any type of criminal activity including driving citations as soon as the infraction occurs rather than wait the required five (5) years as the standard requires.

Standard 115.318 Upgrades to facilities and technologies

☐ 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.

This standard directs the facility when considering upgrades to its facility or technologies.

When designing or acquiring any new facility and in planning any substantial expansion or modification of existing facilities, the agency shall consider the effect of the design, acquisition, expansion, or modification upon the agency’s ability to protect residents from sexual abuse. When installing or updating a video monitoring system, electronic surveillance system, or other monitoring technology, the agency shall consider how such technology may enhance the agency’s ability to protect residents from sexual abuse.

Compliance Documents
(a) (b) P-03-20-01 - Prison Rape Elimination Act – Zero Tolerance Policy
(a) OJC4G – Facility Projects Weekly Reports – Building Modifications

(b) OJC4G – Camera Upgrade – Contract/Purchase Order

Agency policy directs that when considering any substantial modifications of existing facilities or when installing or updating video monitoring systems that the agency review the effects the changes will have on the agency's ability to protect residents from sexual abuse. When the agency moved into this facility several changes were made to the existing buildings. This was a result of the agency doing all it can to protect residents from sexual abuse. The front entry way was closed off to staff and visitors, and a new facility entrance was established for all pedestrian traffic including staff.The old kitchen was also walled off to prevent its use by staff or residents. After consideration 32 surveillance cameras were installed and are used to augment staff supervision of residents.

Standard 115.321 Evidence protocol and forensic medical examinations

☐ 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.

This standard directs the facility's evidence protocol and forensic medical examinations as it relates to PREA.

To the extent the agency is responsible for investigating allegations of sexual abuse, the agency shall follow a uniform evidence protocol that maximizes the potential for obtaining usable physical evidence for administrative proceedings and criminal prosecutions. The protocol shall be developmentally appropriate for youth and, as appropriate, shall be adapted from or otherwise based on the most recent edition of the U.S. Department of Justice's Office on Violence Against Women publication, "A National Protocol for Sexual Assault Medical Forensic Examinations, Adults/Adolescents," or similarly comprehensive and authoritative protocols developed after 2011. The agency shall offer all residents who experience sexual abuse access to forensic medical examinations whether on-site or at an outside facility, without financial cost, where evidentiarily or medically appropriate. Such examinations shall be performed by Sexual Assault Forensic Examiners (SAFEs) or Sexual Assault Nurse Examiners (SANEs) where possible. If SAFEs or SANEs cannot be made available, the examination can be performed by other qualified medical practitioners. The agency shall document its efforts to provide SAFEs or SANEs. The agency shall attempt to make available to the victim a victim advocate from a rape crisis center. If a rape crisis center is not available to provide victim advocate services, the agency shall make available to provide these services a qualified staff member from a community-based organization or a qualified agency staff member. Agencies shall document efforts to secure services from rape crisis centers. For the purpose of this standard, a rape crisis center refers to an entity that provides intervention and related assistance, such as the services specified in 42 U.S.C. 14043g(b)(2)(C), to victims of sexual assault of all ages. The agency may utilize a rape crisis center that is part of a governmental unit as long as the center is not part of the criminal justice system (such as a law enforcement agency) and offers a comparable level of confidentiality as a nongovernmental entity that provides similar victim services. As requested by the victim, the victim advocate, qualified agency staff member, or qualified community-based organization staff member shall accompany and support the victim through the forensic medical examination process and investigatory interviews and shall provide emotional support, crisis intervention, information, and referrals. To the extent the agency itself is not responsible for investigating allegations of sexual abuse, the agency shall request that the investigating agency follow the requirements of paragraphs (a) through (e) of this section. The requirements of this section shall also apply to:

(1) Any State entity outside of the agency that is responsible for investigating allegations of sexual abuse in juvenile facilities; and

(2) Any Department of Justice component that is responsible for investigating allegations of sexual abuse in juvenile facilities.

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

Compliance Documents
(a)(b)(c) P-03-20-01 - Prison Rape Elimination Act – Zero Tolerance Policy
4G40300.50 – Sexual Assault
A National Protocol For Sexual Assault Medical Forensic Examinations
Second Edition – April 2013 (Table of Contents)
Office of Public Integrity (OPI) – Investigators – Training Verification
Office of Public Integrity (OPI) - Memo of Understanding – Conducting Investigations for OJA
(c)(d)(e)(h) OJC4G – Memo of Understanding – Victim Advocate/SANE
OJC4G – SANE Exam with Investigation – Note to Auditor: There has been no incidents during this audit period where a resident had a SANE exam for the collection of evidence.
(f)(g) Not Applicable – OPI conducts all investigations for OJA facilities

The Oklahoma Office of Public Integrity is the agency charged with conducting Administrative and Criminal Investigations for the Office of Juvenile Affairs. The Office of Public Integrity is a part of the OJA. It has three investigators and a staff who supervises the unit. Two of its investigators are sworn police officers who have the credentials to conduct criminal investigations. The other OPI staff member conducts only administrative investigations. When an allegation is made at the facility the JSOS will notify the Institutional Advocate and the OPI. The Institutional Advocate is a separate office located in the Department of Human Services called the Advocate General but one of its staff members is located in the facility but is not part of the facility's staffing plan.There also exist a MOU with the Cleveland County Sheriff's Office who will assist any OPI Investigator in the conduct of Criminal Investigations at this facility should the need arise. The National Protocol for Sexual Assault Medical Forensic Examinations, Second Edition is integrated into the training curicculum and has been used in the training of its investigators. There exists a MOU with the Women's Resource Center in Norman to provide SANE services and provides victim advocates to victims of sexual assault. The Center is funded by various grants in order to operate and is not part of any law enforcement agency. The auditor visited this center as part of the audit and met with the agency's coordinator of services. She explained that when a call is received from the OJC4G arrangements are made to transport the victim to the Norman Regional Hospital or the offices of the Center to conduct forensic examinations. Transportation is provided by OJC4G staff. In addition to this the Women's Resource Center has provided training to staff at the OJC4G and in turn the PREA Coordinator has trained staff from the Women's Center. Resident interviews revealed that residents were familiar with victim services being available to them if they were sexually assaulted.

Standard 115.322 Policies to ensure referrals of allegations for investigations

☐ 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.

This standard directs the facility's efforts at referring allegations for investigations to an appropriate investigatory agency for all sexual abuse or harassment allegations.

The agency shall ensure that an administrative or criminal investigation is completed for all allegations of sexual abuse and sexual harassment. The agency shall have in place a policy to ensure that allegations of sexual abuse or sexual harassment are referred for investigation to an agency with the legal authority to conduct criminal investigations, unless the allegation does not involve potentially criminal behavior. The agency shall publish such policy on its website or, if it does not have one, make the policy available through other means. The agency shall document all such referrals. If a separate entity is responsible for conducting criminal investigations, such publication shall describe the responsibilities of both the agency and the investigating entity. Any State entity responsible for conducting administrative or criminal investigations of sexual abuse or sexual harassment in juvenile facilities shall have in place a policy governing the conduct of such investigations. Any Department of Justice component responsible for conducting administrative or criminal investigations of sexual abuse or sexual harassment in juvenile facilities shall have in place a policy governing the conduct of such investigations.

Compliance Documents
(a)(b) P-03-20-01 - Prison Rape Elimination Act – Zero Tolerance Policy
Office of Public Integrity (OPI) – Investigators – Training Verification
Office of Public Integrity (OPI) - Memo of Understanding – Conducting Investigations for OJA
OJC4G – Referrals with Investigations
OJA Public Website – Showing PREA Policy
(c)(d)(e) Not Applicable – OPI conducts all investigations for OJA facilities

There exists a MOU with the Office of Public Integrity and the Cleveland County Sheriff's Office that outlines the role each entity in the conduct of Criminal Investigations at the OJC4G. The Sheriff's Office defers to the OPI investigation team in the conduct of sexual assault and harassment allegations. Once an allegation is received at the facility, the Advocate General and the OPI are notified of the event. An investigation is begun as soon as possible. Before the investigators arrive on the scene facility first responders assume their role and ensure that the resident victim is safe and seperated from the perpetrator and all of the other requirements of first responders are completed. All allegations are also reported to the PREA Coordinator who collects data from all three OJA facilities. The agency's policy relating to sexual assault and harassment investigations is published on the OJA website at https://www.ok.gov/oja. The OPI policy outlines the conduct of all investigations conducted in OJA facilities.

Standard 115.331 Employee training

☐ 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.

This standard directs the facility in its efforts to train all facility staff in the PREA requirements.

The agency shall train all employees who may have contact with residents on:
(1) Its zero-tolerance policy for sexual abuse and sexual harassment;
(2) How to fulfill their responsibilities under agency sexual abuse and sexual harassment prevention, detection, reporting, and response policies and procedures;
(3) Residents' right to be free from sexual abuse and sexual harassment;
(4) The right of residents and employees to be free from retaliation for reporting sexual abuse and sexual harassment;
(5) The dynamics of sexual abuse and sexual harassment in juvenile facilities;
(6) The common reactions of juvenile victims of sexual abuse and sexual harassment;
(7) How to detect and respond to signs of threatened and actual sexual abuse and how to distinguish between consensual sexual contact and sexual abuse between residents;
(8) How to avoid inappropriate relationships with residents;
(9) How to communicate effectively and professionally with residents, including lesbian, gay, bisexual, transgender, intersex, or gender nonconforming residents; and
(10) How to comply with relevant laws related to mandatory reporting of sexual abuse to outside authorities;
(11) Relevant laws regarding the applicable age of consent.
Such training shall be tailored to the unique needs and attributes of residents of juvenile facilities and to the gender of the residents at the employee's facility. The employee shall receive additional training if the employee is reassigned from a facility that houses only male residents to a facility that houses only female residents, or vice versa. All current employees who have not received such training shall be trained within one year of the effective date of the PREA standards, and the agency shall provide each employee with refresher training every two years to ensure that all employees know the agency's current sexual abuse and sexual harassment policies and procedures. In years in which an employee does not receive refresher training, the agency shall provide refresher information on current sexual abuse and sexual harassment policies. The agency shall document, through employee signature or electronic verification that employees understand the training they have received.

Compliance Documents
(a) (b) P-03-20-01 - Prison Rape Elimination Act – Zero Tolerance Policy
PREA Training Curriculum for Staff
PREA Guide Book for Staff
(c) (d) OJC4G – Staff Training Rosters

The agency/facility trains each employee on the requirements of PREA. Interviews with staff at the facility indicated they had received this training and were able to articulate this information to the auditor. The auditor also examined training records and the curriculum and found both to be in compliance with this standard's requirements. Each staff is also given a PREA handbook that contains information related to PREA. On at least an annual basis PREA training is provided by the PREA Coordinator at each OJA facility including OJC4G. The superintendent also declared in a memo to the auditor that all staff have been trained in PREA. When employee from a male institution begins working at the OJC4G he receives the PREA training in working with females. This has happended because there is another OJA male facility approximately 30 miles away and occassionally staff relocate to the OJC4G.

Standard 115.332 Volunteer and contractor training

☐ 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.

This standard directs an agency's efforts to train volunteers and contractors in the PREA requirement.

The agency shall ensure that all volunteers and contractors who have contact with residents have been trained on their responsibilities under the agency's sexual abuse and sexual harassment prevention, detection, and response policies and procedures. The level and type of training provided to volunteers and contractors shall be based on the services they provide and level of contact they have with residents, but all volunteers and contractors who have contact with residents shall be notified of the agency's zero-tolerance policy regarding sexual abuse and sexual harassment and informed how to report such incidents. The agency shall maintain documentation confirming that volunteers and contractors understand the training they have received.

Compliance Documents
(a) (b) (c) P-03-20-01 - Prison Rape Elimination Act – Zero Tolerance Policy
PREA Guide Book – Volunteer's, Contractor's and Intern's
OJC4G – Volunteer PREA Training Roster
Contract Teacher PREA Training Roster
Contract Doctors – PREA Specialized Training

The auditor spoke with both teachers who are contract employees and interviewed them using the PREA questionnaire for volunteers and contractors. Each knew the requirements of PREA and how to report any sexual abuse or harassment allegation.The auditor examined training records, the curriculum, and the PREA Guidebook for Volunteers, Contractors and Interns. The doctor while not interviewed had received appropriate training in the PREA curriclum as well as receiving the training for medical and mental health professionals through the National Institute of Corrections.

Standard 115.333 Resident education

☐ 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.

This standard directs the facility to provide during the intake process for a resident that residents receive information regarding the facility's zero tolerence policy about sexual abuse and harassment and how to report sexual abuse and harassment.

During the intake process, residents shall receive information explaining, in an age appropriate fashion, the agency's zero tolerance policy regarding sexual abuse and sexual harassment and how to report incidents or suspicions of sexual abuse or sexual harassment. Within 10 days of intake, the agency shall provide comprehensive age-appropriate education to residents either in person or through video regarding their rights to be free from sexual abuse and sexual harassment and to be free from retaliation for reporting such incidents, and regarding agency policies and procedures for responding to such incidents. Current residents who have not received such education shall be educated within one year of the effective date of the PREA standards, and shall receive education upon transfer to a different facility to the extent that the policies and procedures of the resident's new facility differ from those of the previous facility. The agency shall provide resident education in formats accessible to all residents, including those who are limited English proficient, deaf, visually impaired, or otherwise disabled, as well as to residents who have limited reading skills. The agency shall maintain documentation of resident participation in these education sessions. In addition to providing such education, the agency shall ensure that key information is continuously and readily available or visible to residents through posters, resident handbooks, or other written formats.

Compliance Documents
(a) – (f) P-03-20-01 - Prison Rape Elimination Act – Zero Tolerance Policy
(a)(b)(d)(e) OJC4G – Juvenile Orientation, PREA Acknowledgement & Risk Assessment
(d) (f) PREA Juvenile Guide –English
PREA Juvenile Guide – Spanish
PREA Brochure – English
PREA Brochure – Spanish
PREA Posters – English
PREA Posters – Spanish

Each resident is provided information during the intake process related to how to report sexual abuse or harassment, the resident's right to be free from sexual abuse or harassment and the resident's right not be be punished for reporting sexual assault and abuse. Each residents signs an acknowledgement form verifying receiving this information of which the auditor reveiwed five case records and found the acknowldgement forms for all five. Within ten days of arrival the resident is shown a PREA Video. The residents also receive a PREA Handbook. This material is available in both English and Spanish as are PREA brochures and posters that are located throughout the facility. The facility also makes this information available to any resident who is not English proficient or has any other disabilities such as hard of hearing, or visually impaired. All residents at the facility during the audit had received this information. Resident interviews confirmed that this PREA related material is provided during the intake process.

Standard 115.334 Specialized training: Investigations

☐ 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.

This standard directs the training requirements for investigators.

In addition to the general training provided to all employees pursuant to § 115.331, the agency shall ensure that, to the extent the agency itself conducts sexual abuse investigations, its investigators have received training in conducting such investigations in confinement settings. Specialized training shall include techniques for interviewing juvenile sexual abuse victims, proper use of Miranda and Garrity warnings, sexual abuse evidence collection in confinement settings, and the criteria and evidence required to substantiate a case for administrative action or prosecution referral. The agency shall maintain documentation that agency investigators have completed the required specialized training in conducting sexual abuse investigations. Any State entity or Department of Justice component that investigates sexual abuse in juvenile confinement settings shall provide such training to its agents and investigators who conduct such investigations.

Compliance Documents
(a) – (d) P-03-20-01 - Prea Policy
(a) (b) NIC – Training Curriculum
PREA: Investigating Sexual Abuse in a Confinement Setting
(a) (c) PREA Training Verification for Investigators
(b) (c) Specialized Training for Investigators

The Office of Public Integrity is part of the Office of Juvenile Affairs but is a separate entity within the Department. The OPI is charged with conducting all sexual abuse or harassment investigations in the OJA. During the audit an OPI investigator was interviewed. His office is located in the OJC4G. He conducts administrative investigations. He had in the past been a sworn police officer but chose not to continue his certification in that field. He explained how the investigation process works. He explained that in an admistrative investigation he interviews staff and residents, reviews any film footage if applicable, and also reviews log book entries related to an incident. If the administrative investigation reveals criminal activity he will contact his supervisor who will then assign a criminal investigator to the case. Each investigator receives training in PREA and additional training from the National Institute of Corrections relating to investigations. This training is documented and a certificate is issued to the recipient. The training inlcudes the proper use of Garrity and Miranda Warnings, techniques for interviewing juvenile sexual abuse victims, sexual abuse evidence collection in confinement settings, and the criterea and evidence required to substantiate a case for administrative or prosecution referral.

Standard 115.335 Specialized training: Medical and mental health care

☐ 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.

This standard directs the facility to have each medical and mental health staff member go through additional specialized training beyond that given to all employees.

The agency shall ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in:
(1) How to detect and assess signs of sexual abuse and sexual harassment;
(2) How to preserve physical evidence of sexual abuse;
(3) How to respond effectively and professionally to juvenile victims of sexual abuse and sexual harassment; and
(4) How and to whom to report allegations or suspicions of sexual abuse and sexual harassment.
If medical staff employed by the agency conduct forensic examinations, such medical staff shall receive the appropriate training to conduct such examinations. The agency shall maintain documentation that medical and mental health practitioners have received the training referenced in this standard either from the agency or elsewhere. Medical and mental health care practitioners shall also receive the training mandated for employees under § 115.331 or for contractors and volunteers under § 115.332, depending upon the practitioner's status at the agency.

Compliance Documents
(a) –(d) P-03-20-01 –Prea Policy
(a) NIC –Training Curriculum PREA: Medical Health Care for Sexual Assault Victims in a Confinement Setting
(b) Not Applicable – Medical staff employed by the agency do no conduct forensic examinations. When the need arises, the juvenile is taken to the local hospital and the forensic examination is conducted by a SAFE/SANE examiner.
(c)(d) Specialized Training Certificates with PREA Acknowledgement
•□OJC4G Medical Staff
•□OJC4G Mental Health Staff
•□Contract Doctors

One medical staff and one mental health staff was interviewed using the PREA Questionnaire for Medical and Mental Health Staff. Each revealed their understanding of PREA and how and to who to report any allegation received by them. Each staff member indicated they had received PREA training as well as training specific to Medical and Mental Health Staff provided by the National Institute of Corrections. This training is documented and each staff member was able to articulate to the auditor that the training included how to detect and assess signs of sexual abuse and harassment; how to preserve physical evidence; how to respond effectively and professionally to juvenile victims of sexual abuse or harassment; and how and to whom to report allegations or suspicions of sexual abuse or harassment. The medical staff at the OJC4G do not conduct forensic exams. These are conducted at either the Norman Regional Hospital or at the Women's Resource Center.

Standard 115.341 Screening for risk of victimization and abusiveness

☐ 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.

This standard directs the facility's effort at gathering information within 72 hours of intake and periodically thereafter during confinement.

Within 72 hours of the resident's arrival at the facility and periodically throughout a resident's confinement, the agency shall obtain and use information about each resident's personal history and behavior to reduce the risk of sexual abuse by or upon a resident. Such assessments shall be conducted using an objective screening instrument.
At a minimum, the agency shall attempt to ascertain information about:
(1) Prior sexual victimization or abusiveness;
(2) Any gender nonconforming appearance or manner or identification as lesbian, gay, bisexual, transgender, or intersex, and whether the resident

may therefore be vulnerable to sexual abuse; (3) Current charges and offense history;
(4) Age;
(5) Level of emotional and cognitive development;
(6) Physical size and stature;
(7) Mental illness or mental disabilities;
(8) Intellectual or developmental disabilities;
(9) Physical disabilities;
(10) The resident's own perception of vulnerability; and
(11) Any other specific information about individual residents that may indicate heightened needs for supervision, additional safety precautions, or separation from certain other residents. This information shall be ascertained through conversations with the resident during the intake process and medical and mental health screenings; during classification assessments; and by reviewing court records, case files, facility behavioral records, and other relevant documentation from the resident's files. The agency shall implement appropriate controls on the dissemination within the facility of responses to questions asked pursuant to this standard in order to ensure that sensitive information is not exploited to the resident's detriment by staff or other residents.

Compliance Documents
(a) – (e) P-03-20-01 Prison Rape Elimination Act (PREA) – Zero Tolerance Policy
OJC4G – DRS-05 form – Risk Assessment Done at Intake

The auditor interviewed the staff member charged with performing the screening and intake process. He revealed that he reads a PREA phamplet to each resident during the intsake process and has the resident sign acknowledgeing having received the information. After this is completed he said within 72 hours he does a mental health assessment including the MAYSI II, and reviews other available information about the resident's past history. During this process he ask questions of the resident and reviews other related documents. The mental health practitioner also inquires about a resident's past victimization and takes into consideration the size and demeanor of the resident. He then combines the medical assessment completed by the facility nurse with all other assessments and related information before deciding where the resident should be placed. He also indicated he would offer mental health services to any resident who had prior sexual victimization or was a perpetrator of abuse after the intake process was completed. The facility ascertains the information listed in items above labeled 1-11 on its objective screening instrument DRS-05. The risk assessment and related documents are maintained by the mental health staff in a locked cabinet accessible only to mental health staff.

Standard 115.342 Use of screening information

☐ 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.

This standard sets forth guidelines for the use of screening information that is used in making housing, programming, bed, education, and work assignments.

The agency shall use all information obtained pursuant to § 115.341 and subsequently make housing, bed, program, education, and work assignments for residents with the goal of keeping all residents safe and free from sexual abuse. Residents may be isolated from others only as a last resort when less restrictive measures are inadequate to keep them and other residents safe, and then only until an alternative means of keeping all residents safe can be arranged. During any period of isolation, agencies shall not deny residents daily large-muscle exercise and any legally required educational programming or special education services. Residents in isolation shall receive daily visits from a medical or mental health care clinician. Residents shall also have access to other programs and work opportunities to the extent possible. Lesbian, gay, bisexual, transgender, or intersex residents shall not be placed in particular housing, bed, or other assignments solely on the basis of such identification or status, nor shall agencies consider lesbian, gay, bisexual, transgender, or intersex identification or status as an indicator of likelihood of being sexually abusive. In deciding whether to assign a transgender or intersex resident to a facility for male or female residents, and in making other housing and programming assignments, the agency shall consider on a case-by-case basis whether a placement would ensure the resident's health and safety, and whether the placement would present management or security problems. Placement and programming assignments for each transgender or intersex resident shall be reassessed at least twice each year to review any threats to safety experienced by the resident. A transgender or intersex resident's own views with respect to his or her own safety shall be given serious consideration. Transgender and intersex residents shall be given the opportunity to shower separately from other residents. If a resident is isolated pursuant to paragraph (b) of this section, the facility shall clearly document: The basis for the facility's concern for the resident's safety; and the reason why no alternative means of separation can be arranged. Every 30 days, the facility shall afford each resident described in this standard a review to determine whether there is a continuing need for separation from the general population.

Compliance Documents
(a) P-03-20-01 Prison Rape Elimination Act (PREA) – Zero Tolerance Policy
OJC4G – Intake Tracking
Treatment Plan
(b)(h)(i) Not Applicable: OJA Facilities do not use Segregation Units. Facilities do use Solitary Confinement as a last resort and for no longer than (3) hours.
4G30300.02 Solitary Confinement
(c) – (f) P-35-13-01 Reception, Classification and Transfers – Admissions
(e) Vulnerability Questionnaire – ISD-40 SAVQ Form
(g) P-35-03-01 Security and Control
Note: OJC4G has not had any occurrence of a resident with the gender orientation of transgender or intersex.

The OJC4G uses the information gathered under the guidance of 115.341 when making decisions regarding each resident's placement into a housing unit, bed, program, education and work assignments. The facility does not utilize segregation cells or units. There is a safe room for residents who have suicidal ideations and while in the room the resident is monitored by a staff person who sits in the room with the resident. However, this room is not used to punish a resident nor is this room used to house a LGBTI resident. There has been no transgender or intersex residents at this facility since it opened. If there was, policy dictates that a resident who identifies as LGBTI is given the opportunity to shower alone (all residents shower alone) and their views of their own safety is given consideration when making housing, bed, program, education, or work assignments. If a resident remains in the program beyond six (6) months that person would be reassessed to enusre the resident safety is not comprimised. This reassessment would be completed every six (6) months thereafter.

Standard 115.351 Resident reporting

☐ 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.

This standard directs the facility's on how residents are allowed to report sexual abuse and harassment.

The agency shall provide multiple internal ways for residents to privately report sexual abuse and sexual harassment, retaliation by other residents or staff for reporting sexual abuse and sexual harassment, and staff neglect or violation of responsibilities that may have contributed to such incidents. The agency shall also provide at least one way for residents to report abuse or harassment to a public or private entity or office that is not part of the agency and that is able to receive and immediately forward resident reports of sexual abuse and sexual harassment to agency officials, allowing the resident to remain anonymous upon request. Residents detained solely for civil immigration purposes shall be provided information on how to contact relevant consular officials and relevant officials at the Department of Homeland Security. Staff shall accept reports made verbally, in writing, anonymously, and from third parties and shall promptly document any verbal reports. The facility shall provide residents with access to tools necessary to make a written report.The agency shall provide a method for staff to privately report sexual abuse and sexual harassment of residents.

Compliance Documents
(a) – (e) P-03-20-01 Prison Rape Elimination Act (PREA) – Zero Tolerance Policy
Juvenile PREA Guide Book
PREA Brochure
PREA Posters

The auditor interviewed six (6) residents at random. Two residents were picked from each of the three housing units. Each was able to articulate how to report any sexual abuse or harassment. While not every resident expressed all six methods of reporting sexual abuse or harassment each resident was able to articulate at least two methods. All resident said they could tell a trusted staff member of call the hotline. Other answers including telling the Institutional Advocate, their parents, or tell or write the Superintendent. Residents also said they could remain anonymous when reporting sexuasl abuse or harassment. The Institutional Advocate Defender reports to the State's Advocate General who is not part of the OJA. In addition the hotline number is part of the Department of Human Services and not part of the OJA. The facility does not house civil immigration residents. Staff interviews said they make verbal reports relating to sexual assault and would do so immediately after the report is made to them. Staff also acknowleged being able to make reports anonymously and privately.

Standard 115.352 Exhaustion of administrative remedies

☐ 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.

This standard directs the facility's efforts in how residents may use the grievance system for PREA allegations.

An agency shall be exempt from this standard if it does not have administrative procedures to address resident grievances regarding sexual abuse. The agency shall not impose a time limit on when a resident may submit a grievance regarding an allegation of sexual abuse. The agency may apply otherwise-applicable time limits on any portion of a grievance that does not allege an incident of sexual abuse. The agency shall not require a resident to use any informal grievance process, or to otherwise attempt to resolve with staff, an alleged incident of sexual abuse. Nothing in this section shall restrict the agency's ability to defend against a lawsuit filed by a resident on the ground that the applicable statute of limitations has expired. The agency shall 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, and such grievance is not referred to a staff member who is the subject of the complaint. The agency shall issue a final agency decision on the merits of any portion of a grievance alleging sexual abuse within 90 days of the initial filing of the grievance. Computation of the 90-day time period shall not include time consumed by residents in preparing any administrative appeal. The agency may claim an extension of time to respond, of up to 70 days, if the normal time period for response is insufficient to make an appropriate decision. The agency shall notify the resident in writing of any such extension and provide a date by which a decision will be made. At any level of the administrative process, including the final level, if the resident does not receive a response within the time allotted for reply, including any properly noticed extension, the resident may consider the absence of a response to be a denial at that level. Third parties, including fellow residents, staff members, family members, attorneys, and outside advocates, shall be permitted to assist residents in filing requests for administrative remedies relating to allegations of sexual abuse, and shall also be permitted to file such requests on behalf of residents. 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. If the resident declines to have the request processed on his or her behalf, the agency shall document the resident's decision. A parent or legal guardian of a juvenile shall be allowed to file a grievance regarding allegations of sexual abuse, including appeals, on behalf of such juvenile. Such a grievance shall not be conditioned upon the juvenile agreeing to have the request filed on his or her behalf. The agency shall establish procedures for the filing of an emergency grievance alleging that a resident is subject to a substantial risk of imminent sexual abuse. After receiving an emergency grievance alleging a resident is subject to a substantial risk of imminent sexual abuse, the agency shall immediately forward the grievance (or any portion thereof that alleges the substantial risk of imminent sexual abuse) to a level of review at which immediate corrective action may be taken, shall provide an initial response within 48 hours, and shall issue a final agency decision within 5 calendar days. The initial response and final agency decision shall document the agency's determination whether the resident is in substantial risk of imminent sexual abuse and the action taken in response to the emergency grievance. The agency may discipline a resident for filing a grievance related to alleged sexual abuse only where the agency demonstrates that the resident filed the grievance in bad faith.

Compliance Documents
(a) – (g) Oklahoma Administrative Code 377: 3-1-27 and 377: 3-1-28
4G30100.02 – Grievance Procedure
Juvenile Program Manual

There has been no grievance filed related to sexual abuse, harrassment or neglect at the OJC4G during the past 12 months. The agency/facility grievance process is outlined in Agency policy and the resident's handbook. There is no time frame for when a resident may file a grievance related to sexual abuse or harassment. The agency policy complies with the reporting mechanisms outlined in this standard including all applicable time frames. All grievances are forwarded to the Advocate Defender at the institution who also forwards it to the Advocate General for Oklahoma .Any grievance filed concerning sexual abuse, harassment, or neglect is immediately reported to the Department of Human Services Hotline. All elements of this standard are contained in the agency PREA policy. Each resident is made aware of the grievance process through the Resident Handbook. It is also the practice of the facility's Advocate Defender to speak to the residents daily thus making it easier for a resident to confide in that person should the need arise. Resident interviews also revealed their knowledge of the grievance process.

Standard 115.353 Resident access to outside confidential support services

☐ 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.

This standard directs the facility's effort at providing residents with access to support services and legal representation.

The facility shall provide residents with access to outside victim advocates for emotional support services related to sexual abuse, by providing, posting, or otherwise making accessible mailing addresses and telephone numbers, including toll free hotline numbers where available, of local, State, or national victim advocacy or rape crisis organizations, and, for persons detained solely for civil immigration purposes, immigrant services agencies. The facility shall enable reasonable communication between residents and these organizations and agencies, in as confidential a manner as possible.The facility shall inform residents, prior to giving them access, of the extent to which such communications will be monitored and the extent to which reports of abuse will be forwarded to authorities in accordance with mandatory reporting laws. The agency shall maintain or attempt to enter into memoranda of understanding or other agreements with community service providers that are able to provide residents with confidential emotional support services related to sexual abuse. The agency shall maintain copies of agreements or documentation showing attempts to enter into such agreements.The facility shall also provide residents with reasonable and confidential access to their attorneys or other legal representation and reasonable access to parents or legal guardians.

Compliance Documents
(a) – (d) P-03-20-01 Prison Rape Elimination Ac provides SAFE/SANE t (PREA) – Zero Tolerance Policy
P-35-09-04 Access to Courts and Counsel
(c) OJC4G - Memorandum of Understanding – Victim Advocate/SANE
(d) Juvenile Program Manual
OJC4G – Attorney and Family Contact

There exists a MOU between the OJC4G and the Women's Resource Center. The MOU outlines the responsibilities of each party in relation to PREA. The Women's Center provides SAFE/SANE services as well as offering victim advocacy services including counseling and realted follow up services. Resident interviews revealed their knowledge of these services and that any conversations would be confidential.There are posters and the handbook telling residents of available services. These posters and brochures contain the addresses and telephone numbers for these services. Resident knew the telephone numbers were free to call. Residents also said the facility would allow them to communicate and see their attorney privately should the need arise. Residents also explained how they are allowed to see their parents or others through the visitation and telephone usage.

Standard 115.354 Third-party reporting

☐ 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.

This standard requires the facility to establish a third party reporting mechanism for sexuaol abuse or harassment.

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

Compliance Documents:
P-03-20-01 - Prison Rape Elimination Act – Zero Tolerance Policy
Juvenile PREA Guide Book
PREA Brochure
PREA Posters

OJA – PREA Public Website

The OJA provides for the confidential and anonymous reporting of sexual abuse or harassment though third parties such as a friend, family member or legal guardian. The general public can also make calls to the DHS hotline, send a confiedential email to PREA.Complaints@ oja.ok.gov, or send a letter to the Office of Public Integrity. Resident interviews indicate they are aware that friends or family members could make a call on their behalf. This information is also contained in the resident's handbook. The reporting mechanisms are also listed on the Agency Website.

Standard 115.361 Staff and agency reporting duties

☐ 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.

This standard requires the facility regarding staff and facility reporting duties.

The agency shall require all staff to report immediately and according to agency policy any knowledge, suspicion, or information they receive regarding an incident of sexual abuse or sexual harassment that occurred in a facility, whether or not it is part of the agency; retaliation against residents or staff who reported such an incident; and any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation.The agency shall also require all staff to comply with any applicable mandatory child abuse reporting laws. Apart from reporting to designated supervisors or officials and designated State or local services agencies, staff shall be prohibited from revealing any information related to a sexual abuse report to anyone other than to the extent necessary, as specified in agency policy, to make treatment, investigation, and other security and management decisions. Medical and mental health practitioners shall be required to report sexual abuse to designated supervisors and officials pursuant to the first paragraph of this section, as well as to the designated State or local services agency where required by mandatory reporting laws. Such practitioners shall be required to inform residents at the initiation of services of their duty to report and the limitations of confidentiality. Upon receiving any allegation of sexual abuse, the facility head or his or her designee shall promptly report the allegation to the appropriate agency office and to the alleged victim's parents or legal guardians, unless the facility has official documentation showing the parents or legal guardians should not be notified. If the alleged victim is under the guardianship of the child welfare system, the report shall be made to the alleged victim's caseworker instead of the parents or legal guardians. If a juvenile court retains jurisdiction over the alleged victim, the facility head or designee shall also report the allegation to the juvenile's attorney or other legal representative of record within 14 days of receiving the allegation. The facility shall report all allegations of sexual abuse and sexual harassment, including third party and anonymous reports, to the facility's designated investigators.

Compliance Documents
(a) – (f) P-03-20-01 - Prison Rape Elimination Act – Zero Tolerance Policy
Oklahoma State Statute 10A § 1-2-101
OJA Administrative Code 344:3-1-25
ISD-18 Form

Agency policy requires staff to immediately report any incident of sexual abuse or harassment to the appropriate investigatory agencies. The staff at OJC4G are required to report any such incident to their immediatel supervisor and the supervisor in turn notifies the facility superintendent. The facility superintendent then notifies the State Advocate General and the Office of Public Integrity. Once a referral is made the OPI will assign an investigator to review the facts of the allegation. Medical and mental health staff are required to report any allegation or suspicion to the facility superintendent. This has occurred on one occasion in the past 12 months. The proper notifications were made by the medical staff and the case was assigned an investigator. The agency policy also prohibits staff from telling other staff except those with a need to know about the alleged incident or any details related to it. The facility superintendent told the auditor that he notifies the resident's parents immediately unless prohibited by an order from the court. If the resident is under the guarianship of the child welfare agency the allegation is reported to that resident's case worker. The facility superintendent went on to say that if the juvenile court retains jurisdiction then the resident's juvenile probation officer is notified within 14 days after the allegation is received. Oklahoma state statute and the OJA Administrative code outline the requirements of reporting sexual abuse or harassment. Agency policy is identical to the state statutes and Administrative Code. Interviews with medical and mental health staff said they tell a resident of their duty to report and the limitations of confidentiality.

Standard 115.362 Agency protection duties

☐ 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.

This standard addresses the agency's protection duties.

When an agency learns that a resident is subject to a substantial risk of imminent sexual abuse, it shall take immediate action to protect the resident.

Compliance Documents
P-03-20-01 - Prison Rape Elimination Act – Zero Tolerance Policy
OJC4G – Referral with Investigation

Interviews with random staff and the facility superintendent revealed that the first thing they would do is to separate/remove the victim from the imminent danger and do so immediately in order to protect the victim. If the perpetrator is a staff, that staff would be moved to another location or be asked to leave the facility. If the perpetrator is another juvenile that resident would also be moved to ensure the safety of all resients. The facility superintendent would then send a referral to the Advocate General and the Office of Public Integrity for an investigation.

Standard 115.363 Reporting to other confinement facilities

☐ 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.

This standard directs the facility to report any allegations received from a resident that may have occurred at another confinement facility.

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

Compliance Documents
(a) – (d) P-03-20-01 - Prison Rape Elimination Act – Zero Tolerance Policy
Proof of Notification
Investigation Report
Note: During this audit period, there has been no occurrence at OJC4G where a resident has alleged sexual abuse while confined at another facility.

The facility superintendent said he has not received any allegations that a resident was sexually abused while confined to another facility. He said if he did receive an allegation he would immediately refer it the Advocate General and the Office of Public Integrity just as he would any allegation at his facility. He also said he would inform the facility superintendent at the facility that received the allegation. The agency has a notification form in the event this occurs.

Standard 115.364 Staff first responder duties

☐ 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.

This standard directs the facility's first responders actions.

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

Compliance Documents
(a) (b) P-03-20-01 - Prison Rape Elimination Act – Zero Tolerance Policy
OJC4G – Investigation with SANE Exam
Note: There has been no occurrence of sexual abuse where a SANE exam was required for collection of forensic evidence.
Form – ISD-18-FR

Agency policy outlines the duties of the first responders. In addition to confirming the policy meets the standard requirements, random staff interviews and first responder interviews confirmed the requirements that include separate the victim and perpetrator and preserve and protect the crime scene. The interviewees also said if the incident occurred within 72 hours they would request that no evidence be tampered with or destroyed. The first responder has a checklist called the ISD 18 FR form which outlines all of the requirements/actions that a first responder is expected to take in a sexual abuse situation. The agency policy also requires that if a first responder is not a security staff member then he should request that the victim or perpetrator not take any steps to destroy physical evidence until a security staff member arrives on the scene. There has been no occurrence of sexual abuse where a SANE examination was required for the collection of forensic evidence.

Standard 115.365 Coordinated response

☐ 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.

This standard directs the facility to have a coordinated response plan for sexual abuse.

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

The OJC4G has developed a coordinated response procedure (approved by the OJA Director) in facility procedure 4G30500.01. The plan includes the responsibilities of first responders, medical and mental health staff, investigators and facility management if an allegation occurs according to the facility superintendent.

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.

This standard directs the agency's use of union agreements.

Neither the agency nor any other governmental entity responsible for collective bargaining on the agency's behalf shall enter into or renew any collective bargaining agreement or other agreement that limits the agency's ability to remove alleged staff sexual abusers from contact with residents pending the outcome of an investigation or of a determination of whether and to what extent discipline is warranted. Nothing in this standard shall restrict the entering into or renewal of agreements that govern: The conduct of the disciplinary process, as long as such agreements are not inconsistent with the provisions of §§ 115.372 and 115.376; or whether a no-contact assignment that is imposed pending the outcome of an investigation shall be expunged from or retained in the staff member's personnel file following a determination that the allegation of sexual abuse is not substantiated

The Office of Juvenile Affairs does not utilize unions for its staff therefore this standard is Non-Applicable.

Standard 115.367 Agency protection against retaliation

☐ 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.

This standard directs the facility in its effort to protect residents and staff from retaliation.

The agency shall establish a policy to protect all residents and staff who report sexual abuse or sexual harassment or cooperate with sexual abuse or sexual harassment investigations from retaliation by other residents or staff and shall designate which staff members or departments are charged with monitoring retaliation.The agency shall employ multiple protection measures, such as housing changes or transfers for resident victims or abusers, removal of alleged staff or resident abusers from contact with victims, and emotional support services for residents or staff who fear retaliation for reporting sexual abuse or sexual harassment or for cooperating with investigations. For at least 90 days following a report of sexual abuse, the agency shall monitor the conduct or treatment of residents or staff who reported the sexual abuse and of residents who were reported to have suffered sexual abuse to see if there are changes that may suggest possible retaliation by residents or staff, and shall act promptly to remedy any such retaliation. Items the agency should monitor include any resident disciplinary reports, housing, or program changes, ornegative performance reviews or reassignments of staff. The agency shall continue such monitoring beyond 90 days if the initial monitoring indicates a continuing need. In the case of residents, such monitoring shall also include periodic status

checks. If any other individual who cooperates with an investigation expresses a fear of retaliation, the agency shall take appropriate measures to protect that individual against retaliation. An agency's obligation to monitor shall terminate if the agency determines that the allegation is unfounded.

Compliance Documents
(a) – (f) P-03-20-01 Prison Rape Elimination Act (PREA) – Zero Tolerance Policy
OJC4G – Documentation of Monitoring for Retaliation

The person charged with monitoring retaliation is a mental health staff member. He said in an interview that he checks on each resident who reports sexual abuse or harassment at least weekly. He said he reviews disciplinary actions, observes any changes in behavior or mood and also just speaking to the resident helps him to learn if retaliation is occurring. He maintains a form that documents his concerns and the nature of what he reviews. He said he would monitor a situation as long as there is an issue going beyond 90 days if necessary. This information was verified during the interview with the facility superintendent.

Standard 115.368 Post-allegation protective custody

☐ 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.

This standard directs the agency's efforts when utilizing segregated housing.

Any use of segregated housing to protect a resident who is alleged to have suffered sexual abuse shall be subject to the requirements of § 115.342.

Compliance Documents
OJC4G Procedures: 4G40300.46 Seclusion – Isolation
4G30300.02 Solitary Confinement

This standard is Non Applicable because the agency does not allow the use of segreation housing for victims or perpetrators of sexual abuse. While the facility can confine a resident in a room for three (3) hours for non sexual abuse incidents and then only to protect the youth from harm or from doing harm to others.

Standard 115.371 Criminal and administrative agency investigations

☐ 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.

This standard directs the facility in regards to administrative and criminal investigations.

When the agency conducts its own investigations into allegations of sexual abuse and sexual harassment, it shall do so promptly, thoroughly, and objectively for all allegations, including third-party and anonymous reports. Where sexual abuse is alleged, the agency shall use investigators who have

received special training in sexual abuse investigations involving juvenile victims pursuant to § 115.334. Investigators shall gather and preserve direct and circumstantial evidence, including any available physical and DNA evidence and any available electronic monitoring data; shall interview alleged victims, suspected perpetrators, and witnesses; and shall review prior complaints and reports of sexual abuse involving the suspected perpetrator. The agency shall not terminate an investigation solely because the source of the allegation recants the allegation. When the quality of evidence appears to support criminal prosecution, the agency shall conduct compelled interviews only after consulting with prosecutors as to whether compelled interviews may be an obstacle for subsequent criminal prosecution. The credibility of an alleged victim, suspect, or witness shall be assessed on an individual basis and shall not be determined by the person's status as resident or staff. No agency shall require a resident who alleges sexual abuse to submit to a polygraph examination or other truth telling device as a condition for proceeding with the investigation of such an allegation. Administrative investigations: Shall 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, the reasoning behind credibility assessments, and investigative facts and findings. Criminal investigations shall be documented in a written report that contains a thorough description of physical, testimonial, and documentary evidence and attaches copies of all documentary evidence where feasible. Substantiated allegations of conduct that appears to be criminal shall be referred for prosecution. The agency shall retain all written reports for as long as the alleged abuser is incarcerated or employed by the agency, plus five years, unless the abuse was committed by a juvenile resident and applicable law requires a shorter period of retention. The departure of the alleged abuser or victim from the employment or control of the facility or agency shall not provide a basis for terminating an investigation. Any State entity or Department of Justice component that conducts such investigations shall do so pursuant to the above requirements. When outside agencies investigate sexual abuse, the facility shall cooperate with outside investigators and shall endeavor to remain informed about the progress of the investigation.

Compliance Documents
(a) – (m) P-03-20-01 - Prison Rape Elimination Act – Zero Tolerance Policy
(b) Office of Public Integrity (OPI) – Investigators – Training Verification
Office of Public Integrity (OPI) - Memo of Understanding – Conducting Investigations for OJA
(c) – (i), (k) OJC4G – Referrals with Investigations
(j) Records Disposition Schedule
(l), (m) Not Applicable – OPI conducts all investigations for OJA facilities

The Office of Public Integrity conducts all administrative and criminal investigations. Each investigator employed by OPI has received the appropriate training to conduct investigations that follow the requirements of this standard. Each OPI employee is a sworn police officer with the exception of one staff who only conducts administrative investigations. This person decided he did not want to continue as a criminal investigator so he has not maintained his credentials to do so according to the interview with him. In addition to training as a police officer each investigator including the administrative investigator has completed a training course from the National Institute of Corrections called "PREA: Investigating Sexual Assault in Confinement Settings". The investigator interviewed as part of this audit said that after he receives an allegation from his supervisor he will begin the investigation as soon as possible but no later that 24 hours afterwards. If when investigating an allegation and it appears criminal in nature the OPI will notify the local proscecutor for further action. The investigator also said the investigation does not terminate if the resident or staff member is no longer at the facility. For each investigation a very thorough and descriptive report is generated. Once completed the report is desiminated to appropriate parties including the facility superintendent. Each report breaks down the facts of the case and speaks to each facet of the investigation in his report. The investigator will interview all parties included in the allegation, review video footage if appropriate, collect physical evicence if any, and assess creditability of the parties involved. At a minimum he said the OPI utilizes a preponderance of the evidence when deciding the outcome of an administrative investigation. The OJA also complies with the retention schedule required of this standard. No other agency conducts investigations in OJA facilities.

Standard 115.372 Evidentiary standard for administrative investigations

☐ 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.

This standard is related to the evidentiary standard uesed for administrative investigations.

The agency shall impose no standard higher than a preponderance of the evidence in determining whether allegations of sexual abuse or sexual harassment are substantiated.

Compliance Documents
P-03-20-01 - Prison Rape Elimination Act – Zero Tolerance Policy

OJC4G – Referrals with Investigations
The Investigator interviewed for this audit confirmed that a preponderance of the evidence is the standard applied when assessing the outcome of an administrative investigation. The agency also spells this out in it PREA policy. In examining the investigation reports from this facility, the auditor can verify that this was the rule applied in determining outcomes of administrative investigations.

Standard 115.373 Reporting to 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)

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.

This standard establishes the reporting process relating to the outcome of an investigation.

Following an investigation into a resident's allegation of sexual abuse suffered in an agency facility, the agency shall inform the resident as to whether the allegation has been determined to be substantiated, unsubstantiated, or unfounded. If the agency did not conduct the investigation, it shall request the relevant information from the investigative agency in order to inform the resident. Following a resident's allegation that a staff member has committed sexual abuse against the resident, the agency shall subsequently inform the resident (unless the agency has determined that the allegation is unfounded) whenever: 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, the agency shall 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; or the agency learns that the alleged abuser has been convicted on a charge related to sexual abuse within the facility. All such notifications or attempted notifications shall be documented. An agency's obligation to report under this standard shall terminate if the resident is released from the agency's custody.

Compliance Documents
(a) (c) – (f) P-03-20-01 Prison Rape Elimination Act (PREA) – Zero Tolerance Policy
OJC4G – Referral with Investigation
OJA Form – ISD-19-VN – Sexual Abuse Victim Notification Form

There has been one investigation by the Office of Public Integrity leading to the resignation of a staff member. A notice, OJA Form ISD-19-VN was given to the resident and informing her that the officer was no longer working at the facility following the substantiated allegation. The allegation did not involve sexual abuse but sexual misconduct by saying inappropriate and harassing communications. The investigation of the incident was investigated throughly. There was no further legal action taken against the former staff member. The agency policies relating to informing residents of the results of investigation is consistent with the requirements of this standard and practice verifies this to be so after reviewing the documentaiton related to this case.

Standard 115.376 Disciplinary sanctions for staff

☐ 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.

This standard directs the facility's efforts at disciplining staff who have violated the requirements of the PREA.

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

Compliance Documents
(a) – (d) OJA Administrative Code 377:3-13-147
377:3-13-147.1
377:3-13-147.2
455:10-11-14
State Statute 74 OS § 840-6.3
74 OS § 840-6.4
74 OS § 840-6.5
21 OS § 30-843.5
21 OS § 45-1111
OJA – Agency Policy P-03-05-800 Progressive Discipline – Management
P-03-05-801 Progressive Discipline – Causes
P-03-05-805 Procedures for Discharge
P-03-05-806 Reassignment or Removal from Duty
OJC4G – Referral with Investigation

The OJA and state personnel rules as well as Oklahoma Adminstrative Codes and State Statutes follow the requirements of this standard. Each potential staff is vetted thoroughly before being hired in a position at an OJA facility including OJC4G. A crinminal background check is conducted on each potential employee as well as a check with the sexual abuse registry. There is also a reporting system where if any employee of an agency such as OJA that has violated a law it is automatically reported to the OJA and the facility by law enforcement officials.There has been one OJC4G staff member whose employment was terminated in the past 12 months because of a substantiated sexual harassment allegation. The case was not criminal and no charges were filed against the former employee by the local prosecutor.

Standard 115.377 Corrective action for contractors and volunteers

☐ 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.

This standard provides guidance to the facility as it relates to disciplinary sanctions against a contractor or volunteer.

Any contractor or volunteer who engages in sexual abuse shall be prohibited from contact with residents and shall be reported to law enforcement agencies, unless the activity was clearly not criminal, and to relevant licensing bodies. The facility shall take appropriate remedial measures, and shall consider whether to prohibit further contact with residents, in the case of any other violation of agency sexual abuse or sexual harassment policies by a contractor or volunteer.

Compliance Documents
(a)(b) P-03-01-48 Volunteer Program
P-35-01-04 Sexual Activity
Note:
The OJC4G facility has had no occurrence of a volunteer or contractor engaging in sexual abuse with a resident during this audit period.
The OJC4G has had no occurrence of a volunteer or contractor removed from contact with the residents due to violations of PREA.

The agency policy and state statutes govern the conduct of volunteers, contractors and interns. A volunteer or contractor cannot be hired if that person has been convicted of a felony or any sexual abuse or harassment charge whether felony or misdemeanor. In the past 12 months no volunteer, contractor or intern has been terminated for any reason related to sexual abuse or harassment. The agency policy spells out that no volunteer or contractor can have any contact with residents if there are any allegations of sexual abuse or harassment against a resident by that person. There have been no allegations against any volunteer, contractor or intern.

Standard 115.378 Disciplinary sanctions for 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)

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.

This standard directs the facility's disciplinary sanctions agianst residents for violation of sexual abuse or harassment of staff or a resident.

A resident may be subject to disciplinary sanctions only pursuant to a formal disciplinary process following an administrative finding that the resident engaged in resident-on-resident sexual abuse or following a criminal finding of guilt for resident-on-resident sexual abuse. Any disciplinary sanctions shall be commensurate with the nature and circumstances of the abuse committed, the resident's disciplinary history, and the sanctions imposed for comparable offenses by other residents with similar histories. In the event a disciplinary sanction results in the isolation of a resident, agencies shall not deny the resident daily large-muscle exercise or access to any legally required educational programming or special education services. Residents in isolation shall receive daily visits from a medical or mental health care clinician. Residents shall also have access to other programs and work opportunities to the extent possible. The disciplinary process shall consider whether a resident's mental disabilities or mental illness contributed to his or her behavior when determining what type of sanction, if any, should be imposed.If the facility offers therapy, counseling, or other interventions designed to address and correct underlying reasons or motivations for the abuse, the facility shall consider whether to offer the offending resident participation in such interventions. The agency may require participation in such interventions as a condition of access to any rewards-based behavior management system or other behavior-based incentives, but not as a condition to access to general programming or education. The agency may discipline a resident for sexual contact with staff only upon a finding that the staff member did not consent to such contact. For the purpose of disciplinary action, a report of sexual abuse made in good faith based upon a reasonable belief that the alleged conduct occurred shall not constitute falsely reporting an incident or lying, even if an investigation does not establish evidence sufficient to substantiate the allegation. An agency may, in its discretion, prohibit all sexual activity between residents and may discipline residents for such activity. An agency may not, however, deem such activity to constitute sexual abuse if it determines that the activity is not coerced.

Compliance Documents
(a) – (g) PREA Guide Book for Juveniles
Juvenile Program Manual
OJC4G – Offense Report with Disciplinary Hearing Report for Sexual Activity
OJC4G – There has been no occurrence of a juvenile receiving disciplinary action for committing sexual abuse.

The PREA Guide Book for Juveniles is given to each resident at intake. It contains information for protecting a resident against any form of sexual abuse or harassment while at the facility. There is also a Juvenile Program Manual that contains the disciplinary process for violations of the rules including sexual activity with another resident or staff. The agency does not allow the use of segregation for violations of sexual assault or harassment. If a resident has sexual contact with another juvenile that is not coerced both residents are subject to disciplinary hearings and sanctions. Agency policy also spells out that if resident making an allegation in good faith does not constitute false reporting even if the allegaiton is not proven to be substanitated. The OJA policy does not allow sexual activity between residents. When determining sanctions against residents, mental disability or illness is considered when determining sanctions as is the nature and circumstances of the abuses committed by the residents, and the resident's disciplinary histories according to the facility superintendent. To date there has been occurrence of a juvenile receiving disciplinary actions for committing sexual abuse. According to the mental health staff interviewed a resident will be offered counseling to address and correct the underlying reason for committing sexual abuse if it occurs.

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

☐ 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.

This standard directs the facility in regards to conducting medical and mental health screenings and history of sex abuse.

If the screening pursuant to § 115.341 indicates that a resident has experienced prior sexual victimization, whether it occurred in an institutional setting or in the community, staff shall ensure that the resident is offered a follow-up meeting with a medical or mental health practitioner within 14 days of the intake screening. If the screening pursuant to § 115.341 indicates that a resident has previously perpetrated sexual abuse, whether it occurred in an institutional setting or in the community, staff shall ensure that the resident is offered a follow-up meeting with a mental health practitioner within 14 days of the intake screening. Any information related to sexual victimization or abusiveness that occurred in an institutional setting shall be strictly limited to medical and mental health practitioners and other staff, as necessary, to inform treatment plans and security and management decisions, including housing, bed, work, education, and program assignments, or as otherwise required by Federal, State, or local law. Medical and mental health practitioners shall obtain informed consent from residents before reporting information about prior sexual victimization that did not occur in an institutional setting, unless the resident is under the age of 18.

Compliance Documents
(a) – (d) P-03-20-01 - Prison Rape Elimination Act – Zero Tolerance Policy
(a) – (b) OJC4G – DRS-05 Risk Assessment
ISD-40 Juvenile Intake Tracking Form
Initial Treatment Plan

According to the staff member that conducts the risk assessment a resident would be offered a follow up meeting with medical or mental health staff within 14 days if the resident has experienced prior sexual victimization in the community or institutional setting. He said in most cases it would occur sooner than 14 days. Counseling is offered to a perpetrator of sexual abuse within 14 days according to the staff member interviewed. Information connected to a sexual assault, harassment or prior sexual victimization can only be discussed by staff members needing to know when determining housing, programming, work assignments, and educational pursuits. According to the medical and mental health staff interviewed informed consent is obtained in writing for residents over 18, but not for those residents under 18.

Standard 115.382 Access to emergency medical and mental health services

☐ 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.

This standard directs the facility in providing access to emergency medical and mental health services.

Resident victims of sexual abuse shall receive timely, unimpeded access to emergency medical treatment and crisis intervention services, the nature and scope of which are determined by medical and mental health practitioners according to their professional judgment. If no qualified medical or mental health practitioners are on duty at the time a report of recent abuse is made, staff first responders shall take preliminary steps to protect the victim pursuant to § 115.362 and shall immediately notify the appropriate medical and mental health practitioners. Resident victims of sexual abuse while incarcerated shall be offered timely information about and timely access to emergency contraception and sexually transmitted infections prophylaxis, in accordance with professionally accepted standards of care, where medically appropriate. Treatment services shall be provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident.

Compliance Documents
(a) – (d) P-03-20-01 - Prison Rape Elimination Act – Zero Tolerance Policy
OJC4G – Investigation with Corresponding SANE Exam Notes
Note: There has been no occurrence of incidents of sexual abuse that would require a SANE Exam for the collection of forensic evidence.

Agency policy complies with the requirements of this standard by having unimpeded access to emergency medical and crises intervention services available to all residents in need. There exists an agreement with the Women's Resource Center for SANE/SAFE services for crises intervention services and emotional support services. If a resident needs emerency medical or mental health treatment the resident can be transported to the Norman Regional Hospital Emergency Room. In interviews with medical and mental health staff, each said that the nature and scope of the emergency services provided to residents are determined according to their professional judgement. The medical staff interviewed said that a resident would be offered emergency contraception and sexually transmitted infections prophylaxis and these services would be without cost to the resident or her family.

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

This standard directs the facility's ongoing medical and mental health care for sexual abuse victims and abusers.

The facility shall offer medical and mental health evaluation and, as appropriate, treatment to all residents who have been victimized by sexual abuse in any prison, jail, lockup, or juvenile facility. The evaluation and treatment of such victims shall include, as appropriate, follow-up services, treatment plans, and, when necessary, referrals for continued care following their transfer to, or placement in, other facilities, or their release from custody. The facility shall provide such victims with medical and mental health services consistent with the community level of care. Resident victims of sexually abusive vaginal penetration while incarcerated shall be offered pregnancy tests. If pregnancy results from conduct specified in this section, such victims shall receive timely and comprehensive information about and timely access to all lawful pregnancy related medical services. Resident victims of sexual abuse while incarcerated shall be offered tests for sexually transmitted infections as medically appropriate. Treatment services shall be provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident. The facility shall attempt to conduct a mental health evaluation of all known resident-on resident abusers within 60 days of learning of such abuse history and offer treatment when deemed appropriate by mental health practitioners.

Compliance Documents
(a) – (h) P-03-20-01 Prison Rape Elimination Act – Zero Tolerance Policy
OJC4G – Investigation with Corresponding SANE Exam Notes and Mental Health Follow-up Treatment Plan
Note: During this audit period, there has been no occurrence of incidents of sexual assault/sexual abuse that would require a SANE Exam for the collection of forensic evidence.

The agency policy provides for the treatment and evaluation of all residents who have been victimized by sexual abuse while incarcerated. Medical and mental health staff indicated that ongoing treatment such as counseling and therapy is provided and referrals to other community providers can be made in the event that it is needed for the ongoing care of that resident. The medical staff interviewed said that pregnancy tests are offered at no cost to the victim or her family. This staff also said that services provided in the community are consistent with those services offered at the facility. The agency policy also says that resident on resident abusers must have a mental health evaluation within 60 days of staff learning of such abuse history and offers treatment as appropriate.

Standard 115.386 Sexual abuse incident reviews

☐ 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.

This standard directs the facility's efforts at reviewing any sexual abuse incident that occurred at the facility.

The facility shall conduct a sexual abuse incident review at the conclusion of every sexual abuse investigation, including where the allegation has not been substantiated, unless the allegation has been determined to be unfounded. Such review shall ordinarily occur within 30 days of the conclusion of the investigation. The review team shall include upper-level management officials, with input from line supervisors, investigators, and medical or mental health practitioners. The review team shall: Consider whether the allegation or investigation indicates a need to change policy or practice to better prevent, detect, or respond to sexual abuse; Consider whether the incident or allegation was motivated by race; ethnicity; gender identity; lesbian, gay, bisexual, transgender, or intersex identification, status, or perceived status; or, gang affiliation; or was motivated or otherwise caused by other group dynamics at the facility; Examine the area in the facility where the incident allegedly occurred to assess whether physical barriers in the area may enable abuse; Assess the adequacy of staffing levels in that area during different shifts; Assess whether monitoring technology should be deployed or augmented to supplement supervision by staff; and Prepare a report of its findings, including but not necessarily limited to determinations made pursuant to this section, and any recommendations for improvement and submit such report to the facility head and PREA compliance manager. The facility shall implement the recommendations for improvement, or shall document its reasons for not doing so.

Compliance Documents
(a) – (e) P-03-20-01 Prison Rape Elimination Act – Zero Tolerance Policy
OJC4G – Completed Investigation
OJC4G - ISD-19-SA Administrative Sexual Abuse Incident Review Report

The agency policy sets forth the guidelines for conducting sexual abuse incidents that are substantiated or unsubstantiated. The review team is comprised of the facility superintendent, PREA Coordinator, medical and mental health staff as appropriate, the investigator and any other staff with connections to the allegation. According to the facility superintendent reviews have been held once the investigation is complete and the findings outlined in the investigation report. The superintendent said he and the review team reviews staffing, physical barriers that may have contributed to the incident, considers whether the incident was motivated by race, ethnicity, gender identity, gang affiliation or other factors at the facility and whether more video surveillance is needed. The incident review report is completed and forwarded to appropriate staff at the agency's central office. The auditor reviewed an incident review report and found it contained all of the elements and requirements of this standard.

Standard 115.387 Data collection

☐ 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.

This standard guides the agency in its data collection efforts.

The agency shall collect accurate, uniform data for every allegation of sexual abuse at facilities under its direct control using a standardized instrument and set of definitions. The agency shall aggregate the incident-based sexual abuse data at least annually. The incident-based data collected shall include, at a minimum, the data necessary to answer all questions from the most recent version of the Survey of Sexual Violence conducted by the Department of Justice. The agency shall maintain, review, and collect data as needed from all available incident based documents, including reports, investigation files, and sexual abuse incident reviews. The agency also shall obtain incident-based and aggregated data from every private facility with which it contracts for the confinement of its residents. Upon request, the agency shall provide all such data from the previous calendar year to the Department of Justice no later than June 30.

Compliance Documents
(a) – (f) P-03-20-01 Prison Rape Elimination Act (PREA) – Zero Tolerance Policy
Aggregated Data Report

Agency policy and the PREA Coordinator says that the agency PREA Coordinator will collect accurate and uniform data for every allegation of sexual abuse and harassment at facilities under its control and by using a standardized instrument and set of defintions. The PREA Coordinator aggregates the incident based sexual abuse data at least annually and includes its answers from the most recent Survey of Sexual Violence conducted by the Department of Justice. The OJA does not contract with any private agencies for housings its residents. The auditor reviewed the most recent data report and found it to be compliant with the PREA standard guidelines for reporting.

Standard 115.388 Data review for corrective action

☐ 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.

This standard directs the facility efforts at reviewing data for corrective action.

The agency shall review data collected and aggregated pursuant to § 115.387 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training, including: Identifying problem areas; taking corrective action on an ongoing basis; and preparing an annual report of its findings and corrective actions for each facility, as well as the agency as a whole. Such report shall include a comparison of the current year's data and corrective actions with those from prior years and shall provide an assessment of the agency's progress in addressing sexual abuse. The agency's report shall be approved by the agency head and made readily available to the public through its website or, if it does not have one, through other means. The agency may redact specific material from the reports when publication would present a clear and specific threat to the safety and security of a facility, but must indicate the nature of the material redacted.

Compliance Documents
(a) - (d) P-03-20-01 Prison Rape Elimination Act – Zero Tolerance Policy
Aggregated Data Report

The PREA Coordinator aggregates all sexual abuse data from its three facilities annually. In the report she compares data from the previous year and makes recommendations for any policy changes, practices, and training as a result of the review of data. The report is approved by the agency head and published on its website at https://www.ok.gov/oja. There are no names or personal qualifiers in the report itself. Each year of operation is compared from the previous years to ensure that any corrections are made to improve its performance related to PREA.

Standard 115.389 Data storage, publication, and destruction

☐ 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.

This standard directs the facility in its efforts to comply with data storage, publication, and destruction of records related to PREA.

The agency shall ensure that data collected pursuant to § 115.387 are securely retained. The agency shall make all aggregated sexual abuse data, from facilities under its direct control and private facilities with which it contracts, readily available to the public at least annually through its website or, if it does not have one, through other means. Before making aggregated sexual abuse data publicly available, the agency shall remove all personal identifiers. The agency shall maintain sexual abuse data collected pursuant to § 115.387 for at least 10 years after the date of its initial collection unless Federal, State, or local law requires otherwise.

Compliance Documents
(a) – (d) P-03-20-01 Prison Rape Elimination Act – Zero Tolerance Policy
Aggregated Data Report

The PREA related documentation is kept secure in a locked file cabinet and door. Any information on the PREA Coordinator's computer is password protected. All PREA related documents are retained for 10 years. The report is approved by the agency administrator prior to the report being placed on the agency website. All personal identifiers are removed from the report.

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 inmate or staff member, except where the names of administrative personnel are specifically requested in the report template.

Jeff Rogers — May 26, 2016

Auditor Signature — Date