PREA AUDIT REPORT ☐ INTERIM ■ FINAL

JUVENILE FACILITIES

NATIONAL PREA RESOURCE CENTER

BJA Bureau of Justice Assistance U.S. Department of Justice

Auditor Information			
Auditor name: Kyle D. Barrington			
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Telephone number: 830-305-4792			
Date of facility visit: 05/11/2015 to 05/14/2015			
Facility Information			
Facility name: Naselle Youth Camp			
Facility physical address: 11 Youth Camp Lane, Naselle, WA 98638			
Facility mailing address: *(if different from above)*			
Facility telephone number: 360-484-3223			
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: Greg Do			
Number of staff assigned to the facility in the last 12 months: 102			
Designed facility capacity: 76			
Current population of facility: 66			
Facility security levels/inmate custody levels: Minimum-Medium			
Age range of the population: 15-20			
Name of PREA Compliance Manager: Cary Bloom		**Title:**	PREA Compliance
Email address: BloomCA@dshs.wa.gov		**Telephone number:**	360-484-3223 x7622
Agency Information			
Name of agency: Juvenile Justice & Rehabilitation Administration			
Governing authority or parent agency: *(if applicable)* Department of Social & Health Services			
Physical address: 14th & Jefferson Street, Olympia, WA 98504			
Mailing address: *(if different from above)*			
Telephone number: 360-902-8080			
Agency Chief Executive Officer			
Name: John Clayton		**Title:**	Assistant Secretary
Email address: Claytjl@dshs.wa.gov		**Telephone number:**	360-902-0230
Agency-Wide PREA Coordinator			
Name: Eric Crawford		**Title:**	PREA Administrator
Email address: Crawfem@dshs.wa.gov		**Telephone number:**	360-902-0230

AUDIT FINDINGS

NARRATIVE

The Juvenile Justice & Rehabilitation Administration (JJRA) requested a PREA Audit for the Naselle Youth Camp (Naselle), located in Naselle, Washington, on February 19, 2015. Naselle is a medium security facility that is not fenced. It provides educational and treatment services for male offenders. Educational options include high school diploma and general equivalency diploma (GED). Treatment services include dialectical behavior therapy, anger replacement training, cultural programming, sex offense, and outpatient chemical dependency treatment. Naselle, in collaboration with the Department of Natural Resources, offers a forestry work program and in collaboration with the Department of Fish and Wildlife an aquaculture program. The Pre-Audit work commenced on March 23, 2015, and the Onsite Audit was conducted on May 11, 2015, through May 14, 2015.

Naselle is an institution that can house up to 108 male residents between the ages of 15 and 20. As of the date of the onsite the facility was funded to house up to 80 residents, however during the onsite visit the total population was 69. Routine medical care is provided onsite with referrals to local area medical clinics and hospitals on an as needed basis. Mental health services are provided by onsite by the staff Psychologist and staff counselors. At the time of the Onsite Audit, there were three (3) volunteers and 23 contractors authorized to enter the facility. The primary function of the staff, volunteers, and contractors is to assist the residents' as they integrated back into the community.

Naselle’s security level is rated as a “minimum to medium” and the resident custody levels range is considered “minimum-medium” per interviews with Naselle and JJRA staff. For purposes of the PREA audit Naselle is considered a "secure" facility. As of April 2015, the facility was authorized to employ up to 110 staff members (76 full-time staff and up to 34 on-call staff). All but 10 staff are considered “security” staff for the purpose of the staff-to-resident ratio as defined by PREA. The facility has approximately 51 security cameras located in and around the facility but none of the cameras are located in, or have a view of, the residents’ bedroom or shower/toileting areas.

During the previous 12 month period, the facility reported 11 allegations of sexual abuse and sexual harassment. However, after review during the Onsite Audit the total number of allegations was eight (8) as several allegations were recorded twice. None of these allegations were investigated by facility staff. The facility had never had a previous PREA Audit.

DESCRIPTION OF FACILITY CHARACTERISTICS

The Naselle campus is comprised of 16 buildings. Housing for Naselle youth consists of a five lodges or living units, three of which are in use for housing juveniles. Cougar and Moolock Lodges are each funded for 24 youth beds, and can physically house up to 30 youth each. Both lodges each have 18 single occupancy and 6 double occupancy bedrooms. Both lodges are single story buildings and have 4 open pods, with each pod having 6 resident bedrooms and 2 bathrooms/showers. In both lodges a staff duty office is on one side of the building facing all four pods. These buildings also contain a manager's office, a mud room, and a laundry room. Behind the staff duty office is another staff office, a staff bathroom, a storage room, an isolation room used for youth confinement, and a shower room for youth in isolation. Harbor Lodge is a two story building with four pods or wings, two upstairs and two down. It is funded to house 32 youth and can physically house up to 48 youth. It has 20 double occupancy and 8 single occupancy bedrooms. In each pod are 7 bedrooms and two bathrooms/showers. The staff duty office is in the center of the lodge, and each pod or wing is open and visually accessible from the middle of the lodge. The building also has 3 staff offices, a large kitchen area, a mud room, a staff bathroom, 2 isolation rooms, 6 mop closets, and a closet with a tub. All youth bedroom doors have security windows. Resident bathrooms in pods all have a shower stall. None of the youth bathroom doors have windows, and only one youth is allowed inside at a time.

Mariner Lodge is currently unoccupied and is undergoing a remodel. When completed it will be a single story building and house up to 24 youth, having 16 single occupancy and four (4) double occupancy bedrooms along with eight (8) resident bathrooms, one (1) staff bathroom, three (3) staff offices with doors, and a staff area that will be open facing the pods. It will also have an isolation room used for confinement, a group room in the back, a storage room, a mud room, and a laundry room. Based on interviews with Naselle staff, the remodel included added “line of sight” improvements to improve security.

Eagle Lodge is a two (2) story building, with the downstairs containing staff offices, a kitchen, isolation rooms, and a laundry room. There is a kitchen/Dining Hall with a food preparation and cooking area, eating area with tables, offices, large freezers and coolers, and storage areas. There is a chapel with a large gathering area and an office. Upstairs this lodge contains a staff office, group rooms, bathrooms, and several bedrooms that are currently used for storage.

At the Naselle entrance there is a small water treatment plant, with a pump house. Next, there is an administration building with staff offices, a mail/copy room, and a conference room. There is a Visitor Center with a large open room with tables and vending machines, staff offices, and a group room. Next to the Visitor Center there is a building used as a maintenance shop with vehicle repair bays, an open shed, and an upstairs group room. There is a Medical Clinic with exam rooms, offices, storage, and an adjacent Dental Clinic (staffed by a contracted dentist). There is a greenhouse, fish hatchery, and eight (8) storage sheds. There is a maintenance shop with storage areas along with Department of Natural Resources shops and offices as well. Behind the Department of Natural Resources buildings is a "Sweat Lodge" for Native American ceremonies. There is a school with classrooms, offices, teacher break room, a gymnasium and locker room. Outside the school there is a storage shed and parked vehicles, including 3 trailers.

SUMMARY OF AUDIT FINDINGS

Prior to the PREA Onsite Audit, which was conducted between May 11, 2015, and May 14, 2015, it was confirmed, via photographic evidence provided via email by the Naselle PREA Compliance Manager (PCM) on March 25, 2015, that the required PREA Audit notice was posted at least 42 days in advance. The photographs confirmed that the notices were posted in various, conspicuous, areas throughout the facility.

On April 20, 2015, this Auditor received multiple emails containing the completed Pre-Audit Questionnaire, the Naselle policies, and other supporting documentation from both the Naselle Superintendent, the Naselle PREA Compliance Manager (PCM), and the Naselle Administrative Program Manager (APM). Upon review of the information and data provided, it became clear that the facility had taken significant steps toward meeting PREA compliance. A conference call with this Auditor and the PCM and the APM on April 30, 2015, confirmed that the facility had made great progress toward PREA compliance and that the staff felt that the facility became PREA “compliant” in June of 2014.

On the first day of the Onsite Audit, May 11, 2015, an introduction meeting was held at approximately 8:30 AM with the Naselle Superintendent, PCM, APM, Assistant Superintendent, and this Auditor. It was noted that there were 69 residents onsite at the time of the audit. Following this meeting, a tour of the entire facility was conducted and this Auditor noted the location of the security cameras, the physical grounds, and the various structures. Notification of the PREA Audit, as well as, notices regarding the rights of the residents to be free from sexual abuse and sexual harassment were observed. These notices included information on how residents could report sexual abuse and sexual harassment. During this tour it was noted that there were areas of the facility that had "blind spots" and these areas were noted by the PCM and APM. However, other “blind spots” were not noted (e.g., walkway to Sweat Lodge, counseling room, stairways, etc.). It was also noted that there were no cameras in the residents' sleeping quarters or in the residents' shower/toileting areas.

During this tour, this Auditor observed residents being supervised by Naselle staff (i.e., security staff) or contractors (i.e., medical or teachers). Further, it was observed that in each housing unit (called a Lodge) there were staff of both genders consistently present.

This Auditor interviewed 11 residents, 10 via random sampling and one (1) via discussion during the resident’s routine auditing work assignment. Thus, 15.6% of the total resident population was interviewed as part of the Onsite Audit. Residents reported being informed of the facility's Zero-Tolerance Policy related to sexual abuse and sexual harassment and their right to be free from sexual abuse and sexual harassment as well as their right to be free from retaliation for reporting sexual abuse and/or sexual harassment. Seven (7) of 11 residents (63.6%) noted that they didn't get PREA information at time of intake but all (100.0%) indicated that they received PREA Education within 10 days of intake. A review of 44 residents’ files (66.8% of all residents) indicated that 22 (50.0%) did not receive PREA information at their time of intake but 100.0% of the files reviewed documented PREA Education within 10 days of intake.

During the routine auditing work assignment, this Auditor talked to security staff, counselors, contractors, and intake staff. In all, a total of 19 staff (JJRA employees, and/or contractors) were interviewed. Ten of the 19 interviewed staff were security staff that were randomly selected and represented security staff from all shifts and all lodges. Overall, the staff interviews revealed that staff were trained in the PREA Standards, in their obligations as first-responders, and in their respective responsibilities and duties to prevent, detect, and respond to sexual abuse, sexual harassment, and allegations of retaliation for reporting sexual abuse and sexual harassment. All staff reported being trained in how to search transgender or intersex residents. Staff responsible for conducting intake risk assessments noted that they completed a risk factor analysis (called a SAVY) for each resident to determine proper room assignments. In a review of 44 resident files, one (1) resident, or 2.3%, did not get a risk assessment conducted within the 72-hour timeframe (this youth did not get the risk assessment until 14 days after intake). Further, during the review of resident files it was noted that 14 out of all 69 residents had reported prior sexual abuse or sexual perpetration. Of these 14, three (3) had requested a mental health follow-up. Of these three (3), only one (1) received the mental health follow-up within 14 days. The others received the mental health follow-up in 19 and 21 days, respectively.

Through the Naselle Pre-Audit Questionnaire and Onsite Audit processes, it was determined that one (1) PREA Standard was “Not Applicable”, that 29 Standards were “Met”, and that 11 Standards were “Not Met”. A corrective action plan for compliance was jointly developed between this Auditor and the Naselle facility staff and implemented on June 13, 2015 to facilitate Naselle’s efforts to become fully compliant with all PREA Standards.

On December 2, 2015, Naselle completed their Corrective Action Plan and the facility is deemed to "meet" standards. The following is a standard-by-standard summary of this Auditor’s findings and corrective actions, if any.

Number of standards exceeded: 0

Number of standards met: 40

Number of standards not met: 0

Number of standards not applicable: 1

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.

REQUIREMENTS: 115.311: Requires that: (a) 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; (b) 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; and (c) 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.

EVIDENCE OF COMPLIANCE: As evidence of compliance with this standard, the facility (Naselle) submitted or provided to this Auditor the following: 1) the Department of Social and Health Services (DSHS) Juvenile Rehabilitation (JJRA) Policy 49, which was put into effect on February 27, 2015; 2) the Pre-Audit Questionnaire; 3) Naselle's Organizational Chart; 4) Naselle's Facility Policy (effective on February 5, 2015); and 5) interviews with staff (i.e., specifically the Superintendent, Facility PREA Compliance Manager, and the PREA Administrator for the State of Washington).

OBSERVATIONS: All elements of this standard were determined to be met. As noted in the Auditor's Worksheet, there were zero Corrective Action Plan (CAP) items that needed be addressed after the Onsite Audit.

DETERMINATION: Based on the agency and facility policies and procedures, Pre-Audit Questionnaire, and the Onsite Audit (including th

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.

REQUIREMENTS: 115.312: Requires that: (a) A public agency that contracts for the confinement of its inmates 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; (b) Any new contract or contract renewal shall provide for agency contract monitoring to ensure that the contractor is complying with the PREA standards.

EVIDENCE OF COMPLIANCE: As evidence of compliance with this standard, the facility (Naselle) and JJRA submitted or provided to this Auditor the Pre-Audit Questionnaire and provided interviews with staff (specifically, the DSHS Contract Manager) and copies of a contract with Pioneer Human Services.

OBSERVATIONS: Interviews with the DSHS Contract Manager reinforced that DSHS only contracts with one facility for confinement services. That facility is Camp Outlook and is part of Pioneer Human Services. Review of the only contract for confinement services noted on page 17 (Statement of Work) under section 1, subsection (b-1), that the Contractor shall "adopt and be in compliance with PREA standards for preventing, detecting, and responding to sexual misconduct in criminal and juvenile justice settings." Further, the review of the only contract for confinement services noted on page 17 (Statement of Work) under section 1, subsection (b-2) that the Contractor shall "provide the JJRA contract monitoring to ensure compliance with the PREA standards." As noted in the Auditor's Worksheet, there were zero Corrective Action Plan (CAP) items that needed be addressed after the Onsite Audit.

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.

REQUIREMENTS: 115.313: This standard has four components: (a) a staffing plan has been created; (b) deviations from the staffing plan are documented; (c) the staffing plan is reviewed annually; and (d) for secure facilities, where unannounced rounds occur, staff are prohibited from alerting other staff that such rounds are occurring.

EVIDENCE OF COMPLIANCE: As evidence of compliance with this standard, the facility (Naselle) submitted or provided to this Auditor the following: 1) the Department of Social and Health Services (DSHS) Juvenile Rehabilitation (JJRA) Policy 49, which was put into effect on February 27, 2015; 2) the Pre-Audit Questionnaire; 3) Naselle's Facility Staffing Plan (effective April 15, 2015); 4) Naselle's PREA Policy (called the Preamble); 5) video evidence of unannounced checks; and 6) interviews with staff (specifically, the Superintendent and the PREA Compliance Manager).

OBSERVATIONS: Interviews and paperwork documented that a staffing plan was developed, implemented, and reviewed annually (last reviewed April 10, 2015). Naselle reported zero staffing plan deviations. In addition, this Auditor found 61 documents supporting unannounced round checks (called Unscheduled Safety Checks at the facility). However, in a review of the video evidence provided, in only two occasions out of the five reviewed (40.0% of the total) supported evidence of an unscheduled safety checks. On two of the three occasions that were not supported by video evidence, staff appeared to only review the staff office and did not appear to verify that all residents were accounted, which appears to be a violation of the Naselle policy. Further, the other unsupported video (20.0% of the total) there was no indication of an unscheduled safety check being performed. Overall, this resulted in four CAP recommendations that

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.

REQUIREMENTS: 115.315: This standard has six components: (a) 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; (b) The agency shall not conduct cross-gender pat-down searches except in exigent circumstances; (c) The facility shall document all cross-gender strip searches and cross-gender visual body cavity searches, and shall document all cross-gender pat-down searches of female inmates; (d) The facility shall implement policies and procedures that enable inmates 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 an inmate housing unit; (e) The facility shall not search or physically examine a transgender or intersex inmate for the sole purpose of determining the inmate's genital status. If the inmate's genital status is unknown, it may be determined during conversations with the inmate, 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; and (f) The agency shall train security staff in how to conduct cross-gender pat-down searches, and searches of transgender and intersex inmates, in a professional and respectful manner, and in the least intrusive manner possible, consistent with security needs.

EVIDENCE OF COMPLIANCE: JJRA 49 (effective February 27, 2015) was presented as evidence of compliance along with JJRA Policy 42 (Conducting Searches), JJRA Policy 50, a tour of the facility, and the Pre-Audit Questionnaire. In addition, interviews with 19 staff (employees, contractors, or volunteers) and 11 residents, along with reviews of facility forms helped to form the basis of the determination

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.

REQUIREMENTS: 115.316: This standard has three components: (a) The agency shall take appropriate steps to ensure that inmates with disabilities (including, for example, inmates 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; (b) 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 inmates 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; and (c) The agency shall not rely on inmate interpreters, inmate readers, or other types of inmate assistants except in limited circumstances where an extended delay in obtaining an effective interpreter could compromise the inmate's safety, the performance of first-response duties under §115.64, or the investigation of the inmate's allegations.

EVIDENCE OF COMPLIANCE: JJRA 49 (effective February 27, 2015), JJRA Policy 36 (Using Interpreter and Translation Services [2/27/2015]), Naselle's PREA Policy, and the Pre-Audit Questionnaire were presented as evidence of compliance with this standard. In addition, interviews with 19 staff (employees, contractors, or volunteers) and 11 residents, along with reviews of facility forms helped to form the basis of the determination for this standard.

OBSERVATIONS: JJRA Policy 36 (Using Interpreter and Translation Services [2/27/2015]) notes "JJRA must not rely on youth to provide interpretation, translation of written materials, or other types of assistance except in limited exigent circumstances where an extended

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.

REQUIREMENTS: 115.317: This standard has eight components: (a) The agency shall not hire or promote anyone who may have contact with inmates, and shall not enlist the services of any contractor who may have contact with inmates, 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]; (b) 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 inmates; (c) Before hiring new employees who may have contact with inmates, the agency shall: [(1) Perform a criminal background records check; and (2) 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]; (d) The agency shall also perform a criminal background records check before enlisting the services of any contractor who may have contact with inmates; (e) The agency shall either conduct criminal background records checks at least every five years of current employees and contractors who may have contact with inmates or have in place a system for otherwise capturing such information for current employees; (f) The agency shall ask all applicants and employees who may have contact with inmates directly about previous misconduct described in paragraph (a) of this section in written applications or interviews for hiring or promotions and in any interviews or written self-evaluations conducted as part of reviews of current employees. The agency shall also impose upon employees a continuing affirmative duty to disclose any such misconduct; and (g) Material omissions regarding such misconduct, or the provision of materially

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.

REQUIREMENTS: 115.318: This standard has two components: (a) 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; and (b) 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.

EVIDENCE OF COMPLIANCE: As evidence of compliance with this standard, the facility (Naselle) submitted or provided to this Auditor the Pre-Audit Questionnaire, a facility tour, and interviews with staff (specifically, the Naselle Superintendent and the facility's staff and residents).

OBSERVATIONS: One lodge (Mariner) is undergoing extensive renovations. According to interviews of the PCM and Superintendent the modifications include improved "line of sight" to improve resident safety. Further, the facility's security cameras were upgraded since August 2012 to improve resolution and coverage areas to help investigate allegations of sexual abuse and sexual harassment.

DETERMINATION: Based on the agency and facility policies and procedures, Pre-Audit Questionnaire, and the Onsite Audit (including the facility tour and the staff and resident interviews), it was determined that Naselle, in all material ways, meets this standard.

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.

REQUIREMENTS: 115.321: This standard has eight components: (a) 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; (b) 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; (c) 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; (d) 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; (e) As requested by the victim, the victim advocate, qualified agency staff member, or qualified

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.

REQUIREMENTS: 115.322: This standard has five components: (a) The agency shall ensure that an administrative or criminal investigation is completed for all allegations of sexual abuse and sexual harassment; (b) 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; (c) If a separate entity is responsible for conducting criminal investigations, such publication shall describe the responsibilities of both the agency and the investigating entity; (d) 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; (e) 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.

EVIDENCE OF COMPLIANCE: As evidence of compliance with this standard, the facility (Naselle) submitted or provided to this Auditor the following: 1) JJRA Policy 49 (effective February 27, 2015); 2) JJRA Policy 34; 3) DSHS 18.62; 4) the Pre-Audit Questionnaire; 5) Interviews with the facility's Investigators; and 6) Interviews with staff (specifically, the Naselle Superintendent.

OBSERVATIONS: Agency and facility policies materially meet standard and the agency has posted the investigation policy online. However, an allegation reported by a resident on April 14, 2015, of possible sexual harassment (i.e., a sexual gesture) was not

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.

REQUIREMENTS: 115.331: This standard has four components: (a) The agency shall train all employees who may have contact with residents on 11 required topics; (b) 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; (c) 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; and (d) The agency shall document, through employee signature or electronic verification, that employees understand the training they have received.

EVIDENCE OF COMPLETION: Naselle referenced JJRA Policy 49 (Applying the PREA Juvenile Standards in JJRA 2/27/2015) Policy, page 5, section 25, subsection 25.1. to 25.11 and submitted signed "Acknowledgement of Receipt of PREA Training" forms as evidence of compliance. Further, random interviews with 11 staff (employees, contractors, and volunteers) were also used.

OBSERVATIONS: 11 staff interviewed noted that they did receive all of the required PREA training (specifically, 331[a-7] and 331[a-9]). All staff interviews noted they felt they receive training that was specific to the "unique needs and attributes and gender of the residents at the facility." There appears to be two types of PREA training - Online and Instructor-Led. There is a signature line provided for both. Further,

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.

REQUIREMENTS: 115.332: This standard has three components: (a) 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; (b) 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; and (c) The agency shall maintain documentation confirming that volunteers and contractors understand the training they have received.

EVIDENCE OF COMPLETION: Naselle's Pre-Audit Questionnaire and interviews with the Naselle Superintendent were used to assess compliance with this standard.

OBSERVATIONS: Naselle provided evidence that all contractors and volunteers had received the required training and interviews with contractors noted that they had received the training.

DETERMINATION: Based on the agency and facility policies and procedures, Pre-Audit Questionnaire, and the Onsite Audit (including the facility tour and the staff and resident interviews), it was determined that Naselle, in all material ways, meets this standard.

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.

REQUIREMENTS: 115.333: This standard has six components: (a) 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; (b) 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; (c) 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; (d) 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; (e) The agency shall maintain documentation of resident participation in these education sessions; and (f) 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.

EVIDENCE OF COMPLETION: Naselle's Pre-Audit Questionnaire, JJRA Policy 40, interviews with the Naselle Superintendent, the facility staff and residents, and a review of 44 resident files were used to assess compliance with this standard.

OBSERVATIONS: A review of 44 residents' files indicated that 22, or 50.0%, did not receive PREA information at their time of intake. However, files indicated that all 44 received their PREA Education within 10-days of intake. These findings resulted in three (3) CAP

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.

REQUIREMENTS: 115.334: This standard has four components: (a) 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; (b) Specialized training shall include techniques for interviewing juvenile sexual abuse victims, proper use of Miranda and Garrity warnings, sexual abuse evidence collection in confinement settings, and the criteria and evidence required to substantiate a case for administrative action or prosecution referral; (c) The agency shall maintain documentation that agency investigators have completed the required specialized training in conducting sexual abuse investigations; and (d) Any State entity or Department of Justice component that investigates sexual abuse in juvenile confinement settings shall provide such training to its agents and investigators who conduct such investigations.

EVIDENCE OF COMPLETION: Naselle's Pre-Audit Questionnaire along with interviews with the Naselle Superintendent were used to assess compliance with this standard.

OBSERVATIONS: Naselle provided evidence that two staff had completed investigator training and interviews with those staff indicated that they completed the training.

DETERMINATION: Based on the agency and facility policies and procedures, Pre-Audit Questionnaire, and the Onsite Audit (including the facility tour and the staff and resident interviews), it was determined that Naselle, in all material ways, meets this standard.

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.

REQUIREMENTS: 115.335: This standard has four components: (a) 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]; (b) If medical staff employed by the agency conduct forensic examinations, such medical staff shall receive the appropriate training to conduct such examinations; (c) 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; and (d) 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.

EVIDENCE OF COMPLETION: Naselle's Pre-Audit Questionnaire along with interviews with the Naselle Superintendent, and staff were used to assess compliance with this standard. Further, a review of training files was conducted.

OBSERVATIONS: Per the Pre-Audit Questionnaire the Naselle facility does have medical or mental health practitioners. Of the eight files reviewed seven had completed the required training. Only one contractor had not provided evidence of completing the training. This is scheduled for June 2015. This resulted in two (2) CAP recommendations involving ensuring that the staff member completes the training and submitting evidence of completion to this Auditor.

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.

REQUIREMENTS: 115.341: This standard has five components: (a) 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; (b) Such assessments shall be conducted using an objective screening instrument; (c) At a minimum, the agency shall attempt to ascertain 11 pieces of required information (see standard); (d) 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; and (e) 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.

EVIDENCE OF COMPLETION: Naselle's Pre-Audit Questionnaire, JJRA Policy 39, the Sexually Aggressive/Vulnerable Youth (SAVY) Survey, interviews with the Naselle Superintendent, staff, and residents, and a review of 44 resident files were used to assess compliance with this standard.

OBSERVATIONS: The facility uses a risk assessment tool that utilizes each resident's intake responses to a variety of questions, including past victimizations and abusiveness. This information is used to help determine a youth's risk of sexual aggression and sexual vulnerability. The staff uses the SAVY, a personal interview, and any other available relevant records to assess each youth's risk for

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.

REQUIREMENTS: 115.342: This standard has nine components: (a) The agency shall use all information obtained pursuant to § 115.341 and subsequently to make housing, bed, program, education, and work assignments for residents with the goal of keeping all residents safe and free from sexual abuse; (b) 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; (c) 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; (d) 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; (e) 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; (f) A transgender or intersex resident's own views with respect to his or her own safety shall be given serious consideration; (g) Transgender and intersex residents shall be given the opportunity to shower separately from other residents; (h) If a resident is isolated pursuant to paragraph (b) of this section, the facility shall clearly document: [(1) The basis for the facility's concern for the resident's safety; and (2) The reason why no alternative means of separation can be arranged]; and (i) Every 30 days, the facility

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.

REQUIREMENTS: 115.351: This standard has five components: (a) 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; (b) 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; (c) Staff shall accept reports made verbally, in writing, anonymously, and from third parties and shall promptly document any verbal reports; (d) The facility shall provide residents with access to tools necessary to make a written report; and (e) The agency shall provide a method for staff to privately report sexual abuse and sexual harassment of residents.

EVIDENCE OF COMPLETION: Naselle's Pre-Audit Questionnaire, JJRA Policy 13, JJRA Policy 49, JJRA Policy 14, interviews with the Naselle Superintendent, staff and residents, and an interview with the State of Washington PREA Administrator were used to assess compliance with this standard.

OBSERVATIONS: All staff and residents were able to identify multiple internal ways for a youth to report privately to facility officials about sexual abuse, sexual harassment, retaliation, and staff neglect or violation of responsibilities that may have contributed to any such

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.

REQUIREMENTS: 115.352: This standard has seven components: (a) An agency shall be exempt from this standard if it does not have administrative procedures to address resident grievances regarding sexual abuse; (b)(1) The agency shall not impose a time limit on when a resident may submit a grievance regarding an allegation of sexual abuse; (2) The agency may apply otherwise-applicable time limits on any portion of a grievance that does not allege an incident of sexual abuse; (b)(3) 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; (b)(4) 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; (c) The agency shall ensure that [(1) 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 (2) Such grievance is not referred to a staff member who is the subject of the complaint]; (d)(1) 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; (d)(2) Computation of the 90-day time period shall not include time consumed by residents in preparing any administrative appeal; (d)(3) 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; (d)(4) 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; (e)(1) 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; (e)(2) If a third party, other than a parent or legal guardian, files such a

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.

REQUIREMENTS: 115.353: This standard has four components: (a) 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; (b) 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; (c) 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; and (d) 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.

EVIDENCE OF COMPLETION: Naselle's Pre-Audit Questionnaire, JJRA Policy 28, interviews with the Naselle Superintendent, staff, and residents, an interview with staff at Crisis Support Network and Peace Health St. John Medical Center, and an interview with the State of Washington's PREA Administrator were used to assess compliance with this standard.

OBSERVATIONS: Naselle provided contact phone numbers and addresses to the local area Rape Crisis Center and to Child Protective ⊞

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.

REQUIREMENTS: 115.354: This standard has one component: (a) 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.

EVIDENCE OF COMPLETION: Naselle's Pre-Audit Questionnaire, interviews with the Naselle Superintendent, staff, and residents, and an interview with the State of Washington's PREA Administrator were used to assess compliance with this standard.

OBSERVATIONS: This Naselle facility has multiple means of receiving third-party reports, including phone calls to the facility and via the CPS number. Further, the agency's website has a process for families to report sexual abuse and sexual harassment. The DSHS website https://www.dshs.wa.gov/jjra/juvenile-rehabilitation/prison-rape-elimination-act-compliance notes that anyone, who suspects sexual abuse or sexual harassment has happened at a JJRA facility is free to contact the facility or report to CPS and law enforcement.

DETERMINATION: Based on the agency and facility policies and procedures, Pre-Audit Questionnaire, and the Onsite Audit (including the facility tour and the staff and resident interviews), it was determined that Naselle, in all material ways, meets this standard.

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.

REQUIREMENTS: 115.361: This standard has six components: (a) 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; (b) The agency shall also require all staff to comply with any applicable mandatory child abuse reporting laws; (c) 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; (d)(1) Medical and mental health practitioners shall be required to report sexual abuse to designated supervisors and officials pursuant to paragraph (a) of this section, as well as to the designated State or local services agency where required by mandatory reporting laws; (d)(2) Such practitioners shall be required to inform residents at the initiation of services of their duty to report and the limitations of confidentiality; (e)(1) 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; (e)(2) 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; (e)(3) 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; and (f) The facility shall report all allegations of sexual abuse and sexual harassment, including third-party and anonymous reports, to the facility's designated investigators.

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.

REQUIREMENTS: 115.362: This standard has one component: (a) 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.

EVIDENCE OF COMPLETION: Naselle's Pre-Audit Questionnaire, JJRA Policy 49 (Applying PREA Juvenile Standards in JJRA [2/27/2015]), and interviews with staff and residents were used to assess compliance with this standard.

OBSERVATIONS: JJRA Policy 49, on page 4, section 19, notes that "If a youth is subject to a substantial risk of imminent sexual abuse, the Superintendent, Community Facility Administrator, Regional Administrator, or designee must take immediate action to protect the youth." During interviews all 11 randomly selected staff noted that they would act immediately to protect a resident who was subject to a substantial risk of imminent sexual abuse. Further, all interviewed residents noted that they would "tell staff" if they felt they were at a substantial risk of imminent sexual abuse. However, as written, JJRA Policy 49 does not comply with this PREA standard. All interviewed staff reported they would "immediately" act to protect the youth and would "immediately" report the concern to his/her supervisor. Interviews of residents reinforced that they felt staff would "immediately" take action to protect them if they needed it.

DETERMINATION: Based on the agency and facility policies and procedures, Pre-Audit Questionnaire, and the Onsite Audit (including the facility tour and the staff and resident interviews), it was determined that Naselle, in all material ways, meets this standard.

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.

REQUIREMENTS: 115.363: This standard has four components: (a) 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; (b) Such notification shall be provided as soon as possible, but no later than 72 hours after receiving the allegation; (c) The agency shall document that it has provided such notification; and (d) The facility head or agency office that receives such notification shall ensure that the allegation is investigated in accordance with these standards.

EVIDENCE OF COMPLETION: Naselle's Pre-Audit Questionnaire, JJRA Policy 49 (Applying PREA Juvenile Standards in JJRA [2/27/2015]), and interviews with staff and residents were used to assess compliance with this standard.

OBSERVATIONS: JJRA Policy 49 is compliant with this standard and interviews acknowledge that staff understood and would comply with this standard.

DETERMINATION: Based on the agency and facility policies and procedures, Pre-Audit Questionnaire, and the Onsite Audit (including the facility tour and the staff and resident interviews), it was determined that Naselle, in all material ways, meets this standard.

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.

REQUIREMENTS: 115.364: This standard has two components: (a) Upon learning of an allegation that a resident was sexually abused, the first staff member to respond to the report shall be required to:
[(1) Separate the alleged victim and abuser; (2) Preserve and protect any crime scene until appropriate steps can be taken to collect any evidence; and (3) If the abuse occurred within a time period that still allows for the collection of physical evidence, request that the alleged victim not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating; and (4) If the abuse occurred within a time period that still allows for the collection of physical evidence, ensure that the alleged abuser does not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating]; and
(b) 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.

EVIDENCE OF COMPLETION: Naselle's Pre-Audit Questionnaire, JJRA Policy 49 (Applying PREA Juvenile Standards in JJRA [2/27/2015]), and interviews with staff and residents were used to assess compliance with this standard.

OBSERVATIONS: JJRA Policy 49 does not differentiate between security staff and non-security staff. The policy states that "the first staff member to respond." Further, in each staff interview, including non-security staff, all staff noted that they understood his/her role if they happen to be a first responder and each staff answer was compliant with PREA standards. In addition, Naselle's Coordinated Response

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.

REQUIREMENTS: 115.365: This standard has one component: (a) 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.

EVIDENCE OF COMPLETION: Naselle's Pre-Audit Questionnaire, Naselle Youth Camp Sexual Assault Response Plan, and interviews with staff and residents were used to assess compliance with this standard.

OBSERVATIONS: The Naselle Youth Camp Sexual Assault Response Plan is written and details the coordinated action that staff are to take in response to an incidence of sexual abuse. This includes the responsibilities of first responders, medical and mental health practitioners, investigators, and facility leadership. Interviews with staff confirmed that the staff knew of the plan and that it needed to be followed if there was in allegation of sexual abuse.

DETERMINATION: Based on the agency and facility policies and procedures, Pre-Audit Questionnaire, and the Onsite Audit (including the facility tour and the staff and resident interviews), it was determined that Naselle, in all material ways, meets this standard.

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.

REQUIREMENTS: 115.366: This standard has two components: (a) 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, and (b) Nothing in this standard shall restrict the entering into or renewal of agreements that govern: [(1) The conduct of the disciplinary process, as long as such agreements are not inconsistent with the provisions of §§ 115.372 and 115.376; or (2) 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.]

EVIDENCE OF COMPLETION: Naselle's Pre-Audit Questionnaire and an interview with the Director of Institutional Programs [designee for the DSHS Agency Head] were used to assess compliance with this standard.

OBSERVATIONS: An interview with the Director of Institutional Programs and designee for the DSHS Agency Head, noted that the agency/state did enter into a new/renewed collective bargaining agreement that was completed since August of 2012 but that nothing in the collective bargaining agreement violated 115.366(b)(1) or 115.366(b)(2) provisions.

DETERMINATION: Based on the agency and facility policies and procedures, Pre-Audit Questionnaire, and the Onsite Audit (including th

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.

REQUIREMENTS: 115.367: This standard has six components: (a) 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; (b) 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; (c) 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, or negative performance reviews or reassignments of staff. The agency shall continue such monitoring beyond 90 days if the initial monitoring indicates a continuing need; (d) In the case of residents, such monitoring shall also include periodic status checks; (e) 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; and (f) An agency's obligation to monitor shall terminate if the agency determines that the allegation is unfounded.

EVIDENCE OF COMPLETION: Naselle's Pre-Audit Questionnaire, JJRA Policy 49 (Applying PREA Juvenile Standards in JJRA [2/27/2015]), and interviews with staff and residents were used to assess compliance with this standard.

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.

REQUIREMENTS: 115.368: This standard has one component: (a) 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.

EVIDENCE OF COMPLETION: Naselle's Pre-Audit Questionnaire, JJRA Policy 22, and interviews with staff and residents were used to assess compliance with this standard.

OBSERVATIONS: Based on the pre-onsite visit conference calls with the PCM and via the Pre-Audit Questionnaire, Naselle does not, ever, place a resident in isolation for their own safety. However, the policies do allow for this to happen if needed and these policy meet standard.

DETERMINATION: Based on the agency and facility policies and procedures, Pre-Audit Questionnaire, and the Onsite Audit (including the facility tour and the staff and resident interviews), it was determined that Naselle, in all material ways, meets this standard.

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.

REQUIREMENTS: 115.371: This standard has 13 components: (a) 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; (b) 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; (c) 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; (d) The agency shall not terminate an investigation solely because the source of the allegation recants the allegation; (e) 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; (f) 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; (g) Administrative investigations: [(1) Shall include an effort to determine whether staff actions or failures to act contributed to the abuse; and (2) 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]; (h) 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; (i) Substantiated allegations of conduct that appears to be criminal shall be referred for prosecution; (j) The agency shall retain all written reports referenced in paragraphs (g) and (h) of this section

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.

REQUIREMENTS: 115.372: This standard has one component: (a) 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.

EVIDENCE OF COMPLETION: Naselle's Pre-Audit Questionnaire and interviews with staff and residents were used to assess compliance with this standard.

OBSERVATIONS: Staff noted that they would only use a standard of "preponderance of evidence" in determining whether allegations of sexual abuse or sexual harassment are substantiated.

DETERMINATION: Based on the agency and facility policies and procedures, Pre-Audit Questionnaire, and the Onsite Audit (including the facility tour and the staff and resident interviews), it was determined that Naselle, in all material ways, meets this standard.

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.

REQUIREMENTS: 115.373: This standard has six components: (a) 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; (b) If the agency did not conduct the investigation, it shall request the relevant information from the investigative agency in order to inform the resident; (c) 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 [(1) The staff member is no longer posted within the resident's unit; (2) The staff member is no longer employed at the facility; (3) The agency learns that the staff member has been indicted on a charge related to sexual abuse within the facility; or (4) The agency learns that the staff member has been convicted on a charge related to sexual abuse within the facility]; (d) 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: [(1) The agency learns that the alleged abuser has been indicted on a charge related to sexual abuse within the facility; or (2) The agency learns that the alleged abuser has been convicted on a charge related to sexual abuse within the facility]; (e) All such notifications or attempted notifications shall be documented; and (f) An agency's obligation to report under this standard shall terminate if the resident is released from the agency's custody.

EVIDENCE OF COMPLETION: Naselle's Pre-Audit Questionnaire and interviews with staff and residents were used to assess compliance with this standard.

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.

REQUIREMENTS: 115.376: This standard has four components: (a) Staff shall be subject to disciplinary sanctions up to and including termination for violating agency sexual abuse or sexual harassment policies; (b) Termination shall be the presumptive disciplinary sanction for staff who have engaged in sexual abuse; (c) 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; (d) 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.

EVIDENCE OF COMPLETION: Naselle's Pre-Audit Questionnaire, JJRA Policy 49, JJRA Policy 20, and interviews with JJRA Human Resources and with Naselle's staff and residents were used to assess compliance with this standard.

OBSERVATIONS: JJRA Policy 49, page 2, section 7, notes that "Termination will be the presumptive disciplinary sanction for staff who have engaged in sexual abuse in accordance with RCW 13.40.570." Interviews with administrative staff noted that violations of the agency policies relating to sexual abuse or sexual harassment (other than actually engaging in sexual abuse) are commensurate with the nature and circumstance of the acts committed. This was supported by JJRA Policy 49, page 2, section 8. Interviews with administrative staff noted that law enforcement is notified and investigations completed even if the alleged abusers resigns.

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.

REQUIREMENTS: 115.377: This standard has two components: (a) 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; and (b) 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.

EVIDENCE OF COMPLETION: Naselle's Pre-Audit Questionnaire, JJRA Policy 43 [Contract Compliance], and interviews with Naselle's staff and residents were used to assess compliance with this standard.

OBSERVATIONS: JJRA Policy 43 (Managing Vendor/Contractor Compliance [4/1/2014]) notes that "any contractor or volunteer who engages in sexual abuse must be prohibited from contact with youth and shall be reported to law enforcement agencies and to relevant licensing bodies" (page 1, section 2). Interviews with Naselle staff noted that any sexual abuse allegation would be reported to law enforcement regardless if the alleged abuser was a resident, staff, contractor, or volunteer. Additional interviews with staff, including administrative and management staff, noted that the facility would take appropriate remedial measures and would 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.

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.

REQUIREMENTS: 115.378: This standard has seven components: (a) 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; (b) 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; (c) 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; (d) 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; (e) 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; (f) 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; and (g) 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

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.

REQUIREMENTS: 115.381: This standard has four components: (a) If the screening pursuant to § 115.341 indicates that a resident has experienced prior sexual victimization, whether it occurred in an institutional setting or in the community, 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; (b) If the screening pursuant to § 115.341 indicates that a resident has previously perpetrated sexual abuse, whether it occurred in an institutional setting or in the community, staff shall ensure that the resident is offered a follow-up meeting with a mental health practitioner within 14 days of the intake screening; (c) 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; and (d) 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.

EVIDENCE OF COMPLETION: Naselle's Pre-Audit Questionnaire, JJRA Policy 39, JJRA Policy 14, and interviews with Naselle's staff and residents were used to assess compliance with this standard.

OBSERVATIONS: JJRA Policy 39, page 2, section 5, notes that "a meeting with a medical and mental health practitioner must be offered to a youth within 14 days of staff learning that the youth has experienced prior sexual victimization or has perpetrated sexual abuse." JJRA Policy 14 restates the same policy. However, in a review of 44 client records, 14 noted they had experienced past sexual abuse and/or

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.

REQUIREMENTS: 115.382: This standard has four components: (a) 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; (b) If no qualified medical or mental health practitioners are on duty at the time a report of recent abuse is made, staff first responders shall take preliminary steps to protect the victim pursuant to § 115.362 and shall immediately notify the appropriate medical and mental health practitioners; (c) 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; and (d) 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.

EVIDENCE OF COMPLETION: Naselle's Pre-Audit Questionnaire, JJRA Policy 14, and interviews with Naselle's staff and residents were used to assess compliance with this standard.

OBSERVATIONS: The onsite visit interviews noted that resident victims of sexual abuse are provided with unimpeded access to emergency medical treatment and crisis intervention services. JJRA Policy 14 (Providing Health Care to JJRA Youth [4/1/2014]) on page 8, section 20, subsections 20.1-20.2, provides clear directive that supports this component of the standard. Eleven of 11 interviews (100%) with staff, who are all trained as first responders, confirmed this component and noted that they are trained to protect the victim and to

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.

REQUIREMENTS: 115.383: This standard has eight components: (a) 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; (b) 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; (c) The facility shall provide such victims with medical and mental health services consistent with the community level of care; (d) Resident victims of sexually abusive vaginal penetration while incarcerated shall be offered pregnancy tests; (e) If pregnancy results from conduct specified in paragraph (d) of this section, such victims shall receive timely and comprehensive information about and timely access to all lawful pregnancy-related medical services; (f) Resident victims of sexual abuse while incarcerated shall be offered tests for sexually transmitted infections as medically appropriate; (g) 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; and (h) 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.

EVIDENCE OF COMPLETION: Naselle's Pre-Audit Questionnaire, JJRA Policy 14, and interviews with Naselle's staff and residents were used to assess compliance with this standard.

OBSERVATIONS: Interviews with medical staff indicated that the Naselle facility does offer any and all necessary medical and mental

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.

REQUIREMENTS: 115.386: This standard has five components: (a) 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; (b) Such review shall ordinarily occur within 30 days of the conclusion of the investigation; (c) The review team shall include upper-level management officials, with input from line supervisors, investigators, and medical or mental health practitioners; (d) The review team shall: [(1) Consider whether the allegation or investigation indicates a need to change policy or practice to better prevent, detect, or respond to sexual abuse; (2) 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; (3) Examine the area in the facility where the incident allegedly occurred to assess whether physical barriers in the area may enable abuse; (4) Assess the adequacy of staffing levels in that area during different shifts; (5) Assess whether monitoring technology should be deployed or augmented to supplement supervision by staff; and (6) Prepare a report of its findings, including but not necessarily limited to determinations made pursuant to paragraphs (d)(1)-(d)(5) of this section, and any recommendations for improvement and submit such report to the facility head and PREA compliance manager]; (e) The facility shall implement the recommendations for improvement, or shall document its reasons for not doing so.

EVIDENCE OF COMPLETION: Naselle's Pre-Audit Questionnaire, interviews with Naselle staff, and interviews with the State of Washington's PREA Program Administrator, were used to assess compliance with 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.

REQUIREMENTS: 115.387: This standard has six components: (a) 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; (b) The agency shall aggregate the incident-based sexual abuse data at least annually; (c) 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 (SSV) conducted by the Department of Justice; (d) 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; (e) The agency also shall obtain incident-based and aggregated data from every private facility with which it contracts for the confinement of its residents; and (f) Upon request, the agency shall provide all such data from the previous calendar year to the Department of Justice no later than June 30.

EVIDENCE OF COMPLETION: Naselle's Pre-Audit Questionnaire, interviews with Naselle staff, and interviews with the State of Washington's PREA Program Administrator, were used to assess compliance with this standard.

OBSERVATIONS: The Naselle facility did not produce (and does not have) a standardized instrument so that it can collect accurate uniform data for every allegation of sexual abuse at facilities under its direct control using a standardized instrument and set of definitions. However, during the onsite visit interviews it was determined that the facility does collect data that complies with the Survey of Sexual Violence. Data from the DSHS website at https://www.dshs.wa.gov/jjra/juvenile-rehabilitation/prison-rape-elimination-act-compliance notes that aggregated data is presented. An interview with the State of Washington PREA Program Administrator, indicated that JJRA

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.

REQUIREMENTS: 115.388: This standard has four components: (a) 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: [(1) Identifying problem areas; (2) Taking corrective action on an ongoing basis; and (3) Preparing an annual report of its findings and corrective actions for each facility, as well as the agency as a whole]; (b) 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; (c) 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; and (d) 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.

EVIDENCE OF COMPLETION: Naselle's Pre-Audit Questionnaire, JJRA Policy 49, and interviews with the State of Washington's PREA Program Administrator were used to assess compliance with this standard.
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OBSERVATIONS: An annual report is posted at https://www.dshs.wa.gov/jjra/juvenile-rehabilitation/prison-rape-elimination-act-compliance. This report and its posting comply in all material ways with the standard

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.

REQUIREMENTS: 115.389: This standard has four components: (a) The agency shall ensure that data collected pursuant to § 115.387 are securely retained; (b) 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; (c) Before making aggregated sexual abuse data publicly available, the agency shall remove all personal identifiers; and (d) 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.

EVIDENCE OF COMPLETION: Naselle's Pre-Audit Questionnaire, JJRA Policy 49, and interviews with the State of Washington's PREA Program Administrator.

OBSERVATIONS: Interview with the PREA Program Administrator, indicated that incident-based and aggregated data were securely retained. Data from the DSHS website at https://www.dshs.wa.gov/jjra/juvenile-rehabilitation/prison-rape-elimination-act-compliance notes that aggregated data is presented and this is compliant with agency policy (JJRA Policy 49, page 10, section 45). Data from the same DSHS website notes that the agency will remove personal identifiers and this is compliant with agency policy (JJRA Policy 49, page 10, section 45, subsection 45.1). Further, interviews with the PREA Administrator indicated that sexual abuse data is collected and maintained for 10 years.

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.

Kyle D. Barrington Digitally signed by Kyle D. Barrington
DN: cn=Kyle D. Barrington, o=Zajonc Corp, ou=Auditor, email=webkb@zajonc-corp.com, c=US
Date: 2015.12.03 09:51:42 -06'00'

December 2, 2015

Auditor Signature

Date