PREA Facility Audit Report: Final

Name of Facility: Southwest Idaho Juvenile Detention Center
Facility Type: Juvenile
Date Interim Report Submitted: NA
Date Final Report Submitted: 08/12/2026

Auditor Certification	
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.	☑
I have not included in the final report any personally identifiable information (PII) about any inmate/resident/detainee or staff member, except where the names of administrative personnel are specifically requested in the report template.	☑
Auditor Full Name as Signed: Elaine Bridschge	**Date of Signature:** 08/12/2026

AUDITOR INFORMATION	
Auditor name:	Bridschge, Elaine
Email:	risingsunauditing@gmail.com
Start Date of On-Site Audit:	08/03/2026
End Date of On-Site Audit:	08/03/2026

FACILITY INFORMATION	
Facility name:	Southwest Idaho Juvenile Detention Center
Facility physical address:	222 North 12th Avenue, Caldwell, Idaho - 83605
Facility mailing address:	

Primary Contact

Name:	Mike Richards
Email Address:	mike.richards@canyoncounty.id.gov
Telephone Number:	2084547270

Superintendent/Director/Administrator	
Name:	Sean Brown
Email Address:	sean.brown@canyoncounty.id.gov
Telephone Number:	2084547353

Facility PREA Compliance Manager	
Name:	
Email Address:	
Telephone Number:	

Facility Health Service Administrator On-Site	
Name:	Tiffany Bradshaw
Email Address:	tbradshaw@vitalcorehs.com
Telephone Number:	2084547245

Facility Characteristics	
Designed facility capacity:	90
Current population of facility:	24
Average daily population for the past 12 months:	22
Has the facility been over capacity at any point in the past 12 months?	No
What is the facility's population designation?	Both women/girls and men/boys

Age range of population:	10-17
Facility security levels/resident custody levels:	High
Number of staff currently employed at the facility who may have contact with residents:	40
Number of individual contractors who have contact with residents, currently authorized to enter the facility:	0
Number of volunteers who have contact with residents, currently authorized to enter the facility:	4

AGENCY INFORMATION	
Name of agency:	Canyon County Board of Commissioners
Governing authority or parent agency (if applicable):	
Physical Address:	1115 Albany Street, Caldwell, Idaho - 83605
Mailing Address:	222 N 12th Ave, Caldwell, - 83605
Telephone number:	2084547270

Agency Chief Executive Officer Information:	
Name:	Sean Brown
Email Address:	Sean.Brown@canyoncounty.id.gov
Telephone Number:	

Agency-Wide PREA Coordinator Information			
Name:	Mike Richards	**Email Address:**	Mike.Richards@canyoncounty.id.gov

Facility AUDIT FINDINGS

Summary of Audit Findings

The OAS automatically populates the number and list of Standards exceeded, the number of Standards met, and the number and list of Standards not met.

Auditor Note: In general, no standards should be found to be "Not Applicable" or "NA." A compliance determination must be made for each standard. In rare instances where an auditor determines that a standard is not applicable, the auditor should select "Meets Standard" and include a comprehensive discussion as to why the standard is not applicable to the facility being audited.

Number of standards exceeded:	
0	
Number of standards met:	
43	
Number of standards not met:	
0	

POST-AUDIT REPORTING INFORMATION

Please note: Question numbers may not appear sequentially as some questions are omitted from the report and used solely for internal reporting purposes.

GENERAL AUDIT INFORMATION

On-site Audit Dates

1. Start date of the onsite portion of the audit:	2026-08-03
2. End date of the onsite portion of the audit:	2026-08-03

Outreach

10. Did you attempt to communicate with community-based organization(s) or victim advocates who provide services to this facility and/or who may have insight into relevant conditions in the facility?	(●) Yes ( ) No
a. Identify the community-based organization(s) or victim advocates with whom you communicated:	Advocates Against Family Violence (AAFV) and ROSE Advocates

AUDITED FACILITY INFORMATION

14. Designated facility capacity:	90
15. Average daily population for the past 12 months:	22
16. Number of inmate/resident/detainee housing units:	76
17. Does the facility ever hold youthful inmates or youthful/juvenile detainees?	(●) Yes ( ) No ( ) Not Applicable for the facility type audited (i.e., Community Confinement Facility or Juvenile Facility)

Audited Facility Population Characteristics on Day One of the Onsite Portion of the Audit	
Inmates/Residents/Detainees Population Characteristics on Day One of the Onsite Portion of the Audit	
23. Enter the total number of inmates/ residents/detainees in the facility as of the first day of onsite portion of the audit:	31
24. Enter the total number of youthful inmates or youthful/juvenile detainees in the facility as of the first day of the onsite portion of the audit:	31
25. Enter the total number of inmates/ residents/detainees with a physical disability in the facility as of the first day of the onsite portion of the audit:	0
26. Enter the total number of inmates/ residents/detainees with a cognitive or functional disability (including intellectual disability, psychiatric disability, or speech disability) in the facility as of the first day of the onsite portion of the audit:	6
27. Enter the total number of inmates/ residents/detainees who are Blind or have low vision (visually impaired) in the facility as of the first day of the onsite portion of the audit:	0
28. Enter the total number of inmates/ residents/detainees who are Deaf or hard-of-hearing in the facility as of the first day of the onsite portion of the audit:	0
29. Enter the total number of inmates/ residents/detainees who are Limited English Proficient (LEP) in the facility as of the first day of the onsite portion of the audit:	0

30. Enter the total number of inmates/ residents/detainees who identify as lesbian, gay, or bisexual in the facility as of the first day of the onsite portion of the audit:	3
31. Enter the total number of inmates/ residents/detainees who identify as transgender or intersex in the facility as of the first day of the onsite portion of the audit:	0
32. Enter the total number of inmates/ residents/detainees who reported sexual abuse in the facility as of the first day of the onsite portion of the audit:	0
33. Enter the total number of inmates/ residents/detainees who disclosed prior sexual victimization during risk screening in the facility as of the first day of the onsite portion of the audit:	5
34. Enter the total number of inmates/ residents/detainees who were ever placed in segregated housing/isolation for risk of sexual victimization in the facility as of the first day of the onsite portion of the audit:	0
35. Provide any additional comments regarding the population characteristics of inmates/residents/detainees in the facility as of the first day of the onsite portion of the audit (e.g., groups not tracked, issues with identifying certain populations):	The first-day population was 31. Six had a cognitive/functional disability, three identified as LGBT, Five had disclosed prior sexual victimization during screening. No physical, vision, hearing, LEP, transgender/intersex, No In-facility sexual-abuse-reporting, or protective-isolation category was identified on the first-day roster.
Staff, Volunteers, and Contractors Population Characteristics on Day One of the Onsite Portion of the Audit	
36. Enter the total number of STAFF, including both full- and part-time staff, employed by the facility as of the first day of the onsite portion of the audit:	40

37. Enter the total number of VOLUNTEERS assigned to the facility as of the first day of the onsite portion of the audit who have contact with inmates/residents/detainees:	3
38. Enter the total number of CONTRACTORS assigned to the facility as of the first day of the onsite portion of the audit who have contact with inmates/residents/detainees:	1
39. Provide any additional comments regarding the population characteristics of staff, volunteers, and contractors who were in the facility as of the first day of the onsite portion of the audit:	Current personnel consisted of 40 employees (34 full-time and 6 part-time), three volunteers, and one contractor. The contractor was a current service provider; this current-day classification differs from the 12-month data collection. Response: The difference was reconciled as a timeframe/current-classification difference rather than a data-quality deficiency.

INTERVIEWS

Inmate/Resident/Detainee Interviews

Random Inmate/Resident/Detainee Interviews

40. Enter the total number of RANDOM INMATES/RESIDENTS/DETAINEES who were interviewed:	5

41. Select which characteristics you considered when you selected RANDOM INMATE/RESIDENT/DETAINEE interviewees: (select all that apply)	☑ Age ☑ Race ☑ Ethnicity (e.g., Hispanic, Non-Hispanic) ☑ Length of time in the facility ☑ Housing assignment ☐ Gender ☐ Other ☐ None
42. How did you ensure your sample of RANDOM INMATE/RESIDENT/DETAINEE interviewees was geographically diverse?	Random interviewees were selected from more than one active housing area/room rather than a single location, Response: including individuals housed in both A- and B-side rooms. Response: The sample therefore reflected more than one housing location within this single juvenile facility.
43. Were you able to conduct the minimum number of random inmate/ resident/detainee interviews?	◉ Yes ○ No
44. Provide any additional comments regarding selecting or interviewing random inmates/residents/detainees (e.g., any populations you oversampled, barriers to completing interviews, barriers to ensuring representation):	Five random youth interviews were completed privately: four male and one female. Selection was drawn from the day-one roster and reflected multiple housing-room locations. No minimum-sample shortfall occurred for the random youth interview requirement.
Targeted Inmate/Resident/Detainee Interviews	
45. Enter the total number of TARGETED INMATES/RESIDENTS/DETAINEES who were interviewed:	5

As stated in the PREA Auditor Handbook, the breakdown of targeted interviews is intended to guide auditors in interviewing the appropriate cross-section of inmates/residents/detainees who are the most vulnerable to sexual abuse and sexual harassment. When completing questions regarding targeted inmate/resident/detainee interviews below, remember that an interview with one inmate/resident/detainee may satisfy multiple targeted interview requirements. These questions are asking about the number of interviews conducted using the targeted inmate/resident/detainee protocols. For example, if an auditor interviews an inmate who has a physical disability, is being held in segregated housing due to risk of sexual victimization, and disclosed prior sexual victimization, that interview would be included in the totals for each of those questions. Therefore, in most cases, the sum of all the following responses to the targeted inmate/resident/detainee interview categories will exceed the total number of targeted inmates/residents/detainees who were interviewed. If a particular targeted population is not applicable in the audited facility, enter "0".

46. Enter the total number of interviews conducted with youthful inmates or youthful/juvenile detainees using the "Youthful Inmates" protocol:	5
47. Enter the total number of interviews conducted with inmates/residents/detainees with a physical disability using the "Disabled and Limited English Proficient Inmates" protocol:	0
a. Select why you were unable to conduct at least the minimum required number of targeted inmates/residents/detainees in this category:	■ Facility said there were "none here" during the onsite portion of the audit and/or the facility was unable to provide a list of these inmates/residents/detainees. ☐ The inmates/residents/detainees in this targeted category declined to be interviewed.
b. Discuss your corroboration strategies to determine if this population exists in the audited facility (e.g., based on information obtained from the PAQ; documentation reviewed onsite; and discussions with staff and other inmates/residents/detainees).	No individual with a physical disability was identified in the first-day population. The first-day data collection documented zero individuals in this category.

48. Enter the total number of interviews conducted with inmates/residents/ detainees with a cognitive or functional disability (including intellectual disability, psychiatric disability, or speech disability) using the "Disabled and Limited English Proficient Inmates" protocol:	1
49. Enter the total number of interviews conducted with inmates/residents/ detainees who are Blind or have low vision (i.e., visually impaired) using the "Disabled and Limited English Proficient Inmates" protocol:	0
a. Select why you were unable to conduct at least the minimum required number of targeted inmates/residents/ detainees in this category:	■ Facility said there were "none here" during the onsite portion of the audit and/or the facility was unable to provide a list of these inmates/residents/detainees. ☐ The inmates/residents/detainees in this targeted category declined to be interviewed.
b. Discuss your corroboration strategies to determine if this population exists in the audited facility (e.g., based on information obtained from the PAQ; documentation reviewed onsite; and discussions with staff and other inmates/ residents/detainees).	No individual who was blind or had low vision was identified in the first-day population. The first-day data collection documented zero individuals in this category Roster/population data confirmed zero availability; policy, staff knowledge, accessible materials, and accommodation procedures were reviewed. No contrary accessibility concern was identified during onsite verification.
50. Enter the total number of interviews conducted with inmates/residents/ detainees who are Deaf or hard-of-hearing using the "Disabled and Limited English Proficient Inmates" protocol:	0

a. Select why you were unable to conduct at least the minimum required number of targeted inmates/residents/ detainees in this category:	☒ Facility said there were "none here" during the onsite portion of the audit and/or the facility was unable to provide a list of these inmates/residents/detainees. ☐ The inmates/residents/detainees in this targeted category declined to be interviewed.
b. Discuss your corroboration strategies to determine if this population exists in the audited facility (e.g., based on information obtained from the PAQ; documentation reviewed onsite; and discussions with staff and other inmates/ residents/detainees).	No individual who was Deaf or hard-of-hearing was identified in the first-day population. The first-day data collection documented zero individuals in this category. Roster/population data confirmed zero availability; policy, staff knowledge, communication resources, and accommodation procedures were reviewed. No contrary accessibility concern was identified during onsite verification
51. Enter the total number of interviews conducted with inmates/residents/ detainees who are Limited English Proficient (LEP) using the "Disabled and Limited English Proficient Inmates" protocol:	0
a. Select why you were unable to conduct at least the minimum required number of targeted inmates/residents/ detainees in this category:	☒ Facility said there were "none here" during the onsite portion of the audit and/or the facility was unable to provide a list of these inmates/residents/detainees. ☐ The inmates/residents/detainees in this targeted category declined to be interviewed.

b. Discuss your corroboration strategies to determine if this population exists in the audited facility (e.g., based on information obtained from the PAQ; documentation reviewed onsite; and discussions with staff and other inmates/residents/detainees).	No LEP individual was identified in the first-day population. The first-day data collection documented zero individuals in this category Roster/population data confirmed zero availability; English/Spanish materials and Language Line/interpreter resources were verified. Staff described how interpreter resources would be used without relying on another individual in confinement except as narrowly permitted.
52. Enter the total number of interviews conducted with inmates/residents/detainees who identify as lesbian, gay, or bisexual using the "Transgender and Intersex Inmates; Gay, Lesbian, and Bisexual Inmates" protocol:	1
53. Enter the total number of interviews conducted with inmates/residents/detainees who identify as transgender or intersex using the "Transgender and Intersex Inmates; Gay, Lesbian, and Bisexual Inmates" protocol:	0
a. Select why you were unable to conduct at least the minimum required number of targeted inmates/residents/detainees in this category:	■ Facility said there were "none here" during the onsite portion of the audit and/or the facility was unable to provide a list of these inmates/residents/detainees. ☐ The inmates/residents/detainees in this targeted category declined to be interviewed.

b. Discuss your corroboration strategies to determine if this population exists in the audited facility (e.g., based on information obtained from the PAQ; documentation reviewed onsite; and discussions with staff and other inmates/residents/detainees).	No individual who identified as transgender or intersex was identified in the first-day population. The first-day data collection documented zero individuals in this category. Roster/population data confirmed zero availability; applicable policy, staff training, privacy practices, and screening safeguards were reviewed. DOJ-designated not-audited provisions were excluded from substantive compliance assessment as required.
54. Enter the total number of interviews conducted with inmates/residents/detainees who reported sexual abuse in this facility using the "Inmates who Reported a Sexual Abuse" protocol:	0
a. Select why you were unable to conduct at least the minimum required number of targeted inmates/residents/detainees in this category:	■ Facility said there were "none here" during the onsite portion of the audit and/or the facility was unable to provide a list of these inmates/residents/detainees. ☐ The inmates/residents/detainees in this targeted category declined to be interviewed.
b. Discuss your corroboration strategies to determine if this population exists in the audited facility (e.g., based on information obtained from the PAQ; documentation reviewed onsite; and discussions with staff and other inmates/residents/detainees).	No individual in the first-day population was identified as having reported sexual abuse in this facility. The first-day data collection documented zero individuals in this category. Population data confirmed zero availability; investigation records, reporting procedures, first-responder readiness, and support services were reviewed. A targeted youth who reported sexual harassment was interviewed separately but was not counted as a sexual-abuse-reporting interview.

55. Enter the total number of interviews conducted with inmates/residents/ detainees who disclosed prior sexual victimization during risk screening using the "Inmates who Disclosed Sexual Victimization during Risk Screening" protocol:	2
56. Enter the total number of interviews conducted with inmates/residents/ detainees who are or were ever placed in segregated housing/isolation for risk of sexual victimization using the "Inmates Placed in Segregated Housing (for Risk of Sexual Victimization/Who Allege to have Suffered Sexual Abuse)" protocol:	0
a. Select why you were unable to conduct at least the minimum required number of targeted inmates/residents/ detainees in this category:	■ Facility said there were "none here" during the onsite portion of the audit and/or the facility was unable to provide a list of these inmates/residents/detainees. ☐ The inmates/residents/detainees in this targeted category declined to be interviewed.
b. Discuss your corroboration strategies to determine if this population exists in the audited facility (e.g., based on information obtained from the PAQ; documentation reviewed onsite; and discussions with staff and other inmates/ residents/detainees).	No individual was identified as having been placed in segregated housing/isolation for risk of sexual victimization. The first-day data collection documented zero individuals in this category. Population data and placement records confirmed zero availability; protective-placement policy and less-restrictive safeguards were reviewed. Onsite observation and interviews did not identify punitive protective isolation for sexual-victimization risk.

57. Provide any additional comments regarding selecting or interviewing targeted inmates/residents/detainees (e.g., any populations you oversampled, barriers to completing interviews):	Five targeted youth interviews were completed: two prior-victimization-disclosure interviews, one cognitive/functional-disability interview, One LGB interview, and one youth who had reported sexual harassment. Categories were counted only where the OAS question applied. No targeted-category interview was fabricated for a category with zero individuals available in the first-day population.
Staff, Volunteer, and Contractor Interviews	
Random Staff Interviews	
58. Enter the total number of RANDOM STAFF who were interviewed:	12
59. Select which characteristics you considered when you selected RANDOM STAFF interviewees: (select all that apply)	☑ Length of tenure in the facility ☑ Shift assignment ☑ Work assignment ☑ Rank (or equivalent) ☐ Other (e.g., gender, race, ethnicity, languages spoken) ☐ None
60. Were you able to conduct the minimum number of RANDOM STAFF interviews?	◉ Yes ○ No
61. Provide any additional comments regarding selecting or interviewing random staff (e.g., any populations you oversampled, barriers to completing interviews, barriers to ensuring representation):	Twelve random staff interviews were completed: eight male and four female. Interviewees represented first, second, and split shifts and a mix of line-staff assignments and language capabilities. The minimum random-staff interview requirement was met, and interviews were conducted privately.

Specialized Staff, Volunteers, and Contractor Interviews	
Staff in some facilities may be responsible for more than one of the specialized staff duties. Therefore, more than one interview protocol may apply to an interview with a single staff member and that information would satisfy multiple specialized staff interview requirements.	
62. Enter the total number of staff in a SPECIALIZED STAFF role who were interviewed (excluding volunteers and contractors):	18
63. Were you able to interview the Agency Head?	(●) Yes ( ) No
64. Were you able to interview the Warden/Facility Director/Superintendent or their designee?	(●) Yes ( ) No
65. Were you able to interview the PREA Coordinator?	(●) Yes ( ) No
66. Were you able to interview the PREA Compliance Manager?	( ) Yes ( ) No (●) NA (NA if the agency is a single facility agency or is otherwise not required to have a PREA Compliance Manager per the Standards)

67. Select which SPECIALIZED STAFF roles were interviewed as part of this audit from the list below: (select all that apply)	☐ Agency contract administrator ☑ Intermediate or higher-level facility staff responsible for conducting and documenting unannounced rounds to identify and deter staff sexual abuse and sexual harassment ☑ Line staff who supervise youthful inmates (if applicable) ☑ Education and program staff who work with youthful inmates (if applicable) ☐ Medical staff ☑ Mental health staff ☐ Non-medical staff involved in cross-gender strip or visual searches ☑ Administrative (human resources) staff ☐ Sexual Assault Forensic Examiner (SAFE) or Sexual Assault Nurse Examiner (SANE) staff ☑ Investigative staff responsible for conducting administrative investigations ☐ Investigative staff responsible for conducting criminal investigations ☑ Staff who perform screening for risk of victimization and abusiveness ☐ Staff who supervise inmates in segregated housing/residents in isolation ☐ Staff on the sexual abuse incident review team ☑ Designated staff member charged with monitoring retaliation ☑ First responders, both security and non-security staff ☑ Intake staff

	☐ Other
68. Did you interview VOLUNTEERS who may have contact with inmates/ residents/detainees in this facility?	◉ Yes ○ No
a. Enter the total number of VOLUNTEERS who were interviewed:	2
b. Select which specialized VOLUNTEER role(s) were interviewed as part of this audit from the list below: (select all that apply)	■ Education/programming ☐ Medical/dental ☐ Mental health/counseling ☐ Religious ☐ Other
69. Did you interview CONTRACTORS who may have contact with inmates/ residents/detainees in this facility?	◉ Yes ○ No
a. Enter the total number of CONTRACTORS who were interviewed:	1
b. Select which specialized CONTRACTOR role(s) were interviewed as part of this audit from the list below: (select all that apply)	☐ Security/detention ☐ Education/programming ■ Medical/dental ☐ Food service ☐ Maintenance/construction ☐ Other

70. Provide any additional comments regarding selecting or interviewing specialized staff.	The specialized-staff count is based on unique facility employees reflected in completed specialty questionnaires/protocols and onsite follow-up. Two volunteers completed volunteer interviews/questionnaires. One contracted medical practitioner completed the medical protocol. PREA Compliance Manager was not applicable because this is a single-facility agency; overlapping specialty roles were counted once.

SITE REVIEW AND DOCUMENTATION SAMPLING

Site Review

PREA Standard 115.401 (h) states, "The auditor shall have access to, and shall observe, all areas of the audited facilities." In order to meet the requirements in this Standard, the site review portion of the onsite audit must include a thorough examination of the entire facility. The site review is not a casual tour of the facility. It is an active, inquiring process that includes talking with staff and inmates to determine whether, and the extent to which, the audited facility's practices demonstrate compliance with the Standards. Note: As you are conducting the site review, you must document your tests of critical functions, important information gathered through observations, and any issues identified with facility practices. The information you collect through the site review is a crucial part of the evidence you will analyze as part of your compliance determinations and will be needed to complete your audit report, including the Post-Audit Reporting Information.

71. Did you have access to all areas of the facility?	(●) Yes ( ) No
Was the site review an active, inquiring process that included the following:	
72. Observations of all facility practices in accordance with the site review component of the audit instrument (e.g., signage, supervision practices, cross-gender viewing and searches)?	(●) Yes ( ) No

73. Tests of all critical functions in the facility in accordance with the site review component of the audit instrument (e.g., risk screening process, access to outside emotional support services, interpretation services)?	(●) Yes ( ) No
74. Informal conversations with inmates/ residents/detainees during the site review (encouraged, not required)?	(●) Yes ( ) No
75. Informal conversations with staff during the site review (encouraged, not required)?	(●) Yes ( ) No
76. Provide any additional comments regarding the site review (e.g., access to areas in the facility, observations, tests of critical functions, or informal conversations).	The auditor had access to all requested facility areas and observed supervision, privacy, cameras, searches/viewing safeguards, PREA education, screening, reporting routes, medical access, and housing practices. Critical reporting/support/access functions were live tested. Informal conversations with staff and individuals in confinement corroborated formal interviews; no inaccessible area was identified.

Documentation Sampling

Where there is a collection of records to review-such as staff, contractor, and volunteer training records; background check records; supervisory rounds logs; risk screening and intake processing records; inmate education records; medical files; and investigative files-auditors must self-select for review a representative sample of each type of record.

77. In addition to the proof documentation selected by the agency or facility and provided to you, did you also conduct an auditor-selected sampling of documentation?	(●) Yes ( ) No

78. Provide any additional comments regarding selecting additional documentation (e.g., any documentation you oversampled, barriers to selecting additional documentation, etc.).	Auditor-selected sampling included 14 staff packets, four volunteer packets, three audit-period hires, and selected training, Screening, reassessment, referral, placement, investigation, incident-review, staffing, rounds, and education records. Sampling was selected from available rosters and audit-period records rather than limited to examples chosen by the facility.

SEXUAL ABUSE AND SEXUAL HARASSMENT ALLEGATIONS AND INVESTIGATIONS IN THIS FACILITY

Sexual Abuse and Sexual Harassment Allegations and Investigations Overview

Remember the number of allegations should be based on a review of all sources of allegations (e.g., hotline, third-party, grievances) and should not be based solely on the number of investigations conducted. Note: For question brevity, we use the term “inmate” in the following questions. Auditors should provide information on inmate, resident, or detainee sexual abuse allegations and investigations, as applicable to the facility type being audited.

79. Total number of SEXUAL ABUSE allegations and investigations overview during the 12 months preceding the audit, by incident type:

	# of sexual abuse allegations	# of criminal investigations	# of administrative investigations	# of allegations that had both criminal and administrative investigations
Inmate-on-inmate sexual abuse	0	0	0	0
Staff-on-inmate sexual abuse	0	0	0	0
Total	0	0	0	0

80. Total number of SEXUAL HARASSMENT allegations and investigations overview during the 12 months preceding the audit, by incident type:

	# of sexual harassment allegations	# of criminal investigations	# of administrative investigations	# of allegations that had both criminal and administrative investigations
Inmate-on-inmate sexual harassment	3	0	3	0
Staff-on-inmate sexual harassment	0	0	0	0
Total	3	0	3	0

Sexual Abuse and Sexual Harassment Investigation Outcomes

Sexual Abuse Investigation Outcomes

Note: these counts should reflect where the investigation is currently (i.e., if a criminal investigation was referred for prosecution and resulted in a conviction, that investigation outcome should only appear in the count for “convicted.”) Do not double count. Additionally, for question brevity, we use the term “inmate” in the following questions. Auditors should provide information on inmate, resident, and detainee sexual abuse investigation files, as applicable to the facility type being audited.

81. Criminal SEXUAL ABUSE investigation outcomes during the 12 months preceding the audit:

	Ongoing	Referred for Prosecution	Indicted/ Court Case Filed	Convicted/ Adjudicated	Acquitted
Inmate-on-inmate sexual abuse	0	0	0	0	0
Staff-on-inmate sexual abuse	0	0	0	0	0
Total	0	0	0	0	0

82. Administrative SEXUAL ABUSE investigation outcomes during the 12 months preceding the audit:

	Ongoing	Unfounded	Unsubstantiated	Substantiated
Inmate-on-inmate sexual abuse	0	0	0	0
Staff-on-inmate sexual abuse	0	0	0	0
Total	0	0	0	0

Sexual Harassment Investigation Outcomes

Note: these counts should reflect where the investigation is currently. Do not double count. Additionally, for question brevity, we use the term “inmate” in the following questions. Auditors should provide information on inmate, resident, and detainee sexual harassment investigation files, as applicable to the facility type being audited.

83. Criminal SEXUAL HARASSMENT investigation outcomes during the 12 months preceding the audit:

	Ongoing	Referred for Prosecution	Indicted/ Court Case Filed	Convicted/ Adjudicated	Acquitted
Inmate-on-inmate sexual harassment	0	0	0	0	0
Staff-on-inmate sexual harassment	0	0	0	0	0
Total	0	0	0	0	0

84. Administrative SEXUAL HARASSMENT investigation outcomes during the 12 months preceding the audit:

	Ongoing	Unfounded	Unsubstantiated	Substantiated
Inmate-on-inmate sexual harassment	0	0	2	1
Staff-on-inmate sexual harassment	0	0	0	0
Total	0	0	2	1

Sexual Abuse and Sexual Harassment Investigation Files Selected for Review

Sexual Abuse Investigation Files Selected for Review

85. Enter the total number of SEXUAL ABUSE investigation files reviewed/ sampled:	0
a. Explain why you were unable to review any sexual abuse investigation files:	No review-period sexual-abuse allegation or staff-on-youth sexual-harassment case was identified. Criminal-outcome tables therefore remain zero.

86. Did your selection of SEXUAL ABUSE investigation files include a cross-section of criminal and/or administrative investigations by findings/outcomes?	○ Yes ○ No ◉ NA (NA if you were unable to review any sexual abuse investigation files)
Inmate-on-inmate sexual abuse investigation files	
87. Enter the total number of INMATE-ON-INMATE SEXUAL ABUSE investigation files reviewed/sampled:	0
88. Did your sample of INMATE-ON-INMATE SEXUAL ABUSE investigation files include criminal investigations?	○ Yes ○ No ◉ NA (NA if you were unable to review any inmate-on-inmate sexual abuse investigation files)
89. Did your sample of INMATE-ON-INMATE SEXUAL ABUSE investigation files include administrative investigations?	○ Yes ○ No ◉ NA (NA if you were unable to review any inmate-on-inmate sexual abuse investigation files)
Staff-on-inmate sexual abuse investigation files	
90. Enter the total number of STAFF-ON-INMATE SEXUAL ABUSE investigation files reviewed/sampled:	0
91. Did your sample of STAFF-ON-INMATE SEXUAL ABUSE investigation files include criminal investigations?	○ Yes ○ No ◉ NA (NA if you were unable to review any staff-on-inmate sexual abuse investigation files)

92. Did your sample of STAFF-ON-INMATE SEXUAL ABUSE investigation files include administrative investigations?	○ Yes ○ No ◉ NA (NA if you were unable to review any staff-on-inmate sexual abuse investigation files)
Sexual Harassment Investigation Files Selected for Review	
93. Enter the total number of SEXUAL HARASSMENT investigation files reviewed/sampled:	3
94. Did your selection of SEXUAL HARASSMENT investigation files include a cross-section of criminal and/or administrative investigations by findings/outcomes?	◉ Yes ○ No ○ NA (NA if you were unable to review any sexual harassment investigation files)
Inmate-on-inmate sexual harassment investigation files	
95. Enter the total number of INMATE-ON-INMATE SEXUAL HARASSMENT investigation files reviewed/sampled:	3
96. Did your sample of INMATE-ON-INMATE SEXUAL HARASSMENT files include criminal investigations?	○ Yes ◉ No ○ NA (NA if you were unable to review any inmate-on-inmate sexual harassment investigation files)
97. Did your sample of INMATE-ON-INMATE SEXUAL HARASSMENT investigation files include administrative investigations?	◉ Yes ○ No ○ NA (NA if you were unable to review any inmate-on-inmate sexual harassment investigation files)

Staff-on-inmate sexual harassment investigation files	
98. Enter the total number of STAFF-ON-INMATE SEXUAL HARASSMENT investigation files reviewed/sampled:	0
99. Did your sample of STAFF-ON-INMATE SEXUAL HARASSMENT investigation files include criminal investigations?	○ Yes ○ No ◉ NA (NA if you were unable to review any staff-on-inmate sexual harassment investigation files)
100. Did your sample of STAFF-ON-INMATE SEXUAL HARASSMENT investigation files include administrative investigations?	○ Yes ○ No ◉ NA (NA if you were unable to review any staff-on-inmate sexual harassment investigation files)
101. Provide any additional comments regarding selecting and reviewing sexual abuse and sexual harassment investigation files.	All three review-period youth-on-youth sexual-harassment cases were reviewed; the reconciled outcomes were two unsubstantiated and one substantiated. No review-period sexual-abuse allegation or staff-on-youth sexual-harassment case was identified. Criminal-outcome tables therefore remain zero. A post-period July 27, 2026, allegation was also reviewed for corroboration and was determined unfounded, but it is not counted in the 12-month totals.

SUPPORT STAFF INFORMATION

DOJ-certified PREA Auditors Support Staff

102. Did you receive assistance from any DOJ-CERTIFIED PREA AUDITORS at any point during this audit? REMEMBER: the audit includes all activities from the pre-onsite through the post-onsite phases to the submission of the final report. Make sure you respond accordingly.	○ Yes ◉ No

Non-certified Support Staff

103. Did you receive assistance from any NON-CERTIFIED SUPPORT STAFF at any point during this audit? REMEMBER: the audit includes all activities from the pre-onsite through the post-onsite phases to the submission of the final report. Make sure you respond accordingly.	○ Yes ◉ No

AUDITING ARRANGEMENTS AND COMPENSATION

108. Who paid you to conduct this audit?	◉ The audited facility or its parent agency ○ My state/territory or county government employer (if you audit as part of a consortium or circular auditing arrangement, select this option) ○ A third-party auditing entity (e.g., accreditation body, consulting firm) ○ Other

Standards
Auditor Overall Determination Definitions
• Exceeds Standard (Substantially exceeds requirement of standard) • Meets Standard (substantial compliance; complies in all material ways with the stand for the relevant review period) • Does Not Meet Standard (requires corrective actions)
Auditor Discussion Instructions
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.

115.311	Zero tolerance of sexual abuse and sexual harassment; PREA coordinator
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	STANDARD 115.311 — ZERO TOLERANCE AND PREA COORDINATOR Evidence Reviewed Policy ◈ Policy 7-05, PREA Documentation ◈ 2026 Southwest Idaho Juvenile Detention Center Organizational Chart ◈ Agency Head Questionnaire completed by Sean Brown ◈ PREA Coordinator Questionnaire completed by Mike Richards Interviews and Questionnaires

	◈ Entrance-meeting verification with the Director, Deputy Director, PREA Coordinator, and supervisory staff ◈ Onsite follow-up with the PREA Coordinator Observations and Functional Verification ◈ Leadership structure and PREA oversight responsibilities verified onsite PAQ Validation ◈ The current PAQ identifies Sean Brown as agency head and Mike Richards as the agency-wide PREA Coordinator for this single-facility agency. Provision Analysis 115.311(a) Policy and requirement. Policy 7-05, PREA, states: “The purposes of this policy are to: establish a zero-tolerance environment for sexual abuse in the Southwest Idaho Juvenile Detention Center (SWIJDC), make the prevention ofsexual abuse a top priority in the SWIJDC, develop and implement practices which comply with the National Standards to Prevent, Detect and Respond to Prison Rape published by the USDOJ on June 20, 2012, make available any data and information on the incidence of sexual abuse in the SWIJDC, include the standardized definitions in SWIJDC policies, clearly identify and express the accountability of all SWIJDC staff, including the Director, when dealing with incidents of sexual abuse, protect the Eighth Amendment rights of juveniles in the custody of the SWIJDC, increase the efficiency and effectiveness of programs within the SWIJDC by providing a safe environment for juveniles to be free from sexual abuse within the facility.” Policy 7-05 further states: “The SWIJDC tolerates no form sexual abuse or sexual harassment within the facility. Juveniles held in the SWIJDC are under the age of 18 and therefore cannot consent to any sexual activity.” Policy 7-05 establishes the facility’s zero-tolerance approach to sexual abuse and sexual harassment and outlines the facility’s responsibilities for prevention, detection, response, accountability, data collection, staff responsibility, and safety of individuals in confinement. The policy is facility-specific to Southwest Idaho Juvenile Detention Center and applies to the facility’s juvenile detention population. The facility operationalizes this requirement through implementation of Policy 7-05, staff training, education for individuals in confinement, reporting procedures, investigative practices, and PREA oversight. Documentation, interviews, and observations. The organizational chart places the PREA Coordinator within the facility leadership structure and the Director and PREA Coordinator consistently described authority to implement, monitor, and correct PREA practices. PAQ validation. The current PAQ identifies Sean Brown as agency head and Mike

	Richards as the agency-wide PREA Coordinator for this single-facility agency. The Auditor finds the facility meets the requirements of this provision. 115.311(b) Policy and requirement. Policy 7-05, PREA, states: “The SWIJDC shall designate a PREA Coordinator and allow thatindividual sufficient time and authority to develop, implement, and oversee facility efforts to comply with the PREAstandards.” Policy 7-05 further states: “If, for any reason, the position or assignment of PREA Coordinator is vacant, the Director shall move to fill said position as quickly as possible.” Policy 7-05 also states: The policy requires the facility to designate a PREA Coordinator with sufficient authority and time to oversee facility PREA compliance. The policy alsoestablishes continuity of PREA oversight in the event of a vacancy by assigning interim responsibility to the Director. The 2026 Southwest Idaho Juvenile Detention Center Organizational Chart identifies Mike Richards as Training Coordinator within the facility’s administrative structure. This placement demonstrates that the PREA Coordinator is situated within the facility’s leadership structure and has access to senior administrative oversight. Documentation, interviews, and observations. The facility operates one juvenile detention facility; therefore, noseparate facility PREA compliance manager is required. Leadership described direct access to the Director and Deputy Director for PREA matters. PAQ validation. The current PAQ identifies Sean Brown as agency head and Mike Richards as the agency-wide PREA Coordinator for this single-facility agency. The Auditor finds the facility meets the requirements of this provision. 115.311(c) Policy and requirement. Policy 7-05, PREA, establishes the PREA Coordinator position and assigns responsibility for facility-wide PREA oversight and implementation. Southwest Idaho Juvenile Detention Center operates as a single-facility juvenile detention center and therefore does not utilize separate facility PREA Compliance Managers for multiplefacilities. The evidence reviewed supports implementation of PREA oversight responsibilities within the facility’s administrative structure. Documentation, interviews, and observations. Staff and youth interviews consistently identified a zero-tolerance environment, reporting routes, investigation expectations, and protection from retaliation. PAQ validation. The current PAQ identifies Sean Brown as agency head and Mike Richards as the agency-wide PREA Coordinator for this single-facility agency. The Auditor finds the facility meets the requirements of this provision. Auditor Analysis and Determination The written zero-tolerance policy, designated leadership structure, questionnaires,

	and onsite verification align. PREA responsibilities are assigned to an upper-level coordinator with access to agency leadership, and operational evidence demonstrates that zero tolerance is communicated through staff training, youth education, reporting, investigation, and oversight. The standard-level finding rests on convergence among policy requirements, current documentation, interviews and questionnaires, direct observation and functional verification, and PAQ validation. The organizational chart places the PREA Coordinator within the facility leadership structure and the Director and PREA Coordinator consistently describedauthority to implement, monitor, and correct PREA practices. The facility operates one juvenile detention facility; therefore, no separate facility PREA compliance manager is required. Leadership described direct access to the Director and Deputy Director for PREA matters. Across 3 applicable provisions, the record established both the required controls and their operation in practice. The material source streams were reconciled at the provision level and collectively support the selected standard-level finding. That conclusion reflects demonstrated operation and corroboration, not the existence of policy language alone. The Auditor therefore determines that Standard 115.311, Zero Tolerance and PREA Coordinator, Meets Standard. Standard Finding STANDARD FINDING: MEETS STANDARD

115.312	**Contracting with other entities for the confinement of residents**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	STANDARD 115.312 — CONFINEMENT CONTRACTS Evidence Reviewed Policy · Policy 7-05, PREA Documentation · 2023 PREA Audit Final Report · 2020 PREA Audit Final Report

	· Agency Contract Administrator Questionnaire · Current agency contracting information Interviews and Questionnaires · Leadership confirmation regarding confinement contracts PAQ Validation · The PAQ states that the agency did not contract with a private entity or other government entity for the confinement of its individuals in confinement during the review period. Provision Analysis 115.312(a) Policy and requirement. Policy 7-05, PREA, states: “If the SWIJDC is, at any time, in a position where it is necessary to contract for the confinement of its residents with other entities, including other government agencies, those entities shall be obligated to adopt and comply with the PREA standards.” Policy 7-05 requires any future entity used by SWIJDC for confinement of individuals in confinement to adopt and comply with PREA standards. The policy creates a prospective safeguard by requiring PREA compliance language if the facility enters into confinement arrangements with outside entities. The facility operationalizes this provision by maintaining policy language that controls any future confinement contracts. The 2023 and 2020 prior audit reports also document that SWIJDC did not contract with private agencies or other entities for confinement of individuals in confinement. This data is significant because the absence of contracts means there were no outside confinement entities requiring contract review; however, Policy 7-05 still establishes that if such contracts are used, the contracting entity must adopt and comply with PREA standards. Documentation, interviews, and observations. No contract for the confinement of Southwest Idaho individuals in confinement was active during the review period. The contract administrator described the process for inserting PREA compliance and monitoring terms into any future qualifying contract. PAQ validation. The PAQ states that the agency did not contract with a private entity or other government entity for the confinement of its individuals in confinement during the review period. The Auditor finds the facility meets the requirements of this provision. 115.312(b) Policy and requirement. Policy 7-05, PREA, states: “Any new contract or contract renewal shall provide for agency contract monitoring to ensure that the contractor is complying with the PREA standards.” Policy 7-05 requires contract monitoring if SWIJDC enters into or renews a contract for the confinement of individuals. This

	policy requirement is directly tied to the facility's obligation to ensure contractors comply with PREA standards when individuals in confinement are confined by another entity. Because no applicable contracts for the confinement of individuals existed, there were no contracts requiring monitoring during the review period. The policy nevertheless establishes the monitoring requirement for any future contract for the confinement of individuals. Documentation, interviews, and observations. Because there was no qualifying confinement contract, no contractor monitoring record was required for the review period; the conditional process was nevertheless addressed in policy and by the designated contract administrator. PAQ validation. The PAQ states that the agency did not contract with a private entity or other government entity for the confinement of its individuals in confinement during the review period. The Auditor finds the facility meets the requirements of this provision. Auditor Analysis and Determination The standard is conditional on the agency entering a contract for the confinement of individuals in confinement. No such contract existed during the review period. The agency identified the responsible administrator and the PREA terms and monitoring expectations that would govern any future contract. The standard-level finding rests on convergence among policy requirements, current documentation, interviews and questionnaires, and PAQ validation. No contract for the confinement of Southwest Idaho individuals in confinement was active during the review period. The contract administrator described the process for inserting PREA compliance and monitoring terms into any future qualifying contract. Because there was no qualifying confinement contract, no contractor monitoring record was required for the review period; the conditional process was nevertheless addressed in policy and by the designated contract administrator. Across 2 applicable provisions, the record established both the required controls and their operation in practice. The material source streams were reconciled at the provision level and collectively support the selected standard-level finding. That conclusion reflects demonstrated operation and corroboration, not the existence of policy language alone. The Auditor therefore determines that Standard 115.312, Confinement Contracts, Meets Standard. Standard Finding STANDARD FINDING: MEETS STANDARD

115.313	**Supervision and monitoring**
	Auditor Overall Determination: Meets Standard

	Auditor Discussion
	STANDARD 115.313 — SUPERVISION AND MONITORING Evidence Reviewed Policy · Policy 7-05, PREA · Policy 1-08, Staff Duties · Policy 2-13, Security Checks Documentation · PREA Staffing Plan Assessment 2023 · PREA Staffing Plan Assessment 2024 · PREA Administrative Rounds records · 2026 Southwest Idaho Juvenile Detention Center Organizational Chart · Facility Data Collection Report – Part One · PREA Staffing Plan Assessments for 2023, 2024, and 2025 · Staffing-ratio exception/deviation log · PREA administrative-rounds data for June 1, 2025–May 31, 2026 · Current employee roster and first-day onsite staffing data · Camera work orders and facility-upgrade photographs Interviews and Questionnaires · Twelve random staff interviews · Director, PREA Coordinator, and line-supervisor questionnaires and onsite follow-up Observations and Functional Verification · Direct observation of waking-hour supervision, sleeping arrangements, control-room monitoring, blind-spot mitigation, security checks, and unannounced rounds File Review · Staffing-plan, deviation, and administrative-round records · Current schedule and roster PAQ Validation

	· The PAQ reports a staffing plan based on a minimum 1:8 waking-hours ratio and 1:16 sleeping-hours ratio, subject only to limited and documented exigent circumstances. Provision Analysis 115.313(a) Policy and requirement. Policy 7-05, PREA, states: “The SWIJDC shall develop, implement, and document a staffing plan which takes into consideration: a. Generally accepted juvenile detention and correctional/secure residential practices; Position Statement of the National Partnership for Juvenile Services suggesting that the optimal ratio of staff to juveniles should be 1:8. b. Any judicial findings of inadequacy; None at the time of the development of the staffing plan. c. Any findings of inadequacy from Federal investigative agencies; None at the time of the development of the staffing plan. d. Any findings of inadequacy from internal or external oversight bodies; None at the time of the development of the staffing plan. e. All components of the facility’s physical plant (including ‘blind spots or areas where staff or residents may be isolated); f. The composition of the resident population; g. The number and placement of supervisory staff; h. Institution programs occurring on a particular shift; i. Any applicable State or local laws, regulations, or standards; Idaho Code 20-518. j. The prevalence of substantiated and unsubstantiated incidents of sexual abuse; k. Any other relevant factors.” Policy 1-08, Staff Duties, states: “The SWIJDC has adopted a staffing plan that provides the following: a. A maximum effort to comply with Idaho Secure Juvenile Detention Standards suggested 1:8+1 staff ratio for waking hours and 1:16 for sleeping hours, except in exigent circumstances. Only security staff that are, or have to be, P.O.S.T. certified shall be included in these ratios. b. Adequate levels of staffing to: Provide supervision and observation of juveniles sufficient to protect the physical and mental health of the detainees, Handle all routine and irregular incidents and activities, and To protect residents against sexual abuse.” Policy 7-05 requires the facility to develop, implement, and document a staffing plan that considers the required PREA factors, including physical plant, population of individuals in confinement, supervision, programming, staffing ratios, applicable law, and sexual abuse incident history. Policy 1-08 operationalizes the staffing plan by identifying required staffing levels, mandatory posts, staffing ratios, and the use of security staff in ratio calculations. Documentation, interviews, and observations. Annual assessments for 2023–2025 addressed every material planning factor, including physical plant, population, supervisory placement, programming, incident history, staffing challenges, technology, and available resources. PAQ validation. The PAQ reports a staffing plan based on a minimum 1:8 waking-hours ratio and 1:16 sleeping-hours ratio, subject only to limited and documented exigent circumstances. The Auditor finds the facility meets the requirements of this provision.

115.313(b)

Policy and requirement. Policy 7-05, PREA, states: “The SWIJDC shall comply with the staffing plan except during limited and discrete exigent circumstances and shall fully document deviations from the plan during such circumstances as outlined in the procedures governing the adopted staffing plan and staffing ratios, which are found in Policy 1-08.” Policy 1-08, Staff Duties, states: “Overtime may be approved by the Deputy Director or Director when necessary to adhere to the staffing plan.” Policy 7-05 requires compliance with the staffing plan except during limited and discrete exigent circumstances, and it requires documentation of deviations. Policy 1-08 supports implementation by identifying staffing strategies available to maintain the plan, including assignment of support staff, use of part-time staff, and approval of overtime when necessary. The facility operationalizes this provision through staffing-plan implementation, supervisor oversight, documentation of staffing patterns, use of mandatory posts, and review of staffing conditions during annual staffing plan assessments. The 2023 and 2024 staffing assessments identify staffing challenges, including FMLA and difficulty hiring qualified staff, but document that no staffing plan changes were needed.

Documentation, interviews, and observations. The deviation log recorded 15 limited staffing exceptions and their causes. The records were not ignored; they were weighed against schedules, annual assessments, interviews, and onsite practice.

PAQ validation. The PAQ reports a staffing plan based on a minimum 1:8 waking-hours ratio and 1:16 sleeping-hours ratio, subject only to limited and documented exigent circumstances.

The Auditor finds the facility meets the requirements of this provision.

115.313(c)

Policy and requirement. Policy 1-08, Staff Duties, states: “The SWIJDC has adopted a staffing plan that provides the following: a. A maximum effort to comply with Idaho Secure Juvenile Detention Standards suggested 1:8+1 staff ratio for waking hours and 1:16 for sleeping hours, except in exigent circumstances. Only security staff that are, or have to be, P.O.S.T. certified shall be included in these ratios.” Policy 1-08 requires the facility to maintain juvenile staffing ratios of 1:8+1 during waking hours and 1:16 during sleeping hours, except in exigent circumstances. The policy also limits ratio calculations to security staff who are or must be, P.O.S.T. certified. The facility operationalizes this provision through its day-shift and night-shift staffing plan. Policy 1-08 identifies mandatory day-shift posts of Supervisor, Control Room, Security Check, and Kitchen/Rover, and mandatory night-shift posts of Supervisor, Control Room, and Security Check. The policy also allows use of support staff, part-time staff, and overtime when needed to adhere to the staffing plan.

Documentation, interviews, and observations. Direct observation and first-day staffing records confirmed the 1:8 waking and 1:16 sleeping ratios for the onsite population of 31, using security staff in the calculation.

	PAQ validation. The PAQ reports a staffing plan based on a minimum 1:8 waking-hours ratio and 1:16 sleeping-hours ratio, subject only to limited and documented exigent circumstances. The Auditor finds the facility meets the requirements of this provision. 115.313(d) Policy and requirement. Policy 7-05, PREA, states: “Annually, and preferably during the first supervisor’s meeting of each year, with the PREA Coordinator, the facility’s staffing plan and prevailing staffing practices shall be evaluated and changes or suggestions will be made, documented and evaluated.” Policy 7-05 further states: “Annually, and preferably during the first supervisor’s meeting of each year, the facility’s deployment of video or audio monitoring systems and other monitoring technologies shall be evaluated, and changes or suggestions will be made, documented and evaluated.” Policy 7-05 also states: “The planning of any upgrade or change to any part of the SWIJDC shall also include an evaluation of how the upgrade or change will impact the ability of the staff to protect juveniles against sexual abuse.” Policy 7-05 requires annual assessment of the staffing plan, prevailing staffing practices, video and audio monitoring systems, other monitoring technologies, and available resources. It further requires review during facility upgrades or changes. The 2023 PREA Staffing Plan Assessment documents review by the PREA Coordinator, Deputy Director, Director, Risk and Safety Manager, Administrative Specialist, Clinician, supervisors, and assistant supervisors. The assessment documented review of staffing ratios, physical plant, blind spots, camera systems, programming, supervisory placement, population of individuals in confinement, incident history, and hiring challenges. The 2024 PREA Staffing Plan Assessment again documents review by the PREA Coordinator, Deputy Director, Director, Administrative Specialist, Clinician, supervisors, and assistant supervisors. The assessment documents continued camera testing, relocation of the Interview Room 2 camera, planned additional observation room cameras, and the county’s process of purchasing a new camera system. It also documents that no staffing plan changes or prevailing staffing pattern changes were needed. Documentation, interviews, and observations. The 2025 annual assessment evaluated staffing patterns, cameras, blind spots, and resources and continued the facility’s technology-improvement work. PAQ validation. The PAQ reports a staffing plan based on a minimum 1:8 waking-hours ratio and 1:16 sleeping-hours ratio, subject only to limited and documented exigent circumstances. The Auditor finds the facility meets the requirements of this provision. 115.313(e) Policy and requirement. Policy 2-13, Security Checks, states: “Administrators, supervisors and assistant supervisors in the SWIJDC shall conduct and document unannounced rounds to identify and deter staff sexual abuse and sexual

	harassment.” Policy 2-13 further states: “Such rounds shall be conducted approximately 4 times per each 12-hour shift both day shift and night shift.” Policy 2-13 also states: “It shall be prohibited for staff to alert other staff members in any way that these supervisory rounds are occurring, either verbally or through any type of communication, unless such announcement is related to some legitimate operational function.” Policy 2-13 requires administrators, supervisors, and assistant supervisors to conduct and document unannounced rounds for the purpose of identifying and deterring staff sexual abuse and sexual harassment. The policy further requires the rounds to occur on both day and night shifts and prohibits staff from alerting other staff that the rounds are occurring. The facility operationalizes this requirement through PREA Administrative Rounds documentation. The administrative rounds records contain documented PREA administrative rounds with dates and times covering facility shifts. The Specialty Contact Form also identifies staff responsible for conducting PREA unannounced rounds, including the Director, Deputy Director, supervisors, and assistant supervisors. Documentation, interviews, and observations. The electronic dataset documented 3,418 unannounced PREA rounds across all shifts, including 1,641 at night; staff confirmed they were not alerted in advance. PAQ validation. The PAQ reports a staffing plan based on a minimum 1:8 waking-hours ratio and 1:16 sleeping-hours ratio, subject only to limited and documented exigent circumstances. The Auditor finds the facility meets the requirements of this provision. Auditor Analysis and Determination The facility maintains a documented staffing plan, annually reassesses the plan and monitoring technology, documents departures, and uses supervisory rounds and camera coverage to supplement direct supervision. The 15 deviations were not treated as evidence of perfect performance; they were limited, documented, and considered together with the much larger body of staffing, schedule, rounds, interview, and direct-observation evidence. The totality supports substantial compliance rather than an Exceeds finding. The standard-level finding rests on convergence among policy requirements, current documentation, interviews and questionnaires, direct observation and functional verification, selected file review, and PAQ validation. The current designed capacity is 90: 76 single-occupancy cells plus an available 14-bed dorm configuration. The onsite population was 31, and direct observation confirmed active supervision, single-cell sleeping, and the stated 1:8 waking and 1:16 sleeping ratios. The deviation log contained 15 documented staffing exceptions in the review period. They were discrete, attributed to illness, protected leave, vacation, scheduled absence, or temporary coverage gaps, and were evaluated against the broader record rather than ignored. Across 5 applicable provisions, the record established both the required controls and their operation in practice. The material source streams were reconciled at the provision level and collectively support the selected standard-level finding. That conclusion reflects demonstrated

	operation and corroboration, not the existence of policy language alone. The Auditor therefore determines that Standard 115.313, Supervision and Monitoring, Meets Standard. Standard Finding STANDARD FINDING: MEETS STANDARD

115.315	**Limits to cross-gender viewing and searches**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	STANDARD 115.315 — CROSS-GENDER VIEWING AND SEARCHES Evidence Reviewed Policy · Policy 7-05, PREA · Policy 2-19, Personal Searches · Policy 2-13, Security Checks · Policy 1-07, Incident Reports Documentation · PREA Training 2022 · PREA Training Acknowledgements · 2023 PREA Audit Final Report · 2020 PREA Audit Final Report · Current English and Spanish orientation materials for individuals in confinement · Staff PREA training curricula and acknowledgments · Current search procedures Interviews and Questionnaires · Twelve random staff interviews · Five random and five targeted youth interviews

Observations and Functional Verification

· Search areas, showers, toilet areas, cell-door privacy, camera views, privacy curtains, and opposite-gender announcements

PAQ Validation

· The PAQ represents that cross-gender strip, visual body-cavity, and pat-down searches are prohibited except under the limited circumstances authorized by the standard and must be documented.

Provision Analysis

115.315(a)

Policy and requirement. Policy 7-05, PREA, states: “Procedures governing searches, including cross-gender searches, are found in Policy 2-19.” Policy 2-19, Personal Searches, states: “Whenever possible, the strip search should be conducted by two officers of the same gender as the juvenile who are positioned to both see the search and hear any conversation during the search.” Policy 2-19 further states: “If two officers of the same gender as the juvenile are not available, the officer who is the same gender as the juvenile shall conduct the strip search while being observed by another officer who shall position him/herself in such a way that s/he can observe the officer conducting the search, but not observe the juvenile, and hear any conversation during the search.” Policy 2-19 establishes that strip searches are conducted by same-gender officers whenever possible and that if a second officer is present for safety or accountability, that officer must not observe the juvenile. The policy therefore limits cross-gender viewing during strip searches and preserves privacy of individuals in confinement. The facility operationalizes this requirement through its search policy, staff training, incident reporting requirements, and restrictions on officer viewing during strip searches. The 2023 prior audit report documents that SWIJDC does not conduct cross-gender strip searches and that same-sex individuals conduct pat searches. This data is significant because it independently corroborates that cross-gender strip and visual body cavity searches did not occur during the review period.

Documentation, interviews, and observations. No cross-gender strip or visual body-cavity search was reported or observed; staff knew the narrow exigent/medical exceptions.

PAQ validation. The PAQ represents that cross-gender strip, visual body-cavity, and pat-down searches are prohibited except under the limited circumstances authorized by the standard and must be documented.

The Auditor finds the facility meets the requirements of this provision.

115.315(b)

Policy and requirement. Policy 7-05, PREA, states: “Procedures governing searches, including cross-gender searches, are found in Policy 2-19.” Policy 1-08, Staff Duties,

	states: “At least one of the facility employees on duty should be female when females are housed in the facility and at least one of the facility employees should be male when males are housed in the facility.” Policy 1-08 further states: “Canyon County Sheriff’s Office, Caldwell Police Department, Canyon County Dispatch or Jail may be contacted in an emergency to arrange for an appropriate gender law enforcement officer to report to the Center to conduct same sex searches of male/ females, or deal with male/female juveniles, if assistance is needed before the on-call staff member can respond.” Policy 1-08 supports the facility’s ability to conduct same-gender searches by requiring gender-appropriate staff availability when male or female individuals in confinement are housed and by providing an emergency process to obtain an appropriate-gender law enforcement officer if needed. The facility operationalizes this requirement through staffing practices that account for the gender of individuals in confinement housed in the facility and by using same-gender staff for pat searches. The policy provides a contingency process for emergencies, reducing the likelihood that cross-gender pat searches would be needed. This data relates to the provision because it measures whether cross-gender pat searches occurred. Documentation, interviews, and observations. All interviewed staff stated cross-gender pat searches were prohibited absent an emergency and supervisory authorization. PAQ validation. The PAQ represents that cross-gender strip, visual body-cavity, and pat-down searches are prohibited except under the limited circumstances authorized by the standard and must be documented. The Auditor finds the facility meets the requirements of this provision. 115.315(c) Policy and requirement. Policy 2-19, Personal Searches, states: “Incident reporting procedures shall be followed for strip searches per Policy 1.7. The report shall include, but not be limited to, the following: Officer(s) involved in any activities leading up to a strip search. The name of the officer(s) that actually recommends the body cavity search and the information supporting that recommendation. Information regarding the obtaining of a warrant necessary to conduct body cavity search. Specific information regarding the contacting of medical staff. Final results of the body cavity search, along with disposition of contraband.” Policy 2-19 also states: “Information concerning a body cavity search shall be logged on the Daily Activity Log, including, but not limited to: Time of search. Medical officer’s name. Any other officers present.” Policy 2-19 requires documentation of strip searches and body cavity searches through incident reporting and daily activity logs. These requirements support documentation and justification of searches, including any cross-gender search if such a search were to occur. The facility operationalizes this requirement through incident reporting procedures, daily activity log entries, and documentation of staff involved search justification, medical contact, and search outcome. Documentation, interviews, and observations. Staff knew any permitted cross-

	gender search must be justified and documented. PAQ validation. The PAQ represents that cross-gender strip, visual body-cavity, and pat-down searches are prohibited except under the limited circumstances authorized by the standard and must be documented. The Auditor finds the facility meets the requirements of this provision. 115.315(d) Policy and requirement. Policy 7-05, PREA, states: “Procedures governing cross-gender viewing are found in Policy 2-13.” Policy 2-13, Security Checks, states: “Opposite Sex supervision shall be carried out in a manner which accomplishes the mission and goals of the Center and at the same time affords the juvenile the highest degree of privacy possible.” Policy 2-13 further states: “Detention staff shall not observe juveniles of the opposite sex in shower, clothing exchange, toilet areas or any other areas in which juveniles normally are in some state of undress unless such observation is incidental to routine security checks, searches, emergencies or other job functions.” Policy 2-13 also states: “Detention staff shall announce their presence in areas where juveniles of the opposite gender are housed. Due to the constant nature of opposite sex supervision in all areas of the SWIJDC, this announcement shall be made at the beginning of each shift, at meals and other times, and every announcement shall be documented.” Policy 2-13 requires opposite-gender supervision to be carried out in a way that preserves privacy of individuals in confinement, prohibits opposite-gender viewing of individuals in confinement in areas where they may be undressed except as permitted by the standard, and requires opposite-gender staff announcements in housing areas. The facility operationalizes this requirement through opposite-gender announcements, documentation of announcements, use of privacy practices during showers, clothing exchange, and toilet use, and limitations on viewing through video monitoring. Policy 2-13 also requires opaque obstructions on video monitoring devices in the Control Room to preserve privacy while individuals in confinement use bathrooms in observation cells. This data independently corroborates Policy 2-13 and supports implementation of privacy of protections for individuals in confinement. Documentation, interviews, and observations. Privacy curtains, private search areas, single-use showers, cell-window covers, appropriate camera views, and opposite-gender announcements were directly verified. PAQ validation. The PAQ represents that cross-gender strip, visual body-cavity, and pat-down searches are prohibited except under the limited circumstances authorized by the standard and must be documented. The Auditor finds the facility meets the requirements of this provision. 115.315(e) — DOJ-Designated Not Audited This provision is designated by DOJ as “Not Audited by the Auditor” and is excluded from compliance determinations. The Auditor did not request documentation, conduct interviews, or assess implementation for this subsection. Its exclusion does not affect the compliance determination for this standard. 115.315(f) — DOJ-Designated Not Audited This provision is designated by

	DOJ as “Not Audited by the Auditor” and is excluded from compliance determinations. The Auditor did not request documentation, conduct interviews, or assess implementation for this subsection. Its exclusion does not affect the compliance determination for this standard. Auditor Analysis and Determination Policy, training, staff knowledge, youth experience, and direct observation were consistent. The facility limits cross-gender searches, documents any permitted exception, and provides privacy from nonincidental opposite-gender viewing. DOJ-limited subsections were excluded exactly as required. The standard-level finding rests on convergence among policy requirements, current documentation, interviews and questionnaires, direct observation and functional verification, and PAQ validation. No cross-gender search was observed. Staff consistently stated that a cross-gender pat search could occur only in an emergency and with supervisory authorization, and they understood the documentation requirement. The site review confirmed private search locations, single-use showers, privacy curtains, cell-door window covers, and camera positioning that preserved privacy of individuals in confinement while maintaining supervision. Across 4 applicable provisions, the record established both the required controls and their operation in practice. The 2 DOJ-designated not-audited provisions were excluded from the compliance determination and did not supply evidentiary support for the finding. The material source streams were reconciled at the provision level and collectively support the selected standard-level finding. That conclusion reflects demonstrated operation and corroboration, not the existence of policy language alone. The Auditor therefore determines that Standard 115.315, Cross-Gender Viewing and Searches, Meets Standard. Standard Finding STANDARD FINDING: MEETS STANDARD

115.316	**Residents with disabilities and residents who are limited English proficient**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	STANDARD 115.316 — ACCESSIBILITY FOR INDIVIDUALS IN CONFINEMENT Evidence Reviewed Policy · Policy 7-05, PREA

	· Policy 9-09, Orientation Documentation · SWIJDC PREA Intake Orientation · SWIJDC PREA Intake Orientation Revised · SWIJDC PREA Intake Orientation Revised Spanish · PREA Brochure · HRC Glossary of Terms · Vulnerability Assessment 2025 · Current English and Spanish orientation and PREA brochure materials · Language Line access information · Interpreter-resource documentation · Education for records of individuals in confinement Interviews and Questionnaires · Random staff interviews · Targeted youth interview involving an individual in confinement with a cognitive disability · Intake/education specialty follow-up Observations and Functional Verification · Availability of translated materials, staff explanation, private communication, and accommodation processes PAQ Validation · The onsite population profile identified six individuals in confinement with cognitive or functional disabilities, no individuals in confinement with limited English proficiency, and no individuals in confinement with identified hearing or visual disabilities on the audit date. Provision Analysis 115.316(a) Policy and requirement. Policy 7-05, PREA, states: “Procedures dealing with residents who are limited English proficient or disabled are found in Policy 9-09.” Policy 9-09, Orientation, states: “The admitting detention officer shall take appropriate steps to ensure that residents with disabilities including, but not limited

	to, residents who are deaf or hard of hearing, those who are blind or have low vision, or those who have intellectual, psychiatric, or speech disabilities, have an equal opportunity to participate in or benefit from all aspects of the SWIJDC's programs, and especially those efforts to prevent, detect, and respond to sexual abuse and sexual harassment." Policy 9-09 further states: "Providing materials in formats or through methods that ensure effective, age-appropriate communication with residents with disabilities, including residents who have intellectual disabilities, or limited reading skills." Policy 9-09 requires staff to take steps to ensure that individuals in confinement with disabilities can participate in and benefit from SWIJDC programs, especially PREA-related prevention, detection, and response efforts. The policy identifies individuals in confinement who are deaf or hard of hearing, blind or low vision, or who have intellectual, psychiatric, or speech disabilities. The facility operationalizes this provision through the admission and orientation process, PREA intake materials, education for individuals in confinement, and available assistance when literacy, disability, or communication needs are identified. The facility's PREA intake orientation materials explain zero tolerance, definitions of sexual abuse and sexual harassment, reporting options, investigation of reports, protection from retaliation, and safety of individuals in confinement. These materials support accessible communication of PREA information. Documentation, interviews, and observations. English and Spanish orientation and brochure materials were current and included zero tolerance, reporting, retaliation protection, and good-faith-report protection. Language Line and staff/court interpreter resources were available. PAQ validation. The onsite population profile identified six individuals in confinement with cognitive or functional disabilities, no individuals in confinement with limited English proficiency, and no individuals in confinement with identified hearing or visual disabilities on the audit date. The Auditor finds the facility meets the requirements of this provision. 115.316(b) Policy and requirement. Policy 9-09, Orientation, states: "Providing access to interpreters who can interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary, for residents who are deaf or hard of hearing, limited in English proficiency or are blind or have low vision through the following means: a). Staff interpreters. b. Probation interpreters. c). Canyon County Court Interpretive Services. d). Interpretive Services phone line (contact information available in Admissions Office.)" Policy 9-09 establishes procedures for individuals in confinement who are limited English proficient, deaf, or hard of hearing, or blind or low vision by identifying interpreter resources and communication supports. The policy requires interpretation to be effective, accurate, impartial, and capable of using necessary specialized vocabulary. The facility operationalizes this requirement through staff interpreters, probation interpreters, Canyon County Court Interpretive Services, and an interpretive services phone line available through the Admissions Office. The

	availability of Spanish-language PREA intake orientation materials further supports access for individuals in confinement with language needs. Documentation, interviews, and observations. The targeted individual in confinement with a cognitive disability confirmed that written information was read or explained in an understandable manner. Staff described accommodations and knew not to rely on another individual in confinement for a PREA report except in the narrow emergency circumstances permitted by the standard. PAQ validation. The onsite population profile identified six individuals in confinement with cognitive or functional disabilities, no individuals in confinement with limited English proficiency, and no individuals in confinement with identified hearing or visual disabilities on the audit date. The Auditor finds the facility meets the requirements of this provision. 115.316(c) Policy and requirement. Policy 9-09, Orientation, states: “For the admissions process and during other routine operations, the SWIJDC may utilize the services of resident interpreters, resident readers, or other types of resident assistants when necessary. If any incident regarding sexual abuse or sexual harassment is alleged by a resident through a resident interpreter, the resident interpreter’s services will be stopped immediately and a staff interpreter or court interpreter shall be utilized, except in limited circumstances where an extended delay in obtaining an effective interpreter could compromise the resident’s safety, the performance of first-response duties, or the investigation of a resident’s allegations.” Policy 9-09 limits the use of interpreters who are individuals in confinement in PREA-related matters by requiring services of an interpreter who is an individual in confinement to stop immediately if a sexual abuse or sexual harassment allegation is made through an interpreter who is an individual in confinement. The policy then requires use of a staff interpreter or court interpreter except in limited circumstances where delay could compromise safety, first-response duties, or the investigation. The facility operationalizes this requirement by distinguishing routine communication support from PREA allegation communication. The policy permits assistance from individuals in confinement during routine admissions operations when necessary, but it establishes a protective safeguard for PREA allegations by shifting to staff or court interpreters when an allegation is made. Documentation, interviews, and observations. No LEP individual in confinement was housed onsite on August 3, but translated materials and interpreter resources were operationally available and staff described how they would be used. PAQ validation. The onsite population profile identified six individuals in confinement with cognitive or functional disabilities, no individuals in confinement with limited English proficiency, and no individuals in confinement with identified hearing or visual disabilities on the audit date. The Auditor finds the facility meets the requirements of this provision.

	Auditor Analysis and Determination The facility uses translated written materials, interpreter resources, staff assistance, and individualized explanation to ensure meaningful access. The current population did not contain every disability or language category, but the available resources, staff knowledge, and targeted interview supported implementation. The standard-level finding rests on convergence among policy requirements, current documentation, interviews and questionnaires, direct observation and functional verification, and PAQ validation. English and Spanish orientation and brochure materials were current and included zero tolerance, reporting, retaliation protection, and good-faith-report protection. Language Line and staff/court interpreter resources were available. The targeted individual in confinement with a cognitive disability confirmed that written information was read or explained in an understandable manner. Staff described accommodations and knew not to rely on another individual in confinement for a PREA report except in the narrow emergency circumstances permitted by the standard. Across 3 applicable provisions, the record established both the required controls and their operation in practice. The material source streams were reconciled at the provision level and collectively support the selected standard-level finding. That conclusion reflects demonstrated operation and corroboration, not the existence of policy language alone. The Auditor therefore determines that Standard 115.316, Accessibility for Individuals in Confinement, Meets Standard. Standard Finding STANDARD FINDING: MEETS STANDARD

115.317	**Hiring and promotion decisions**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	STANDARD 115.317 — HIRING AND PROMOTION Evidence Reviewed Policy · Policy 1-16, Hiring · Policy 7-05, PREA Documentation · Training Acknowledgement

	· Employee training acknowledgement records · 2023 PREA Audit Final Report · Current employee roster · Audit-period hiring and background-check records · Employee and volunteer screening packets · Hiring policy and personnel forms Interviews and Questionnaires · Agency head, PREA Coordinator, and supervisory questionnaires File Review · Fourteen staff packets and four volunteer packets · Three audit-period hires selected for focused review PAQ Validation · The audit-period data collection reported 46 staff with contact with individuals in confinement, four volunteers, and no contractors; the current onsite roster identified 40 employees, three volunteers, and one contractor. The difference reflects different timeframes and current classifications. Provision Analysis 115.317(a) Policy and requirement. Policy 1-16, Hiring, states: “The Center shall not hire or promote anyone who may have contact with residents, and shall not enlist the services of any contractor who may have contact with residents, who— a. 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) or while acting in any position where supervising other individuals was a part of the duties of the position, such as probation/parole officer, law enforcement officer. b. Has been convicted of, or has been civilly or administratively adjudicated to have engaged or attempted 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.” Policy 1-16 prohibits the facility from hiring or promoting persons who may have contact with individuals in confinement, and from enlisting contractors who may have contact with individuals in confinement, when the person has engaged in the disqualifying conduct identified by the standard. The policy applies to applicants, employees being considered for promotion, and contractors. The facility operationalizes this requirement through hiring procedures, applicant screening, employment applications, criminal background records checks, child abuse registry checks, and review of prior institutional employment when applicable. Training acknowledgement records also require employees to disclose that they have not engaged in the disqualifying conduct identified in the policy.

	Documentation, interviews, and observations. The file review documented 14 staff packets and four volunteer packets, including the selected audit-period hires. Records included required background information and PREA disclosure/ acknowledgment components. PAQ validation. The audit-period data collection reported 46 staff with contact with individuals in confinement, four volunteers, and no contractors; the current onsite roster identified 40 employees, three volunteers, and one contractor. The difference reflects different timeframes and current classifications. The Auditor finds the facility meets the requirements of this provision. 115.317(b) Policy and requirement. Policy 1-16, Hiring, states: “The Center shall consider any incidents of sexual harassment in determining whether to hire or promote anyone, or to enlist the services of any contractor, who may have contact with residents.” Policy 1-16 requires the facility to consider incidents of sexual harassment before hiring or promoting anyone who may have contact with individuals in confinement or before enlisting a contractor who may have contact with individuals in confinement. This requirement ensures that sexual harassment history is considered as part of suitability for employment, promotion, or contractor access. The facility operationalizes this provision through employment screening, review of background information, applicant disclosures, and consideration of prior misconduct. The 2023 prior audit report also documented that SWIJDC considers sexual harassment issues during hiring and promotion decisions. Documentation, interviews, and observations. The current roster contained 34 full-time and six part-time employees. A current service provider was correctly treated as a contractor for onsite population accounting even though the audit-period data collection reported no contractor. PAQ validation. The audit-period data collection reported 46 staff with contact with individuals in confinement, four volunteers, and no contractors; the current onsite roster identified 40 employees, three volunteers, and one contractor. The difference reflects different timeframes and current classifications. The Auditor finds the facility meets the requirements of this provision. 115.317(c) Policy and requirement. Policy 1-16, Hiring, states: “Before hiring new employees who may have contact with residents, the Center shall: a. Perform a criminal background records check. b. Consult any child abuse registry maintained by the Idaho Department of Health and Welfare. c. 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.” Policy 1-16 requires criminal background records checks, child abuse registry consultation, and best efforts to

	contact prior institutional employers before hiring employees who may have contact with individuals in confinement. These procedures directly address the standard's requirements for pre-employment screening. The facility operationalizes this requirement by completing criminal background record checks, consulting the Idaho Department of Health and Welfare child abuse registry, and seeking information from prior institutional employers regarding substantiated allegations of sexual abuse or resignation during a pending investigation. The prior audit report documents that background checks include sex offender registry review, child abuse registry review, work reference checks, prior institutional employer contact, criminal history checks, fingerprint checks, and Idaho repository checks. Documentation, interviews, and observations. Leadership described the required preemployment screening, five-year checks, disclosure duties, and material-omission consequences. No evidence showed that a person barred by the standard was hired, promoted, volunteered, or contracted during the review period. PAQ validation. The audit-period data collection reported 46 staff with contact with individuals in confinement, four volunteers, and no contractors; the current onsite roster identified 40 employees, three volunteers, and one contractor. The difference reflects different timeframes and current classifications. The Auditor finds the facility meets the requirements of this provision. 115.317(d) Policy and requirement. Policy 1-16, Hiring, states: "The Center shall also perform a criminal background records check, and consult applicable child abuse registries, before enlisting the services of any contractor or volunteer who may have contact with residents pending service they provide and level of contact they have with residents." Policy 1-16 requires criminal background records checks and applicable child abuse registry checks before the facility enlists contractors or volunteers who may have contact with individuals in confinement. This provision applies to non-employee persons who may enter the facility or interact with individuals in confinement based on their role and level of contact. The facility operationalizes this requirement through contractor and volunteer screening procedures. The volunteer list and volunteer/contractor documentation identify persons providing services to the facility, and the policy requires background and registry review before applicable service begins. Documentation, interviews, and observations. The file review documented 14 staff packets and four volunteer packets, including the selected audit-period hires. Records included required background information and PREA disclosure/ acknowledgment components. PAQ validation. The audit-period data collection reported 46 staff with contact with individuals in confinement, four volunteers, and no contractors; the current onsite roster identified 40 employees, three volunteers, and one contractor. The difference reflects different timeframes and current classifications.

	The Auditor finds the facility meets the requirements of this provision. 115.317(e) Policy and requirement. Policy 1-16, Hiring, states: “The Center shall conduct criminal background records checks at least every five years of current employees, volunteers and contractors who may have contact with residents, as may be required by the service they provide and level of contact with residents.” Policy 1-16 requires periodic criminal background checks at least every five years for current employees, volunteers, and contractors who may have contact with individuals in confinement. This requirement ensures continuing suitability for contact with individuals in confinement after initial hiring or enlistment. The facility operationalizes this requirement through periodic background check procedures for staff, volunteers, and contractors. The prior audit report documented that background checks are completed every five years for current employees and that employee files were reviewed for initial and five-year background checks. Documentation, interviews, and observations. The current roster contained 34 full-time and six part-time employees. A current service provider was correctly treated as a contractor for onsite population accounting even though the audit-period data collection reported no contractor. PAQ validation. The audit-period data collection reported 46 staff with contact with individuals in confinement, four volunteers, and no contractors; the current onsite roster identified 40 employees, three volunteers, and one contractor. The difference reflects different timeframes and current classifications. The Auditor finds the facility meets the requirements of this provision. 115.317(f) Policy and requirement. Policy 1-16, Hiring, states: “The Center shall also ask all applicants and employees who may have contact with residents directly about previous misconduct described in section II.A.1, 2 of this policy 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.” Policy 1-16 further states: “All employees MUST report to the Director of the Center within 24 hours of any allegations or investigations of misconduct described in section II.A.1, 2 that they may be the subject of, or any convictions, either criminally, civilly or administratively of such conduct.” Policy 1-16 requires direct questioning of applicants and employees about prior misconduct during hiring, promotion, and reviews. It also imposes a continuing affirmative duty for employees to disclose allegations, investigations, or convictions involving covered misconduct within 24 hours. The facility operationalizes this requirement through applicant screening, written applications, interviews, employee reviews, and employee acknowledgement forms. The PREA Training Acknowledgement requires employees to disclose that they have not engaged in institutional sexual abuse, qualifying sexual misconduct in the community, or conduct that resulted in civil or administrative adjudication.

	Documentation, interviews, and observations. Leadership described the required preemployment screening, five-year checks, disclosure duties, and material-omission consequences. No evidence showed that a person barred by the standard was hired, promoted, volunteered, or contracted during the review period. PAQ validation. The audit-period data collection reported 46 staff with contact with individuals in confinement, four volunteers, and no contractors; the current onsite roster identified 40 employees, three volunteers, and one contractor. The difference reflects different timeframes and current classifications. The Auditor finds the facility meets the requirements of this provision. 115.317(g) Policy and requirement. Policy 1-16, Hiring, states: “Material omissions or failure to report to the Director regarding such misconduct, or the provision of materially false information, shall be grounds for termination.” Policy 1-16 establishes that false information, material omissions, or failure to report covered misconduct may result in termination. This policy creates accountability for inaccurate or incomplete disclosures during hiring, promotion, employment, or review processes. The facility operationalizes this provision through employee screening, disclosure requirements, and personnel accountability processes. The policy makes disclosure accuracy a condition of employment and continued employment. Documentation, interviews, and observations. The file review documented 14 staff packets and four volunteer packets, including the selected audit-period hires. Records included required background information and PREA disclosure/ acknowledgment components. PAQ validation. The audit-period data collection reported 46 staff with contact with individuals in confinement, four volunteers, and no contractors; the current onsite roster identified 40 employees, three volunteers, and one contractor. The difference reflects different timeframes and current classifications. The Auditor finds the facility meets the requirements of this provision. 115.317(h) Policy and requirement. Policy 1-16, Hiring, states: “As allowed by law, the Center shall provide information on substantiated allegations of sexual abuse or sexual harassment involving a former employee upon receiving a request from an institutional employer for whom such employee has applied to work and an authorization to investigate and release information which is signed by the former employee and notarized.” Policy 1-16 requires the facility to provide information about substantiated allegations of sexual abuse or sexual harassment involving a former employee when legally permitted and when a proper request and authorization are received from an institutional employer. This supports interagency safety screening and prevents known misconduct from being concealed when former employees seek institutional employment elsewhere. The facility

	operationalizes this provision by maintaining the policy requirement and by making such information available to requesting institutional employers when legally permitted and properly authorized. The prior audit report also documented that the facility provides information on substantiated allegations involving former employees upon request from another institution. Although this provision is less frequently triggered operationally, Policy 1-16 establishes the facility's procedure, and the prior audit documentation corroborates implementation. Documentation, interviews, and observations. The current roster contained 34 full-time and six part-time employees. A current service provider was correctly treated as a contractor for onsite population accounting even though the audit-period data collection reported no contractor. PAQ validation. The audit-period data collection reported 46 staff with contact with individuals in confinement, four volunteers, and no contractors; the current onsite roster identified 40 employees, three volunteers, and one contractor. The difference reflects different timeframes and current classifications. The Auditor finds the facility meets the requirements of this provision. Auditor Analysis and Determination The hiring policy, sampled personnel and volunteer packets, current and audit-period rosters, and leadership responses corroborate the required screening and recurring-check process. The differing current and audit-period counts were reconciled as timeframe and classification differences and did not affect the sampled-record findings. The standard-level finding rests on convergence among policy requirements, current documentation, interviews and questionnaires, selected file review, and PAQ validation. The file review documented 14 staff packets and four volunteer packets, including the selected audit-period hires. Records included required background information and PREA disclosure/ acknowledgment components. The current roster contained 34 full-time and six part-time employees. A current service provider was correctly treated as a contractor for onsite population accounting even though the audit-period data collection reported no contractor. Across 8 applicable provisions, the record established both the required controls and their operation in practice. The material source streams were reconciled at the provision level and collectively support the selected standard-level finding. That conclusion reflects demonstrated operation and corroboration, not the existence of policy language alone. The Auditor therefore determines that Standard 115.317, Hiring and Promotion, Meets Standard. Standard Finding STANDARD FINDING: MEETS STANDARD

115.318	Upgrades to facilities and technologies
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	STANDARD 115.318 — FACILITY AND TECHNOLOGY UPGRADES Evidence Reviewed Policy · Policy 7-05, PREA Documentation · PREA Staffing Plan Assessment 2023 · PREA Staffing Plan Assessment 2024 · 2025 SWIJDC PREA Report · 2023 PREA Audit Final Report · Camera work orders · Photographs of camera and physical-plant upgrades · 2023–2025 staffing-plan and technology assessments Interviews and Questionnaires · Director and PREA Coordinator questionnaires and onsite follow-up Observations and Functional Verification · Camera coverage, control-room views, privacy controls, interview rooms, observation rooms, and blind-spot mitigation PAQ Validation · The PAQ identifies facility and monitoring-technology upgrades and represents that PREA safety and privacy were considered in planning and installation. Provision Analysis 115.318(a) Policy and requirement. Policy 7-05, PREA, states: “The planning of any upgrade or change to any part of the SWIJDC shall also include an evaluation of how the upgrade or change will impact the ability of the staff to protect juveniles against sexual abuse.” Policy 7-05 further states that review during planning stages shall include, but not be limited to: “Construction, remodel, alteration, addition or

	demolition of any part of the physical structure of the SWIJDC." Policy 7-05 requires the facility to evaluate how any physical plant upgrade or change may affect staff's ability to protect individuals in confinement from sexual abuse. This requirement applies during planning for construction, remodeling, alteration, addition, or demolition. The facility operationalizes this requirement through annual staffing plan assessments and review of physical plant issues, blind spots, monitoring technology, and safety of individuals in confinement needs. The 2023 staffing plan assessment documented review of cameras, observation rooms, and the planned movement of the Interview Room 2 camera. The 2024 staffing plan assessment documented that the Interview Room 2 camera had been moved for a better view, additional observation room cameras were planned, and Canyon County was in the process of purchasing a new camera system. Documentation, interviews, and observations. Work orders and annual assessments documented camera repairs, placement changes, and planned upgrades. PAQ validation. The PAQ identifies facility and monitoring-technology upgrades and represents that PREA safety and privacy were considered in planning and installation. The Auditor finds the facility meets the requirements of this provision. 115.318(b) Policy and requirement. Policy 7-05, PREA, states: "The planning of any upgrade or change to any part of the SWIJDC shall also include an evaluation of how the upgrade or change will impact the ability of the staff to protect juveniles against sexual abuse." Policy 7-05 further states that planning-stage review shall include, but not be limited to: "Addition or subtraction of any video, audio or any other monitoring devices." Policy 7-05 requires SWIJDC to evaluate how additions or removals of video, audio, or other monitoring technology may affect the facility's ability to protect individuals in confinement from sexual abuse. The policy directly connects monitoring technology decisions to safety of individuals in confinement. The facility operationalizes this provision through documented review of camera placement and monitoring technology during staffing plan assessments. The 2024 assessment documented that the camera in Interview Room 2 was moved to provide a better view, that additional observation room cameras were planned, and that Canyon County was purchasing a new camera system. The 2025 PREA Report also documents the facility's ongoing use of video monitoring to support investigations and safety improvements. Documentation, interviews, and observations. Onsite observation confirmed broad camera coverage, operational control-room monitoring, and privacy protections in shower, toilet, changing, medical, and interview areas. PAQ validation. The PAQ identifies facility and monitoring-technology upgrades and represents that PREA safety and privacy were considered in planning and installation.

	The Auditor finds the facility meets the requirements of this provision. Auditor Analysis and Determination The facility considered the effect of physical-plant and monitoring changes on sexual-safety supervision and privacy of individuals in confinement. Documentary evidence and direct observation were consistent and no newly created blind spot or privacy intrusion was identified. The standard-level finding rests on convergence among policy requirements, current documentation, interviews and questionnaires, direct observation and functional verification, and PAQ validation. Work orders and annual assessments documented camera repairs, placement changes, and planned upgrades. Onsite observation confirmed broad camera coverage, operational control-room monitoring, and privacy protections in shower, toilet, changing, medical, and interview areas. Across 2 applicable provisions, the record established both the required controls and their operation in practice. The material source streams were reconciled at the provision level and collectively support the selected standard-level finding. That conclusion reflects demonstrated operation and corroboration, not the existence of policy language alone. The Auditor therefore determines that Standard 115.318, Facility and Technology Upgrades, Meets Standard. Standard Finding STANDARD FINDING: MEETS STANDARD

115.321	**Evidence protocol and forensic medical examinations**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	STANDARD 115.321 — EVIDENCE PROTOCOL AND FORENSIC EXAMINATIONS Evidence Reviewed Policy · Policy 7-05, PREA · Policy 6-18, Abuse Reporting · Policy 6-18a, Abuse Investigation Documentation · Advocates Against Family Violence Memorandum of Understanding

	· Specialty Contact Form – Juvenile Facilities · Licensed clinical social worker credential · 2023 PREA Audit Final Report · 2020 PREA Audit Final Report · Medical and mental health policies · Abuse-reporting and evidence-preservation procedures · Medical Staff Questionnaire completed by the designated medical practitioner · Community victim advocate and outside support provider questionnaires · Hospital/forensic-care referral information Interviews and Questionnaires · Random staff first-responder interviews · Medical/mental-health specialty follow-up · Community provider verification Observations and Functional Verification · First-responder knowledge and access to private medical/mental-health services File Review · Investigation and response records PAQ Validation · The PAQ represents use of a uniform evidence protocol, referral to qualified outside forensic services, victim-advocate access, and no-cost medical and mental-health care. Provision Analysis 115.321(a) Policy and requirement. Policy 7-05, PREA, states: “Procedures governing the acceptance of a report, grievance or allegation of sexual abuse and the immediate referral of said report to the Caldwell Police Department (CPD) and/or the Canyon County Prosecuting Attorney’s Office are found in Policy 6-18.” Policy 6-18, Abuse Reporting, states: Policy 6- 18 further states: “Relevant information shall be gathered and then immediately reported to the Director, the Canyon County Prosecuting Attorney’s Office and the Caldwell Police Department, even if initial relevant information indicates that the incident did not occur.” Policy 7-05 and Policy 6-18 require immediate referral of sexual abuse allegations to the Caldwell Police Department and/or the Canyon County Prosecuting Attorney’s Office. Policy 6-18

	also requires staff to gather relevant information and take protective action to prevent further abuse, harassment, or retaliation. The facility operationalizes this provision by referring criminal sexual abuse allegations to the Caldwell Police Department and using trained facility staff for administrative investigations when applicable. Policy 6-18a further provides that administrative investigations of sexual abuse and sexual harassment allegations are conducted by trained SWIJDC investigators when the allegation does not involve potentially criminal behavior. Documentation, interviews, and observations. Staff first responders consistently described immediate separation, evidence preservation, prompt medical notification, and protection of the scene. PAQ validation. The PAQ represents use of a uniform evidence protocol, referral to qualified outside forensic services, victim-advocate access, and no-cost medical and mental-health care. The Auditor finds the facility meets the requirements of this provision. 115.321(b) Policy and requirement. Policy 7-05, PREA, states: “Upon receipt of a report of sexual abuse, the CPD will activate their Department’s Sexual Abuse Response Team (SART) and will arrange to provide all victims of sexual abuse a forensic medical examination to be conducted by an appropriately trained examiner, preferably a Sexual Assault Forensic Examiner (SAFE) or a Sexual Abuse Nurse Examiner (SANE).” Policy 7-05 requires use of Caldwell Police Department’s Sexual Abuse Response Team following receipt of a sexual abuse report. The policy also requires forensic medical examination by an appropriately trained examiner, preferably a SAFE or SANE. The facility operationalizes this requirement by immediately referring sexual abuse reports to Caldwell Police Department and relying on CPD’s response protocol for activation of SART and coordination of forensic medical examination services. This approach is developmentally appropriate because the facility serves juveniles and routes allegations to law enforcement and medical professionals trained to respond to sexual abuse allegations involving victims. Documentation, interviews, and observations. The medical practitioner confirmed emergency referral and forensic-care procedures, evidence preservation, confidentiality, and no-cost treatment. PAQ validation. The PAQ represents use of a uniform evidence protocol, referral to qualified outside forensic services, victim-advocate access, and no-cost medical and mental-health care. The Auditor finds the facility meets the requirements of this provision. 115.321(c) Policy and requirement. Policy 7-05, PREA, states: “Upon receipt of a report of sexual abuse, the CPD will activate their Department’s Sexual Abuse Response

	Team (SART) and will arrange to provide all victims of sexual abuse a forensic medical examination to be conducted by an appropriately trained examiner, preferably a Sexual Assault Forensic Examiner (SAFE) or a Sexual Abuse Nurse Examiner (SANE).” Policy 7-05 further states: “If such examination is not covered for payment by the CPD, the SWIJDC shall bear the cost of the examination.” Policy 7-05 requires access to forensic medical examinations for victims of sexual abuse and provides that examinations are conducted by appropriately trained examiners, preferably SAFEs or SANEs. The policy also ensures the victim is not financially responsible for the examination by requiring SWIJDC to bear the cost if the Caldwell Police Department does not cover the examination. The facility operationalizes this provision by using outside forensic examination resources. Luke’s where SANE examinations are performed. The Specialty Contact Form identifies St. Luke’s CARES Unit – Nampa as the SAFE/SANE forensic examination agency. These metrics are significant because they show there were no forensic examination events during the review period; however, policy and referral procedures remain in place to provide examinations at no cost when medically or evidentially appropriate. Documentation, interviews, and observations. Victim-advocacy records and provider questionnaires established available advocate support; the live access checks confirmed usable routes. No review-period sexual-abuse allegation required activation of a forensic examination. PAQ validation. The PAQ represents use of a uniform evidence protocol, referral to qualified outside forensic services, victim-advocate access, and no-cost medical and mental-health care. The Auditor finds the facility meets the requirements of this provision. 115.321(d) Policy and requirement. Policy 7-05, PREA, states: “CPD SART Team also includes a victim advocate/rape crisis advocate.” Policy 7-05 further states: “If a victim advocate/rape crisis advocate is not available through CPD’s normal process, the Advocates Against Family Violence (AAFV) will be contacted as provided by the existing MOU with the AAFV.” The policy requires that a victim advocate or rape crisis advocate be made available through the Caldwell Police Department SART process or, if unavailable, through Advocates Against Family Violence under the existing MOU. The facility operationalizes this requirement through its relationship with Advocates Against Family Violence. The AAFV MOU documents that AAFV provides victim services, confidential emotional support services related to sexual abuse, and outside reporting services to juveniles in SWIJDC custody. The Specialty Contact Form identifies Advocates Against Family Violence as the victim advocacy services agency and identifies Advocates Against Family Violence and Rose Advocates as emotional support services agencies. Documentation, interviews, and observations. Staff first responders consistently described immediate separation, evidence preservation, prompt medical notification, and protection of the scene.

	PAQ validation. The PAQ represents use of a uniform evidence protocol, referral to qualified outside forensic services, victim-advocate access, and no-cost medical and mental-health care. The Auditor finds the facility meets the requirements of this provision. 115.321(e) Policy and requirement. Policy 7-05, PREA, states: “Any member of the SWIJDC staff who has received appropriate training and education concerning sexual assault and forensic examinations issues in general provided by the AAFV, may be assigned at the victim’s request to accompany and support the victim through the forensic medical examination process and investigatory interviews and provide emotional support, crisis intervention, information, and referrals.” Policy 7-05 requires that, when requested by the victim, a qualified advocate or trained staff member may accompany and support the victim during the forensic medical examination process and investigatory interviews and provide emotional support, crisis intervention, information, and referrals. The facility operationalizes this provision through the Caldwell Police Department SART process, AAFV victim advocacy services, and qualified facility support when appropriate. The AAFV MOU supports availability of confidential emotional support services related to sexual abuse and outside reporting services. Documentation, interviews, and observations. The medical practitioner confirmed emergency referral and forensic-care procedures, evidence preservation, confidentiality, and no-cost treatment. PAQ validation. The PAQ represents use of a uniform evidence protocol, referral to qualified outside forensic services, victim-advocate access, and no-cost medical and mental-health care. The Auditor finds the facility meets the requirements of this provision. 115.321(f) Policy and requirement. Policy 7-05, PREA, states: “Procedures governing the acceptance of a report, grievance or allegation of sexual abuse and the immediate referral of said report to the Caldwell Police Department (CPD) and/or the Canyon County Prosecuting Attorney’s Office are found in Policy 6-18.” Policy 6-18a, Abuse Investigation, states: “Any allegation of sexual abuse that potentially involves criminal behavior shall immediately be turned over to the Caldwell Police Department for investigation, especially in all cases that may have happened within a time frame that allows for the collection of physical evidence, or if the allegation involves a staff member.” Policy 6-18a further states: “Staff at the SWIJDC shall cooperate in every way with any investigation.” Policy 7-05 and Policy 6-18a require referral of criminal sexual abuse allegations to the Caldwell Police Department and require facility staff to cooperate with investigations. The policy structure demonstrates that when SWIJDC is not responsible for criminal investigations, it refers allegations to the investigative agency and cooperates with the investigative

process. The facility operationalizes this requirement through immediate referral to Caldwell Police Department and cooperation with criminal investigations. The prior audit documentation also indicates that Caldwell Police Department is the external criminal investigative entity and that the facility has requested the investigating agency follow PREA evidence protocol requirements.

Documentation, interviews, and observations. Victim-advocacy records and provider questionnaires established available advocate support; the live access checks confirmed usable routes. No review-period sexual-abuse allegation required activation of a forensic examination.

PAQ validation. The PAQ represents use of a uniform evidence protocol, referral to qualified outside forensic services, victim-advocate access, and no-cost medical and mental-health care.

The Auditor finds the facility meets the requirements of this provision. 115.321(g) — DOJ-Designated Not Audited This provision is designated by DOJ as “Not Audited by the Auditor” and is excluded from compliance determinations. The Auditor did not request documentation, conduct interviews, or assess implementation for this subsection. Its exclusion does not affect the compliance determination for this standard.

115.321(h)

Policy and requirement. Policy 7-05, PREA, states: “Any member of the SWIJDC staff who has received appropriate training and education concerning sexual assault and forensic examinations issues in general provided by the AAFV, may be assigned at the victim’s request to accompany and support the victim through the forensic medical examination process and investigatory interviews and provide emotional support, crisis intervention, information, and referrals.” Policy 7-05 requires any facility staff member assigned to provide victim support under this provision to have appropriate training and education concerning sexual assault and forensic examination issues. The policy therefore establishes a qualification requirement before staff may perform this support role. The facility operationalizes this provision by relying primarily on victim advocacy services through AAFV and the Caldwell Police Department SART process. If qualified facility staff are used, Policy 7-05 requires appropriate training and education. This corroborates the policy requirement that staff serving in this role must be appropriately trained and qualified.

Documentation, interviews, and observations. The medical practitioner confirmed emergency referral and forensic-care procedures, evidence preservation, confidentiality, and no-cost treatment.

PAQ validation. The PAQ represents use of a uniform evidence protocol, referral to qualified outside forensic services, victim-advocate access, and no-cost medical and mental-health care.

The Auditor finds the facility meets the requirements of this provision.

	Auditor Analysis and Determination The evidence protocol, outside forensic-care pathway, medical and mental-health readiness, advocate access, and staff first-response knowledge align. The absence of a qualifying examination during the review period does not negate compliance because the conditional response framework was fully established and operationally verified. The standard-level finding rests on convergence among policy requirements, current documentation, interviews and questionnaires, direct observation and functional verification, selected file review, and PAQ validation. Staff first responders consistently described immediate separation, evidence preservation, prompt medical notification, and protection of the scene. The medical practitioner confirmed emergency referral and forensic-care procedures, evidence preservation, confidentiality, and no-cost treatment. Across 7 applicable provisions, the record established both the required controls and their operation in practice. The 1 DOJ-designated not-audited provision was excluded from the compliance determination and did not supply evidentiary support for the finding. The material source streams were reconciled at the provision level and collectively support the selected standard-level finding. That conclusion reflects demonstrated operation and corroboration, not the existence of policy language alone. The Auditor therefore determines that Standard 115.321, Evidence Protocol and Forensic Examinations, Meets Standard. Standard Finding STANDARD FINDING: MEETS STANDARD

115.322	**Policies to ensure referrals of allegations for investigations**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	STANDARD 115.322 — INVESTIGATION REFERRALS Evidence Reviewed Policy · Policy 7-05, PREA · Policy 6-18, Abuse Reporting · Policy 6-18a, Abuse Investigation Documentation · Specialty Contact Form – Juvenile Facilities

	· 2023 PREA Audit Final Report · 2020 PREA Audit Final Report · Abuse-investigation policy · PREA policy · Investigator questionnaires · Investigator training records · Administrative investigation files and notification records for individuals in confinement Interviews and Questionnaires · PREA Coordinator and trained investigator follow-up · Agency leadership verification File Review · Three review-period PREA case groups and the post-period July 27, 2026 allegation file PAQ Validation · The PAQ identifies Caldwell Police Department for potentially criminal allegations and trained facility investigators for administrative allegations. Provision Analysis 115.322(a) Policy and requirement. Policy 7-05, PREA, states: “Procedures governing the acceptance of a report, grievance or allegation of sexual harassment and the immediate referral of said report to the Canyon County Prosecuting Attorney’s Office and/or the Canyon County Human Resources Department are found in Policy 6-18.” Policy 6-18, Abuse Reporting, states: “Relevant information shall be gathered and then immediately reported to the Director, the Canyon County Prosecuting Attorney’s Office and the Caldwell Police Department, even if initial relevant information indicates that the incident did not occur.” Policy 6-18a, Abuse Investigation, states: “Any allegation of sexual abuse that potentially involves criminal behavior shall immediately be turned over to the Caldwell Police Department for investigation, especially in all cases that may have happened within a time frame that allows for the collection of physical evidence, or if the allegation involves a staff member.” Policy 7-05, Policy 6-18, and Policy 6-18a require allegations of sexual abuse and sexual harassment to be referred for investigation to the appropriate investigative authority. Criminal sexual abuse allegations are referred to the Caldwell Police Department. Sexual harassment allegations involving staff, contractors, or volunteers are referred for administrative or criminal investigation to the Canyon County Prosecuting Attorney’s Office and/or Canyon

	County Human Resources Department. The facility operationalizes this requirement by separating criminal investigative responsibility from administrative investigative responsibility. Caldwell Police Department is responsible for criminal investigations. Trained SWIJDC investigators may conduct administrative investigations when the allegation does not involve potentially criminal behavior. The Specialty Contact Form identifies internal investigators as the PREA Coordinator, an Assistant Supervisor, and an Admissions Officer, and identifies the Caldwell Police Department as the external investigative agency. Documentation, interviews, and observations. Policy and investigative records separated criminal referral responsibility from administrative investigation responsibility. PAQ validation. The PAQ identifies Caldwell Police Department for potentially criminal allegations and trained facility investigators for administrative allegations. The Auditor finds the facility meets the requirements of this provision. 115.322(b) Policy and requirement. Policy 6-18, Abuse Reporting, states: “All allegations or reports of sexual harassment by staff, contractors or volunteers shall be handled with the same degree of urgency as reports of sexual abuse.” Policy 6-18 further states: “All allegations of sexual harassment by staff, contractors or volunteers shall be immediately reported to the Director, PREA Coordinator or PREA Investigator who shall refer the report for administrative or criminal investigation to the Canyon County Prosecuting Attorney’s Office and/or the Canyon County Human Resources Department.” Policy 6-18a, Abuse Investigation, states: “Allegations of sexual harassment shall be investigated administratively by SWIJDC investigators.” Policy 6-18 and Policy 6-18a require sexual harassment allegations to be investigated and require staff, contractor, or volunteer sexual harassment allegations to be referred for administrative or criminal investigation to appropriate authorities. The policy also requires juvenile-on-juvenile sexual harassment allegations to be investigated by the Director, PREA Coordinator, or trained SWIJDC investigators. The facility operationalizes this provision through trained internal administrative investigators and referral to external authorities when allegations involve criminal behavior or staff misconduct. Documentation, interviews, and observations. The investigation files demonstrated written findings, evidence review, interviews, credibility assessment, notification to individuals in confinement, and case closure. The July 27 allegation was immediately addressed and ultimately determined unfounded. PAQ validation. The PAQ identifies Caldwell Police Department for potentially criminal allegations and trained facility investigators for administrative allegations. The Auditor finds the facility meets the requirements of this provision. 115.322(c)

	Policy and requirement. Policy 6-18a, Abuse Investigation, states: “Staff at the SWIJDC shall cooperate in every way with any investigation.” Policy 6-18a further states: “SWIJDC shall endeavor to remain informed of the progress of the investigation.” Policy 7-05, PREA, states: “To the extent allowed by the investigating agency, the SWIJDC shall endeavor to remain informed of the progress and outcome of the investigation.” The facility’s policies require cooperation with investigations and require the facility to remain informed of investigation progress and outcomes to the extent permitted by the investigating agency. This supports continuity between referral, investigation, facility management, protection of individuals in confinement, and reporting obligations. The facility operationalizes this requirement by referring criminal allegations to Caldwell Police Department, conducting administrative investigations when appropriate, cooperating with external investigative authorities, and maintaining communication regarding investigation progress and outcomes. The Specialty Contact Form identifies Sgt. Aron Streibel of the Caldwell Police Department as the external investigative agency contact. Documentation, interviews, and observations. No allegation was screened out merely because it was anonymous, third-party, or later clarified. PAQ validation. The PAQ identifies Caldwell Police Department for potentially criminal allegations and trained facility investigators for administrative allegations. The Auditor finds the facility meets the requirements of this provision. 115.322(d) — DOJ-Designated Not Audited This provision is designated by DOJ as “Not Audited by the Auditor” and is excluded from compliance determinations. The Auditor did not request documentation, conduct interviews, or assess implementation for this subsection. Its exclusion does not affect the compliance determination for this standard. 115.322(e) Policy and requirement. (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. Training and Education Policy 7-05, PREA, Policy 6-18, Abuse Reporting, Policy 6- 18a, Abuse Investigation establish the facility process applicable to this requirement. Documentation, interviews, and observations. The investigation files demonstrated written findings, evidence review, interviews, credibility assessment, notification to individuals in confinement, and case closure. The July 27 allegation was immediately addressed and ultimately determined unfounded. PAQ validation. The PAQ identifies Caldwell Police Department for potentially criminal allegations and trained facility investigators for administrative allegations. The Auditor finds the facility meets the requirements of this provision. Auditor Analysis and Determination

	The facility has a written and operational referral framework, uses trained internal investigators for administrative matters, refers potentially criminal conduct to law enforcement, and documents investigation and notification outcomes. DOJ-designated provision 115.322(d) was not audited. The standard-level finding rests on convergence among policy requirements, current documentation, interviews and questionnaires, selected file review, and PAQ validation. Policy and investigative records separated criminal referral responsibility from administrative investigation responsibility. The investigation files demonstrated written findings, evidence review, interviews, credibility assessment, notification to individuals in confinement, and case closure. The July 27 allegation was immediately addressed and ultimately determined unfounded. Across 4 applicable provisions, the record established both the required controls and their operation in practice. The 1 DOJ-designated not-audited provision was excluded from the compliance determination and did not supply evidentiary support for the finding. The material source streams were reconciled at the provision level and collectively support the selected standard-level finding. That conclusion reflects demonstrated operation and corroboration, not the existence of policy language alone. The Auditor therefore determines that Standard 115.322, Investigation Referrals, Meets Standard. Standard Finding STANDARD FINDING: MEETS STANDARD

115.331	**Employee training**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	STANDARD 115.331 — EMPLOYEE TRAINING Evidence Reviewed Policy · Policy 7-05, PREA · Policy 1-05, Training Documentation · PREA Training 2022 · PREA Training Acknowledgement · Employee PREA training acknowledgement records

	· HRC Glossary of Terms · 2023 PREA Audit Final Report · Employee PREA curricula, including juvenile-specific training · Training acknowledgments and policy acknowledgments · Current employee roster · Medical, administrative, security, and investigator training records Interviews and Questionnaires · Twelve random staff interviews across shifts and roles · Supervisory and leadership questionnaires Observations and Functional Verification · Staff responses during informal onsite conversations File Review · Selected staff training packets PAQ Validation · The PAQ represents that all employees with contact with individuals in confinement receive juvenile-specific PREA training, refresher training or information, and documented acknowledgment. Provision Analysis 115.331(a) Policy and requirement. Policy 1-05, Training, states: “The SWIJDC shall also train all employees who may have contact with residents on: Zero-tolerance policy for sexual abuse and sexual harassment; How to fulfill the responsibilities of sexual abuse and sexual harassment prevention, detection, reporting, and response policies and procedures; Juveniles’ right to be free from sexual abuse and sexual harassment; The right of juveniles and employees to be free from retaliation for reporting sexual abuse and sexual harassment; The dynamics of sexual abuse and sexual harassment in juvenile facilities; The common reactions of juvenile victims of sexual abuse and sexual harassment; How to detect and respond to signs of threatened and actual sexual abuse and how to distinguish between consensual sexual contact and sexual abuse between residents; How to avoid inappropriate relationships with residents; How to comply with relevant laws related to mandatory reporting of sexual abuse to outside authorities; and Relevant laws regarding the applicable age of consent.” Policy 1-05 requires PREA training for all employees who may have contact with individuals in confinement and identifies the required training topics. The policy addresses zero tolerance, prevention, detection, reporting, response, rights of individuals in confinement, retaliation protection,

	dynamics of sexual abuse in juvenile facilities, victim reactions, signs of abuse, inappropriate relationships, mandatory reporting, and age-of-consent laws. The facility operationalizes this provision through PREA Training 2022 and signed PREA Training Acknowledgement forms. The acknowledgement form mirrors the required training topics and documents employee receipt and understanding of the training. The 2023 prior audit report documented that employee training records were reviewed and that staff training addressed the required PREA topics. Documentation, interviews, and observations. All 12 randomly selected staff demonstrated knowledge across the 13 interview domains, including zero tolerance, mandatory reporting, first response, retaliation, searches, accommodations, and reporting routes. PAQ validation. The PAQ represents that all employees with contact with individuals in confinement receive juvenile-specific PREA training, refresher training or information, and documented acknowledgment. The Auditor finds the facility meets the requirements of this provision. 115.331(a)(9) — DOJ-Designated Not Audited This provision is designated by DOJ as “Not Audited by the Auditor” and is excluded from compliance determinations. The Auditor did not request documentation, conduct interviews, or assess implementation for this subsection. Its exclusion does not affect the compliance determination for this standard. 115.331(b) Policy and requirement. Policy 1-05, Training, states: “Training curriculum shall be related to the needs of the facility and the juveniles served.” Policy 1-05 requires training curriculum to be facility-specific and related to the needs of the juvenile detention population. The PREA Training 2022 curriculum is specific to the Southwest Idaho Juvenile Detention Center and addresses juvenile detention operations, zero tolerance, rights of individuals in confinement, reporting, first responder duties, age of consent, inappropriate relationships, and communication with individuals in confinement. The facility operationalizes this provision by using a PREA training curriculum specifically designed for juvenile detention employees. The training materials address the facility’s population and operational risks, including the fact that individuals in confinement are juveniles and cannot consent to sexual activity in custody. Documentation, interviews, and observations. Training and interview evidence covered male and female individuals in confinement and the facility’s mixed-gender population. PAQ validation. The PAQ represents that all employees with contact with individuals in confinement receive juvenile-specific PREA training, refresher training or information, and documented acknowledgment. The Auditor finds the facility meets the requirements of this provision.

	115.331(c) Policy and requirement. Policy 1-05, Training, states: “Training records shall be maintained for each staff member. These records shall include but not be limited to: a. Staff members name. b. Date hired c. Annual training hours. d. Current, up to date list of all training completed.” Policy 1-05 requires staff training records to be maintained for each staff member. The policy identifies the information that must be retained, including the staff member’s name, hire date, annual training hours, and an up-to-date list of completed training. The facility operationalizes this provision through PREA training acknowledgements and staff training records. The training acknowledgement form documents that the employee attended PREA training and understood the required topics covered. Documentation, interviews, and observations. All 12 randomly selected staff demonstrated knowledge across the 13 interview domains, including zero tolerance, mandatory reporting, first response, retaliation, searches, accommodations, and reporting routes. PAQ validation. The PAQ represents that all employees with contact with individuals in confinement receive juvenile-specific PREA training, refresher training or information, and documented acknowledgment. The Auditor finds the facility meets the requirements of this provision. 115.331(d) Policy and requirement. Policy 1-05, Training requires training records to be maintained for each staff member and to include current training completed. The PREA Training Acknowledgement states: “I, (print name)_____ hereby acknowledge that I have attended the PREA Training presented on (_____) and that I understand the training I have received, which covered the following points.” The acknowledgement form then lists required PREA training topics, including zero tolerance, prevention, detection, reporting, response, rights of individuals in confinement, retaliation protection, dynamics of sexual abuse, victim reactions, detection, and response to signs of abuse, inappropriate relationships, mandatory reporting, and age-of-consent laws. The facility operationalizes this requirement by requiring employees to sign training acknowledgements documenting that they received and understood PREA training. The signed acknowledgement records provide written verification of training completion and employee understanding. Documentation, interviews, and observations. Training curricula addressed juvenile-facility dynamics, victim responses, signs of abuse, professional boundaries, mandatory reporting, and age-of-consent law; records documented completion and acknowledgment. PAQ validation. The PAQ represents that all employees with contact with individuals in confinement receive juvenile-specific PREA training, refresher training or information, and documented acknowledgment.

	The Auditor finds the facility meets the requirements of this provision. Auditor Analysis and Determination The facility's curriculum, acknowledgments, selected records, and unanimous random-staff interview results corroborate a current juvenile-specific training program. The DOJ-limited communication subtopic at 115.331(a)(9) was excluded from the compliance analysis. The standard-level finding rests on convergence among policy requirements, current documentation, interviews and questionnaires, direct observation and functional verification, selected file review, and PAQ validation. All 12 randomly selected staff demonstrated knowledge across the 13 interview domains, including zero tolerance, mandatory reporting, first response, retaliation, searches, accommodations, and reporting routes. Training curricula addressed juvenile-facility dynamics, victim responses, signs of abuse, professional boundaries, mandatory reporting, and age-of-consent law; records documented completion and acknowledgment. Across 4 applicable provisions, the record established both the required controls and their operation in practice. The 1 DOJ-designated not-audited provision was excluded from the compliance determination and did not supply evidentiary support for the finding. The material source streams were reconciled at the provision level and collectively support the selected standard-level finding. That conclusion reflects demonstrated operation and corroboration, not the existence of policy language alone. The Auditor therefore determines that Standard 115.331, Employee Training, Meets Standard. Standard Finding STANDARD FINDING: MEETS STANDARD

115.332	**Volunteer and contractor training**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	STANDARD 115.332 — VOLUNTEER AND CONTRACTOR TRAINING Evidence Reviewed Policy · Policy 7-05, PREA Documentation · PREA Tier 1 Training for Contractors and Volunteers

	· PREA Tier 2 Training for Non-Security Staff · Acknowledgement of Sexual Abuse and Sexual Harassment Policy for Contractors, Vendors, and Volunteers · Volunteers list · 2023 PREA Audit Final Report · PREA Tier 1 curriculum for contractors and volunteers · Volunteer and contractor acknowledgments · Volunteer questionnaires · Current and audit-period volunteer/contractor lists Interviews and Questionnaires · Volunteer questionnaires and facility follow-up File Review · Four volunteer packets PAQ Validation · The audit-period data collection identified four volunteers and no contractor; the current onsite roster identified three volunteers and one contractor. Provision Analysis 115.332(a) Policy and requirement. Policy 7-05, PREA, states: “The SWIJDC shall train all volunteers or contractors who have contact with residents on their responsibilities for sexual abuse and sexual harassment prevention, detection, and response policies and procedures.” Policy 7-05 further states: “All volunteers and contractors shall sign and document that they have received training on PREA and that they understand said training.” Policy 7-05 requires volunteers and contractors who have contact with individuals in confinement to receive training on their responsibilities for sexual abuse and sexual harassment prevention, detection, and response. It also requires documentation that they received and understood the training. The facility operationalizes this provision through the PREA Tier 1 Training for Contractors and Volunteers, PREA Tier 2 Training for Non-Security Staff, and the contractor/vendor/ volunteer acknowledgement form. The Tier 1 training explains that volunteers and contractors are mandated reporters, must recognize and report abuse, must maintain professional boundaries, and must report immediately without investigating. Documentation, interviews, and observations. Volunteer packets and questionnaires showed that volunteers were informed of zero tolerance, reporting duties, and how to report.

	PAQ validation. The audit-period data collection identified four volunteers and no contractor; the current onsite roster identified three volunteers and one contractor. The Auditor finds the facility meets the requirements of this provision. 115.332(b) Policy and requirement. Policy 7-05, PREA, states: “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.” Policy 7-05 further states: “Volunteers and contractors shall be evaluated, rated on a tiered system and given training based on the level of contact that they may have with residents.” Policy 7-05 requires volunteer and contractor training to be tiered based on the services provided and level of contact with individuals in confinement. It also requires all volunteers and contractors with contact with individuals in confinement to be notified of the zero-tolerance policy and told how to report incidents. The facility operationalizes this requirement through tiered training materials. PREA Tier 1 Training for Contractors and Volunteers addresses recognizing abuse, reporting responsibilities, disclosure response, professional boundaries, and reporting procedures. PREA Tier 2 Training for Non-Security Staff addresses broader monitoring, recognition, reporting, response, and professional boundaries. This data independently corroborates Policy 7-05 and the tiered training structure. Documentation, interviews, and observations. The Tier 1 curriculum was tailored to the level of contact with individuals in confinement, and facility records documented acknowledgment. PAQ validation. The audit-period data collection identified four volunteers and no contractor; the current onsite roster identified three volunteers and one contractor. The Auditor finds the facility meets the requirements of this provision. 115.332(c) Policy and requirement. Policy 7-05, PREA, states: “All volunteers and contractors shall sign and document that they have received training on PREA and that they understand said training.” The Acknowledgement of Sexual Abuse and Sexual Harassment Policy for Contractors, Vendors, and Volunteers states: “I acknowledge and understand the above information and my obligation to report any disclosure that could be made to me by a juvenile in the custody of the SWIJDC.” The acknowledgement also states: “I further acknowledge and understand the information presented in the ‘PREA Training for Contractors, Vendors, or Non-Security Staff’ PowerPoint.” Policy 7-05 and the acknowledgement form require written documentation that volunteers and contractors received and understood PREA training. This documentation verifies training completion and understanding of reporting obligations. The facility operationalizes this requirement through signed

	acknowledgement forms and maintenance of volunteer/contractor training documentation. The volunteer list identifies the current volunteer group, and the training materials and acknowledgement form document the content and receipt of training. Documentation, interviews, and observations. The current contractor classification was reconciled onsite and did not reveal an untrained person with contact with individuals in confinement. PAQ validation. The audit-period data collection identified four volunteers and no contractor; the current onsite roster identified three volunteers and one contractor. The Auditor finds the facility meets the requirements of this provision. Auditor Analysis and Determination Training content, acknowledgments, volunteer packets, questionnaires, and current roster reconciliation demonstrate that volunteers and contractors receive training appropriate to their duties and are informed of reporting obligations. The standard-level finding rests on convergence among policy requirements, current documentation, interviews and questionnaires, selected file review, and PAQ validation. Volunteer packets and questionnaires showed that volunteers were informed of zero tolerance, reporting duties, and how to report. The Tier 1 curriculum was tailored to the level of contact with individuals in confinement, and facility records documented acknowledgment. Across 3 applicable provisions, the record established both the required controls and their operation in practice. The material source streams were reconciled at the provision level and collectively support the selected standard-level finding. That conclusion reflects demonstrated operation and corroboration, not the existence of policy language alone. The Auditor therefore determines that Standard 115.332, Volunteer and Contractor Training, Meets Standard. Standard Finding STANDARD FINDING: MEETS STANDARD

115.333	**Resident education**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	STANDARD 115.333 — PREA EDUCATION FOR INDIVIDUALS IN CONFINEMENT Evidence Reviewed Policy

	· Policy 7-05, PREA · Policy 9-09, Orientation Documentation · SWIJDC PREA Intake Orientation · SWIJDC PREA Intake Orientation Revised · SWIJDC PREA Intake Orientation Revised Spanish · Sexual Assault Awareness brochure · 2025 PREA 10-Day Education records · 2026 PREA 10-Day Education Jan-May records · Policy 9-09, Orientation · Current 2026 English and Spanish orientation materials · Current 2026 English and Spanish PREA brochures · PREA Individual in confinement 10-Day Education curriculum and training guide · 2025 and 2026 10-day education participation records · Admission roster for June 2025–May 2026 Interviews and Questionnaires · Five random youth interviews · Five targeted youth interviews · Twelve random staff interviews · Intake/education specialty follow-up Observations and Functional Verification · Intake information, housing-unit materials, written reporting tools, posters, and the recurring Thursday education process File Review · Selected intake and comprehensive-education records PAQ Validation · The data collection reported 558 admissions. The admission roster contained 564 admission entries from June 2, 2025 through May 30, 2026; 338 entries were marked 72 hours or longer and 205 were marked 10 days or longer.

	Provision Analysis 115.333(a) Policy and requirement. Policy 9-09, Orientation, states: Policy 9-09 further states: “The juvenile shall sign a form documenting receipt of pamphlet and education.” Policy 9-09 requires individuals in confinement to receive PREA information during admission, including information about PREA, the facility’s zero-tolerance policy, and reporting methods. The policy also requires documentation of receipt of the pamphlet and education. The facility operationalizes this requirement through intake orientation materials, the Sexual Assault Awareness brochure, and documentation bearing the signature of the individual in confinement. The SWIJDC PREA Intake Orientation form informs individuals in confinement that the facility does not allow sexual abuse or sexual harassment, defines sexual abuse and sexual harassment, identifies reporting options, explains immediate reporting expectations, states that reports will be investigated, and identifies safety protections for victims and reporters. Documentation, interviews, and observations. Current English and Spanish intake materials were in use and ten interviewed youth understood zero tolerance and how to report. PAQ validation. The data collection reported 558 admissions. The admission roster contained 564 admission entries from June 2, 2025 through May 30, 2026; 338 entries were marked 72 hours or longer and 205 were marked 10 days or longer. The Auditor finds the facility meets the requirements of this provision. 115.333(b) Policy and requirement. Policy 9-09, Orientation, states: “Within 10 days of intake, normally, but not necessarily, on every Thursday, SWIJDC 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.” Policy 9- 09 further states: “Documentation of resident’s participation in follow up PREA Resident Education shall be kept by SWIJDC.” Policy 9-09 requires comprehensive, age-appropriate PREA education within 10 days of intake. The education must address rights of individuals in confinement to be free from sexual abuse, sexual harassment, and retaliation, and must explain agency policies and procedures for responding to such incidents. The facility operationalizes this requirement through 10-day PREA education sessions documented in 2025 and 2026 education records. These records show recurring PREA education sessions with documentation of participation by individuals in confinement. The intake and follow-up education process for individuals in confinement provides both immediate and more comprehensive PREA education. This data is significant because it quantifies the group of individuals in confinement most directly subject to the 10-day comprehensive education requirement.

	Documentation, interviews, and observations. Education records and coordinator verification established comprehensive education within 10 days, generally through recurring Thursday sessions. PAQ validation. The data collection reported 558 admissions. The admission roster contained 564 admission entries from June 2, 2025 through May 30, 2026; 338 entries were marked 72 hours or longer and 205 were marked 10 days or longer. The Auditor finds the facility meets the requirements of this provision. 115.333(c) Policy and requirement. Policy 9-09, Orientation, states: Policy 9-09 further states: “Within 10 days of intake, normally, but not necessarily, on every Thursday, SWIJDC 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.” Policy 9-09 requires both initial PREA education at admission and comprehensive follow-up education within 10 days of intake. The content includes rights of individuals in confinement, zero tolerance, reporting methods, retaliation protection, and facility response procedures. The facility operationalizes this requirement through the Sexual Assault Awareness brochure, English and Spanish PREA intake orientation forms, and 10-day PREA education sessions. The Sexual Assault Awareness brochure explains that sexual contact in detention is strictly prohibited, reports will be kept confidential by JDC staff, all allegations will be investigated, and individuals in confinement should report sexual assault immediately to staff, the Director, teacher, or medical staff. This data independently corroborates that education for individuals in confinement is tied to actual facility population and admissions activity. Documentation, interviews, and observations. Current materials and staff explanation were available in English and Spanish, with interpreter and individualized assistance for disability or comprehension needs. PAQ validation. The data collection reported 558 admissions. The admission roster contained 564 admission entries from June 2, 2025 through May 30, 2026; 338 entries were marked 72 hours or longer and 205 were marked 10 days or longer. The Auditor finds the facility meets the requirements of this provision. 115.333(d) Policy and requirement. Policy 9-09, Orientation, states: “If at any time, a literacy or language barrier is recognized, the detention center will make good faith efforts to ensure that the juvenile offender understands the material.” Policy 9- 09 further states: “Providing materials in formats or through methods that ensure effective, age-appropriate communication with residents with disabilities, including residents who have intellectual disabilities, or limited reading skills.” Policy 9-09 requires good faith efforts to ensure individuals in confinement understand orientation materials

	when literacy or language barriers are identified. It also requires effective, age-appropriate communication methods for individuals in confinement with disabilities or limited reading skills. The facility operationalizes this requirement through staff assistance during admission, availability of Spanish-language PREA Intake Orientation materials, interpreter resources, and age-appropriate education materials. The Spanish PREA Intake Orientation provides PREA definitions, reporting methods, investigation expectations, and safety assurances in Spanish. Documentation, interviews, and observations. Signed or otherwise documented intake and follow-up education records were retained; selected records were included in the file review. PAQ validation. The data collection reported 558 admissions. The admission roster contained 564 admission entries from June 2, 2025 through May 30, 2026; 338 entries were marked 72 hours or longer and 205 were marked 10 days or longer. The Auditor finds the facility meets the requirements of this provision. 115.333(e) Policy and requirement. Policy 9-09, Orientation, states: “The juvenile shall sign a form documenting receipt of pamphlet and education.” Policy 9-09 further states: “If the juvenile refuses to sign the form, the detention officer shall make a note of the date and time the form was provided to the juvenile and the juvenile refused to acknowledge receipt of pamphlet and education.” Policy 9-09 requires documentation of PREA education for individuals in confinement at intake and requires staff to document refusal if an individual in confinement declines to sign. The policy also requires documentation of participation in follow-up PREA education for individuals in confinement. The facility operationalizes this requirement through signed PREA intake orientation forms and 10-day education records documenting participation by individuals in confinement. The 2025 and 2026 PREA 10-Day Education records provide ongoing documentation that individuals in confinement participated in comprehensive PREA education after intake. Documentation, interviews, and observations. Written information remained available through brochures, orientation materials, posters, and materials youth could retain in their rooms. PAQ validation. The data collection reported 558 admissions. The admission roster contained 564 admission entries from June 2, 2025 through May 30, 2026; 338 entries were marked 72 hours or longer and 205 were marked 10 days or longer. The Auditor finds the facility meets the requirements of this provision. 115.333(f) Policy and requirement. Policy 9-09, Orientation, requires individuals in confinement to receive PREA education at admission and comprehensive follow-up education within 10 days. The facility also uses written materials, including the Sexual Assault Awareness brochure and PREA Intake Orientation forms, to communicate PREA

	information. The facility operationalizes this provision by providing PREA information in written form and through structured education. The Sexual Assault Awareness brochure explains reporting options, the prohibition against sexual contact in detention, preservation of evidence, medical attention, confidentiality, investigation of allegations, and consequences for sexual abuse. The PREA intake orientation forms summarize zero tolerance, definitions of sexual abuse and sexual harassment, reporting methods, suggestion box reporting, immediate reporting expectations, investigation of allegations, retaliation protections, and safety assurances. Documentation, interviews, and observations. The data-collection form reported 558 admissions while the roster contained 564 entries; the variance did not affect findings because records and youth understanding were independently verified. PAQ validation. The data collection reported 558 admissions. The admission roster contained 564 admission entries from June 2, 2025 through May 30, 2026; 338 entries were marked 72 hours or longer and 205 were marked 10 days or longer. The Auditor finds the facility meets the requirements of this provision. Auditor Analysis and Determination Standard 115.333 was evaluated as a continuous education process rather than as a single admission handout. The applicable provisions require immediate, age-appropriate PREA information at intake; comprehensive education within 10 days; accommodations for language, literacy, disability, and comprehension needs; documentation of participation or refusal; and continuing access to written information. Current English and Spanish orientation materials and brochures, the PREA 10-day curriculum and training guide, recurring 2025 and 2026 participation records, selected intake and comprehensive-education records, and onsite observation addressed each of those functions. Implementation was independently corroborated rather than inferred from policy or the PAQ. All five random and all five targeted individuals in confinement could explain zero tolerance, more than one reporting method, outside support, confidentiality limits, protection from retaliation, and protection for good-faith reporting. Staff responsible for intake and follow-up education described the same sequence, timing, accommodations, and documentation practice. Current materials corrected earlier wording concerns before onsite verification and remained available in housing areas and rooms. The 558 admissions reported in data collection and the 564 roster entries were treated as a disclosed source variance, not as proof that education occurred. Selected records, direct observation, staff interviews, and demonstrated understanding supplied the operative evidence and independently confirmed timely intake education, comprehensive education, accessible delivery, documented participation, and continuing access to information. The source variance was therefore reconciled without weakening the implementation finding. The Auditor determines that the totality of evidence establishes compliance with every applicable provision of Standard 115.333, PREA Education for Individuals in Confinement, and supports a finding of Meets Standard.

	Standard Finding STANDARD FINDING MEETS STANDARD

115.334	Specialized training: Investigations
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	STANDARD 115.334 — INVESTIGATOR TRAINING Evidence Reviewed Policy · Policy 7-05, PREA · Policy 6-18a, Abuse Investigation Documentation · Facility investigator specialized PREA training certificate · Specialty Contact Form – Juvenile Facilities · Abuse-investigation policy · Investigator training certificates for facility investigators · PREA investigator training curriculum · Administrative investigation files Interviews and Questionnaires · Investigative Staff Questionnaire and onsite investigator follow-up File Review · Current PREA investigation files PAQ Validation · The PAQ identifies trained facility administrative investigators and Caldwell Police Department for potentially criminal allegations. Provision Analysis 115.334(a) Policy and requirement. Policy 7-05, PREA, states: “Administrative investigations into allegations of sexual abuse and sexual harassment shall be conducted by

	investigators who have received specialized training in conducting sexual abuse investigations in confinement settings." Policy 6-18a, Abuse Investigation, states: "Investigators assigned to conduct PREA investigations shall receive specialized training regarding sexual abuse investigations in confinement settings." The policy requires investigators conducting PREA-related investigations to receive specialized training specific to confinement settings. This training requirement ensures investigators understand the dynamics of sexual abuse, evidence collection, interviewing techniques, credibility assessments, and reporting requirements applicable to detention environments. The facility operationalizes this requirement through specialized investigator training. Documentation reviewed includes investigator training certificates for the facility investigators demonstrating successful completion of PREA investigative training programs addressing sexual abuse investigations in confinement settings. Documentation, interviews, and observations. Training records documented specialized instruction in juvenile sexual-abuse investigations. PAQ validation. The PAQ identifies trained facility administrative investigators and Caldwell Police Department for potentially criminal allegations. The Auditor finds the facility meets the requirements of this provision. 115.334(b) Policy and requirement. Policy 6-18a, Abuse Investigation, states: "Investigators assigned to conduct sexual abuse investigations shall receive training regarding interviewing sexual abuse victims, proper use of Miranda and Garrity warnings, sexual abuse evidence collection in confinement settings, and criteria and evidence required to substantiate a case for administrative action or prosecution referral." The policy identifies specialized training topics including victim interviewing, legal warnings, evidence collection, and evidentiary standards necessary for administrative and criminal investigative referrals. The facility operationalizes this requirement through investigator training programs. The the facility investigators certificates document coursework covering victim interviewing, trauma response, evidence collection, report writing, legal issues, and investigative practices specific to confinement settings. Documentation, interviews, and observations. Investigation files reflected evidence preservation, interviewing, credibility analysis, written findings, and notification to individuals in confinement. PAQ validation. The PAQ identifies trained facility administrative investigators and Caldwell Police Department for potentially criminal allegations. The Auditor finds the facility meets the requirements of this provision. 115.334(c) Policy and requirement. Policy 6-18a, Abuse Investigation, states: "Documentation of investigator training shall be maintained." The policy requires retention of

	investigator training documentation. Training records provide evidence that assigned investigators have completed the specialized training required by PREA. The facility operationalizes this provision by maintaining investigator training certificates and identifying trained investigators through facility documentation. Training certificates reviewed document successful completion of specialized PREA investigative training. Documentation, interviews, and observations. The designated investigator described the required evidentiary and documentation practices and understood when law-enforcement referral was required. PAQ validation. The PAQ identifies trained facility administrative investigators and Caldwell Police Department for potentially criminal allegations. The Auditor finds the facility meets the requirements of this provision. 115.334(d) Policy and requirement. (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. Policy 7-05, PREA, Policy 6-18a, Abuse Investigation establish the facility process applicable to this requirement. Documentation, interviews, and observations. Training records documented specialized instruction in juvenile sexual-abuse investigations. PAQ validation. The PAQ identifies trained facility administrative investigators and Caldwell Police Department for potentially criminal allegations. The Auditor finds the facility meets the requirements of this provision. Auditor Analysis and Determination Specialized training records, investigator responses, and completed files demonstrate that facility investigators possess the subject-specific training required for juvenile PREA investigations. The standard-level finding rests on convergence among policy requirements, current documentation, interviews and questionnaires, selected file review, and PAQ validation. Training records documented specialized instruction in juvenile sexual-abuse investigations. Investigation files reflected evidence preservation, interviewing, credibility analysis, written findings, and notification to individuals in confinement. Across 4 applicable provisions, the record established both the required controls and their operation in practice. The material source streams were reconciled at the provision level and collectively support the selected standard-level finding. That conclusion reflects demonstrated operation and corroboration, not the existence of policy language alone. The Auditor therefore determines that Standard 115.334, Investigator Training, Meets Standard.

	Standard Finding STANDARD FINDING MEETS STANDARD

115.335	Specialized training: Medical and mental health care
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	STANDARD 115.335 — MEDICAL AND MENTAL HEALTH TRAINING Evidence Reviewed Policy · Policy 7-05, PREA Documentation · Medical and Mental Health PREA Training Acknowledgements · Licensed clinical social worker credential · Specialty Contact Form – Juvenile Facilities · Medical and mental health policies · Medical practitioner PREA acknowledgment · Medical Staff Questionnaire · Medical and mental-health role-specific training records Interviews and Questionnaires · Medical/mental-health specialty follow-up Observations and Functional Verification · Access to private medical and mental-health services PAQ Validation · The PAQ identifies designated medical and mental-health practitioners and represents completion of role-specific PREA training. Provision Analysis 115.335(a)

	Policy and requirement. Policy 7-05, PREA, states: “Medical and mental health care practitioners who work regularly in the facility shall receive specialized training related to sexual abuse and sexual harassment.” The policy requires medical and mental health practitioners to receive training specific to sexual abuse and sexual harassment issues encountered in confinement settings. The facility operationalizes this requirement through specialized PREA training acknowledgements completed by medical and mental health practitioners. Documentation reviewed demonstrates that practitioners received training addressing victim identification, evidence preservation, mandatory reporting requirements, and treatment considerations. Documentation, interviews, and observations. The medical practitioner confirmed knowledge of detection, response, evidence preservation, reporting, confidentiality, emergency referral, and no-cost care. PAQ validation. The PAQ identifies designated medical and mental-health practitioners and represents completion of role-specific PREA training. The Auditor finds the facility meets the requirements of this provision. 115.335(b) Policy and requirement. Policy 7-05, PREA, states: “Medical and mental health practitioners shall be trained in how to detect and assess signs of sexual abuse and sexual harassment, how to preserve physical evidence, how to respond effectively and professionally to victims, and how and to whom to report allegations.” The policy identifies the specialized subject matter required for medical and mental health personnel. These topics directly support victim identification, response, referral, and evidence preservation responsibilities. The facility operationalizes this provision through specialized training and use of qualified professionals. Documentation reviewed includes medical and mental health training acknowledgements and the professional licensure of the designated licensed clinical social worker as a Licensed Clinical Social Worker. Documentation, interviews, and observations. Training acknowledgments and policy records documented the required role-specific instruction. PAQ validation. The PAQ identifies designated medical and mental-health practitioners and represents completion of role-specific PREA training. The Auditor finds the facility meets the requirements of this provision. 115.335(c) Policy and requirement. Policy 7-05, PREA, states: “Documentation of specialized medical and mental health training shall be maintained.” The policy requires retention of documentation demonstrating completion of specialized PREA training by medical and mental health practitioners. The facility operationalizes this requirement through training acknowledgements and personnel records documenting completion of specialized training.

	Documentation, interviews, and observations. Medical and mental-health staff described immediate reporting within professional confidentiality limits. PAQ validation. The PAQ identifies designated medical and mental-health practitioners and represents completion of role-specific PREA training. The Auditor finds the facility meets the requirements of this provision. 115.335(d) Policy and requirement. (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 37226 Federal Register / Vol. 77, No. 119 / Wednesday, June 20, 2012 / Rules and Regulations upon the practitioner’s status at the agency. Screening for Risk of Sexual Victimization and Abusiveness Policy 7-05, PREA establish the facility process applicable to this requirement. Documentation, interviews, and observations. The medical practitioner confirmed knowledge of detection, response, evidence preservation, reporting, confidentiality, emergency referral, and no-cost care. PAQ validation. The PAQ identifies designated medical and mental-health practitioners and represents completion of role-specific PREA training. The Auditor finds the facility meets the requirements of this provision. Auditor Analysis and Determination The role-specific curriculum, acknowledgments, practitioner questionnaire, and onsite follow-up corroborate specialized training for medical and mental-health personnel. The standard-level finding rests on convergence among policy requirements, current documentation, interviews and questionnaires, direct observation and functional verification, and PAQ validation. The medical practitioner confirmed knowledge of detection, response, evidence preservation, reporting, confidentiality, emergency referral, and no-cost care. Training acknowledgments and policy records documented the required role-specific instruction. Across 4 applicable provisions, the record established both the required controls and their operation in practice. The material source streams were reconciled at the provision level and collectively support the selected standard-level finding. That conclusion reflects demonstrated operation and corroboration, not the existence of policy language alone. The Auditor therefore determines that Standard 115.335, Medical and Mental Health Training, Meets Standard. Standard Finding STANDARD FINDING: MEETS STANDARD

115.341	Obtaining information from residents
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	STANDARD 115.341 — SCREENING FOR RISK Evidence Reviewed Policy · Policy 7-05, PREA · Policy 9-07 Classification Documentation · Vulnerability Assessment 2025 · Specialty Contact Form · Policy 9-07, Classification and Housing · Vulnerability Assessment instrument · Screening and reassessment compilations · Assessment referral/review log · Housing-decision guidance Interviews and Questionnaires · Targeted youth interviews involving prior victimization, cognitive disability, and LGB status · Intake/classification specialty follow-up · Random staff interviews Observations and Functional Verification · Private screening location, record access controls, and referral process File Review · Selected screening, reassessment, referral, and placement records PAQ Validation · The PAQ represents that objective screening occurs within 72 hours and is repeated when new information or changed circumstances arise. Onsite population data identified five individuals in confinement with prior victimization histories, six with cognitive/functional disabilities, and three who identified as lesbian, gay, or

	bisexual. Provision Analysis 115.341(a) Policy and requirement. Policy 9-07, Classification, states: “All residents shall be assessed during intake and classification for risk of sexual victimization and risk of sexually aggressive behavior.” The policy requires screening of all individuals in confinement during intake and classification. The screening process is intended to identify individuals in confinement who may be vulnerable to victimization or who may present a risk of sexually aggressive behavior. The facility operationalizes this requirement through completion of the Vulnerability Assessment during the admission process. The assessment evaluates factors related to vulnerability and potential aggressiveness and assists staff in making housing, supervision, and programming decisions. Documentation, interviews, and observations. Screening occurred during intake and periodic reassessment records were available; selected records and private-process observation confirmed implementation. PAQ validation. The PAQ represents that objective screening occurs within 72 hours and is repeated when new information or changed circumstances arise. Onsite population data identified five individuals in confinement with prior victimization histories, six with cognitive/functional disabilities, and three who identified as lesbian, gay, or bisexual. The Auditor finds the facility meets the requirements of this provision. 115.341(b) Policy and requirement. Policy 9-07, Classification, states: “The assessment shall consider all information obtained during intake and classification relevant to risk of sexual victimization or abusiveness.” The policy requires staff to consider information obtained through interviews, records review, observations, and other available sources when conducting the assessment. The facility operationalizes this provision through use of the Vulnerability Assessment process and review of available information about individuals in confinement at intake. Documentation, interviews, and observations. The facility used a structured Vulnerability Assessment rather than unstructured impressions alone. PAQ validation. The PAQ represents that objective screening occurs within 72 hours and is repeated when new information or changed circumstances arise. Onsite population data identified five individuals in confinement with prior victimization histories, six with cognitive/functional disabilities, and three who identified as lesbian, gay, or bisexual. The Auditor finds the facility meets the requirements of this provision.

	115.341(c) Policy and requirement. Policy 9-07 requires consideration of factors associated with vulnerability and aggressiveness when conducting the assessment. The Vulnerability Assessment provides a structured method for evaluating these factors and documenting results. The facility operationalizes this requirement through completion of the assessment at intake and review of identified risk factors. Documentation, interviews, and observations. The assessment captured the applicable risk factors in paragraph (c), excluding DOJ-limited subparagraph (c)(2) from audit analysis. PAQ validation. The PAQ represents that objective screening occurs within 72 hours and is repeated when new information or changed circumstances arise. Onsite population data identified five individuals in confinement with prior victimization histories, six with cognitive/functional disabilities, and three who identified as lesbian, gay, or bisexual. The Auditor finds the facility meets the requirements of this provision. 115.341(d) Policy and requirement. Policy 9-07 requires assessments to be completed promptly during the intake and classification process. The facility operationalizes this requirement by incorporating the Vulnerability Assessment into admission procedures for individuals in confinement. Documentation, interviews, and observations. Staff used conversation with an individual in confinement, screening, court and case information, behavioral records, and medical/mental-health information as appropriate. PAQ validation. The PAQ represents that objective screening occurs within 72 hours and is repeated when new information or changed circumstances arise. Onsite population data identified five individuals in confinement with prior victimization histories, six with cognitive/functional disabilities, and three who identified as lesbian, gay, or bisexual. The Auditor finds the facility meets the requirements of this provision. 115.341(c)(2) — DOJ-Designated Not Audited This provision is designated by DOJ as “Not Audited by the Auditor” and is excluded from compliance determinations. The Auditor did not request documentation, conduct interviews, or assess implementation for this subsection. Its exclusion does not affect the compliance determination for this standard. 115.341(e) Policy and requirement. Policy 9-07 requires reassessment when additional information becomes available that may affect classification, housing, or supervision decisions. The facility operationalizes this provision through ongoing review of information about individuals in confinement and reassessment when warranted.

	Documentation, interviews, and observations. Sensitive screening information was restricted to legitimate treatment, safety, classification, and management use. PAQ validation. The PAQ represents that objective screening occurs within 72 hours and is repeated when new information or changed circumstances arise. Onsite population data identified five individuals in confinement with prior victimization histories, six with cognitive/functional disabilities, and three who identified as lesbian, gay, or bisexual. The Auditor finds the facility meets the requirements of this provision. Auditor Analysis and Determination Objective screening records, referral documentation, private-process observation, targeted interviews, and staff explanations corroborate timely collection and controlled use of risk information. Subparagraph 115.341(c)(2) was excluded under the current DOJ limitation while the remainder of paragraph (c) was assessed. The standard-level finding rests on convergence among policy requirements, current documentation, interviews and questionnaires, direct observation and functional verification, selected file review, and PAQ validation. Selected records and onsite verification showed use of an objective Vulnerability Assessment during intake, periodic reassessment, and referral when qualifying disclosures were identified. Targeted youth confirmed the screening conversation was private and that follow-up or support was offered when risk information was disclosed. Across 5 applicable provisions, the record established both the required controls and their operation in practice. The 1 DOJ-designated not-audited provision was excluded from the compliance determination and did not supply evidentiary support for the finding. The material source streams were reconciled at the provision level and collectively support the selected standard-level finding. That conclusion reflects demonstrated operation and corroboration, not the existence of policy language alone. The Auditor therefore determines that Standard 115.341, Screening for Risk, Meets Standard. Standard Finding STANDARD FINDING: MEETS STANDARD

115.342	**Placement of residents**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	STANDARD 115.342 — PLACEMENT AND HOUSING

	Evidence Reviewed Policy · Policy 7-05, PREA · Policy 9-07 Classification Documentation · Vulnerability Assessment 2025 · Policy 9-07, Classification and Housing · Using the Vulnerability Assessment for Housing Decisions guidance · Selected screening, reassessment, referral, and housing records Interviews and Questionnaires · Targeted youth interviews · Classification and supervisory follow-up Observations and Functional Verification · Single-occupancy sleeping rooms, housing arrangements, programming access, and absence of punitive protective isolation File Review · Selected placement records PAQ Validation · The PAQ represents that screening information informs individualized housing, supervision, education, and programming decisions and that isolation for protection is a last resort. Provision Analysis 115.342(a) Policy and requirement. Policy 9-07, Classification, states: “Information obtained through screening shall be used to make housing, bed assignment, supervision, and program decisions with the goal of protecting residents from sexual abuse.” The policy requires screening results to guide decisions affecting safety of individuals in confinement. The facility operationalizes this requirement through the Vulnerability Assessment process and classification review. Information obtained during screening is used to identify protective measures and supervision needs. Documentation, interviews, and observations. Screening and other current information informed individualized housing, supervision, education, and programming decisions.

	PAQ validation. The PAQ represents that screening information informs individualized housing, supervision, education, and programming decisions and that isolation for protection is a last resort. The Auditor finds the facility meets the requirements of this provision. 115.342(b) Policy and requirement. Policy 9-07 requires staff to consider individual circumstances of the person in confinement when making housing and supervision decisions. The facility operationalizes this provision through individualized classification reviews and use of screening information. Documentation, interviews, and observations. No individual in confinement was isolated because of victimization risk; single rooms and supervision adjustments provided less restrictive safety alternatives. PAQ validation. The PAQ represents that screening information informs individualized housing, supervision, education, and programming decisions and that isolation for protection is a last resort. The Auditor finds the facility meets the requirements of this provision. 115.342(c) — DOJ-Designated Not Audited This provision is designated by DOJ as “Not Audited by the Auditor” and is excluded from compliance determinations. The Auditor did not request documentation, conduct interviews, or assess implementation for this subsection. Its exclusion does not affect the compliance determination for this standard. 115.342(d) — DOJ-Designated Not Audited This provision is designated by DOJ as “Not Audited by the Auditor” and is excluded from compliance determinations. The Auditor did not request documentation, conduct interviews, or assess implementation for this subsection. Its exclusion does not affect the compliance determination for this standard. 115.342(e) — DOJ-Designated Not Audited This provision is designated by DOJ as “Not Audited by the Auditor” and is excluded from compliance determinations. The Auditor did not request documentation, conduct interviews, or assess implementation for this subsection. Its exclusion does not affect the compliance determination for this standard. 115.342(f) — DOJ-Designated Not Audited This provision is designated by DOJ as “Not Audited by the Auditor” and is excluded from compliance determinations. The Auditor did not request documentation, conduct interviews, or assess implementation for this subsection. Its exclusion does not affect the compliance determination for this standard. 115.342(g) — DOJ-Designated Not Audited This provision is designated by DOJ as “Not Audited by the Auditor” and is excluded from compliance determinations. The Auditor did not request documentation, conduct interviews, or assess implementation for this subsection. Its exclusion does not affect the compliance determination for this standard. 115.342(h) Policy and requirement. (h) If an individual in confinement is isolated pursuant to paragraph (b) of this section, the facility shall clearly document: (1) The basis for

	the facility’s concern for the safety of the individual in confinement; and (2) The reason why no alternative means of separation can be arranged. Policy 7-05, PREA, Policy 9-07 Classification establish the facility process applicable to this requirement. Documentation, interviews, and observations. No paragraph (b) isolation placement occurred. Policy and staff responses required written documentation of the safety basis and why no alternative was available if one occurred. PAQ validation. The PAQ represents that screening information informs individualized housing, supervision, education, and programming decisions and that isolation for protection is a last resort. The Auditor finds the facility meets the requirements of this provision. 115.342(i) Policy and requirement. (i) Every 30 days, the facility shall afford each individual in confinement described in paragraph (h) of this section a review to determine whether there is a continuing need for separation from the general population. Policy 7-05, PREA, Policy 9-07 Classification establish the facility process applicable to this requirement. Documentation, interviews, and observations. No paragraph (h) placement required a 30-day review; the conditional review requirement was established in the facility’s process. PAQ validation. The PAQ represents that screening information informs individualized housing, supervision, education, and programming decisions and that isolation for protection is a last resort. The Auditor finds the facility meets the requirements of this provision. Auditor Analysis and Determination Screening information was connected to individualized placement and safety planning. Direct observation and targeted interviews showed use of single rooms, supervision, and support rather than automatic or punitive isolation. DOJ-limited paragraphs were excluded; the applicable isolation-documentation and review provisions were evaluated as conditional requirements. The standard-level finding rests on convergence among policy requirements, current documentation, interviews and questionnaires, direct observation and functional verification, selected file review, and PAQ validation. The facility primarily used single-occupancy rooms and individualized supervision rather than protective isolation. No individual in confinement was in segregated housing because of victimization risk on the audit date. Targeted youth reported that safety concerns prompted monitoring, support, or placement action rather than punishment or loss of programming. Across 4 applicable provisions, the record established both the required controls and their operation in practice. The 5 DOJ-designated not-audited provisions were excluded from the compliance determination and did not supply evidentiary support for the

	finding. The material source streams were reconciled at the provision level and collectively support the selected standard-level finding. That conclusion reflects demonstrated operation and corroboration, not the existence of policy language alone. The Auditor therefore determines that Standard 115.342, Placement and Housing, Meets Standard. Standard Finding STANDARD FINDING MEETS STANDARD

115.351	**Resident reporting**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	STANDARD 115.351 — REPORTING Evidence Reviewed Policy · Policy 7-05, PREA · Policy 6-18, Abuse Reporting Documentation · PREA Intake Orientation · PREA Intake Orientation Spanish · Sexual Assault Awareness Brochure · AAFV Memorandum of Understanding · Policy 7-05, PREA · Policy 7-03, Grievances · Current English and Spanish orientation and brochure materials · Current facility webpage capture · AAFV agreement and ROSE Advocates access information · Grievance submitted by an individual in confinement/reporting forms

	Interviews and Questionnaires · Five random and five targeted youth interviews · Twelve random staff interviews · Provider and facility specialty follow-up Observations and Functional Verification · Live test of the external reporting route · Private, free, unrecorded telephone access · Grievance/suggestion boxes, written reporting tools, posters, and third-party options File Review · July 27, 2026 grievance and response file PAQ Validation · The PAQ identifies verbal, written, private, anonymous, third-party, and external reporting options and requires staff to accept and immediately document any report. Provision Analysis 115.351(a) Policy and requirement. Policy 6-18, Abuse Reporting, states: “Residents may report sexual abuse, sexual harassment, retaliation, or staff neglect and violations of responsibilities that may have contributed to such incidents through verbal reports, written reports, grievances, request forms, suggestion boxes, or reports to any staff member.” The policy provides multiple reporting methods and allows reports to be made through various channels. The policy also permits individuals in confinement to report directly to any staff member. The facility operationalizes this requirement through education for individuals in confinement, reporting forms, suggestion boxes, verbal reporting, written reporting, and grievance procedures. The PREA Intake Orientation informs individuals in confinement how and where reports may be made. Documentation, interviews, and observations. Internal reporting routes included staff, written forms, boxes, medical and mental-health staff, educators, administrators, and private telephone access. PAQ validation. The PAQ identifies verbal, written, private, anonymous, third-party, and external reporting options and requires staff to accept and immediately document any report. The Auditor finds the facility meets the requirements of this provision. 115.351(b)

	Policy and requirement. Policy 6-18 provides individuals in confinement with access to external reporting avenues and requires staff to accept reports regardless of the reporting method used. The facility operationalizes this provision through the AAFV Memorandum of Understanding, education for materials for individuals in confinement, and reporting instructions contained in the PREA Intake Orientation and Sexual Assault Awareness Brochure. Documentation, interviews, and observations. The external reporting route was live-tested and usable, and youth could make a free, private, unrecorded call without a PIN. PAQ validation. The PAQ identifies verbal, written, private, anonymous, third-party, and external reporting options and requires staff to accept and immediately document any report. The Auditor finds the facility meets the requirements of this provision. 115.351(c) Policy and requirement. Policy 6-18 requires staff to accept reports made verbally, in writing, anonymously, and through third parties. The facility operationalizes this requirement through staff training, reporting procedures, and education for individuals in confinement. Staff are instructed to immediately document and report allegations regardless of how they are received. ::: Documentation, interviews, and observations. Staff and youth confirmed that reports could be verbal, written, anonymous, or third-party. PAQ validation. The PAQ identifies verbal, written, private, anonymous, third-party, and external reporting options and requires staff to accept and immediately document any report. The Auditor finds the facility meets the requirements of this provision. 115.351(d) Policy and requirement. (d) The facility shall provide individuals in confinement with access to tools necessary to make a written report. Policy 7-05, PREA, Policy 6-18, Abuse Reporting establish the facility process applicable to this requirement. Documentation, interviews, and observations. Staff had private avenues to report outside the immediate chain when necessary. PAQ validation. The PAQ identifies verbal, written, private, anonymous, third-party, and external reporting options and requires staff to accept and immediately document any report. The Auditor finds the facility meets the requirements of this provision. 115.351(e)

	Policy and requirement. (e) The agency shall provide a method for staff to privately report sexual abuse and sexual harassment of individuals in confinement. Policy 7-05, PREA, Policy 6-18, Abuse Reporting establish the facility process applicable to this requirement. Documentation, interviews, and observations. All 12 random staff understood that any report must be accepted, documented, and immediately forwarded. PAQ validation. The PAQ identifies verbal, written, private, anonymous, third-party, and external reporting options and requires staff to accept and immediately document any report. The Auditor finds the facility meets the requirements of this provision. Auditor Analysis and Determination Standard 115.351 was evaluated for practical access rather than accepted from written policy alone. The applicable provisions require multiple internal reporting methods, at least one outside reporting method, private and anonymous options, verbal and written reporting, third-party assistance, access for staff, and a staff response that accepts and immediately documents every report. Policy 7-05, Policy 7-03, current English and Spanish education materials, the facility webpage, reporting forms, outside-provider information, and the July 27 grievance file established the required framework and demonstrated actual use of that framework. Operational evidence confirmed that the reporting methods were usable. The outside route was live-tested; the call was free, private, unrecorded, and available without a PIN. The site review confirmed written forms, secure boxes, telephone access, posted instructions, and routes through medical, mental-health, education, legal, and administrative personnel. All ten interviewed individuals in confinement identified more than one reporting option. All 12 randomly selected staff understood that verbal, written, anonymous, and third-party reports must be accepted, protected, documented, and forwarded without screening. Current webpage and education language resolved the earlier ambiguity concerning good-faith and knowingly false reports before onsite verification. The policy framework, direct observation, functional testing, actual grievance handling, and consistent staff and individual interview evidence converge on accessible internal, outside, private, anonymous, verbal, written, and third-party reporting. The evidence also demonstrates that staff understood and implemented the immediate documentation and forwarding duty. The Auditor determines that the totality of evidence establishes compliance with every applicable provision of Standard 115.351, Reporting, and supports a finding of Meets Standard. Standard Finding STANDARD FINDING: MEETS STANDARD

115.352	**Exhaustion of administrative remedies**

	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	STANDARD 115.352 — PREA GRIEVANCES Evidence Reviewed Policy · Policy 7-03, Grievance Procedure · Policy 7-05, PREA · Sexual Abuse/Sexual Harassment Grievance Form Documentation · Policy 7-03, Grievances · Juvenile Grievance Form · Policy 7-05, PREA · Current orientation for individuals in confinement and brochure materials · Completed PREA grievance records Interviews and Questionnaires · Random and targeted youth interviews · Random staff interviews Observations and Functional Verification · Accessible grievance forms and secure submission boxes File Review · July 27, 2026 grievance and investigation file PAQ Validation · The PAQ represents that PREA grievances may be submitted without informal-resolution prerequisites, without a filing time limit, and with emergency handling and third-party assistance. Provision Analysis 115.352(a) Policy and requirement. Policy 7-03, Grievance Procedure, states: “Residents may submit a grievance alleging sexual abuse at any time regardless of when the incident is alleged to have occurred.” Policy 7-03 establishes a grievance process for

	allegations of sexual abuse and removes time limitations that might otherwise prevent reporting. The facility operationalizes this provision through the Sexual Abuse/Sexual Harassment Grievance Form, education for materials for individuals in confinement, and grievance procedures available to individuals in confinement throughout confinement. Documentation, interviews, and observations. The grievance policy allowed an individual in confinement to submit a PREA grievance without first using an informal process or submitting to the staff member who was the subject of the complaint. PAQ validation. The PAQ represents that PREA grievances may be submitted without informal-resolution prerequisites, without a filing time limit, and with emergency handling and third-party assistance. The Auditor finds the facility meets the requirements of this provision. 115.352(b) Policy and requirement. Policy 7-03 states: “Residents are not required to use any informal grievance process, or otherwise attempt to resolve with staff, an alleged incident of sexual abuse.” The policy expressly removes any requirement that individuals in confinement attempt informal resolution before filing a PREA grievance. The facility operationalizes this provision by allowing individuals in confinement to submit PREA grievances directly and by educating individuals in confinement regarding reporting options during intake orientation and PREA education. Documentation, interviews, and observations. The grievance process did not impose a filing time limit on an allegation of sexual abuse. PAQ validation. The PAQ represents that PREA grievances may be submitted without informal-resolution prerequisites, without a filing time limit, and with emergency handling and third-party assistance. The Auditor finds the facility meets the requirements of this provision. 115.352(c) Policy and requirement. Policy 7-03 states: “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.” The policy permits third-party assistance and third-party filing of grievances relating to allegations of sexual abuse. The facility operationalizes this requirement through education for materials for individuals in confinement, grievance forms, and victim advocacy resources available through Advocates Against Family Violence. Documentation, interviews, and observations. The process provided prompt decisions and permitted an extension only with required notice.

	PAQ validation. The PAQ represents that PREA grievances may be submitted without informal-resolution prerequisites, without a filing time limit, and with emergency handling and third-party assistance. The Auditor finds the facility meets the requirements of this provision. 115.352(d) Policy and requirement. Policy 7-03 states: “The facility 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.” The policy establishes response timelines for PREA-related grievances and requires timely review and resolution. The facility operationalizes this requirement through the grievance review process and administrative oversight procedures. This metric is significant because it demonstrates no PREA grievance response timelines were triggered during the audit period; however, the policy remains in place to ensure compliance when grievances occur. Documentation, interviews, and observations. Third parties could assist or file on behalf of an individual in confinement, subject to the ability of the individual in confinement to decline processing when appropriate. PAQ validation. The PAQ represents that PREA grievances may be submitted without informal-resolution prerequisites, without a filing time limit, and with emergency handling and third-party assistance. The Auditor finds the facility meets the requirements of this provision. 115.352(e) Policy and requirement. Policy 7-03 states: “Residents may submit emergency grievances alleging that a resident is subject to a substantial risk of imminent sexual abuse.” The policy provides an emergency grievance process when an individual in confinement faces a substantial risk of imminent sexual abuse. The facility operationalizes this requirement by requiring immediate review and response to emergency grievances involving potential sexual abuse risks. Documentation, interviews, and observations. Emergency grievances were routed for immediate risk assessment and protective action. PAQ validation. The PAQ represents that PREA grievances may be submitted without informal-resolution prerequisites, without a filing time limit, and with emergency handling and third-party assistance. The Auditor finds the facility meets the requirements of this provision. 115.352(f) Policy and requirement. Policy 7-03 states: “The facility may discipline a resident for filing a grievance related to alleged sexual abuse only where the facility demonstrates that the resident filed the grievance in bad faith.” The policy protects individuals in confinement from discipline for reporting sexual abuse while allowing

	accountability for knowingly false complaints made in bad faith. The facility operationalizes this provision through administrative review of grievances and disciplinary procedures. Documentation, interviews, and observations. The process permitted discipline only for a demonstrably knowingly false report, not for a good-faith report that could not be substantiated. PAQ validation. The PAQ represents that PREA grievances may be submitted without informal-resolution prerequisites, without a filing time limit, and with emergency handling and third-party assistance. The Auditor finds the facility meets the requirements of this provision. 115.352(g) Policy and requirement. The current applicability matrix identifies this provision as an audited requirement. Policy 7- 03, Grievance Procedure, Policy 7-05, PREA, Sexual Abuse/Sexual Harassment Grievance Form establish the facility process applicable to this requirement. Documentation, interviews, and observations. Current written materials expressly protected good faith reports even when an allegation was not substantiated. PAQ validation. The PAQ represents that PREA grievances may be submitted without informal-resolution prerequisites, without a filing time limit, and with emergency handling and third-party assistance. The Auditor finds the facility meets the requirements of this provision. Auditor Analysis and Determination Standard 115.352 was evaluated through the complete administrative-remedies process, including access, filing protections, response timeframes, third-party assistance, emergency review, and protection for good-faith reports. The applicable provisions prohibit informal-resolution prerequisites and filing deadlines for sexual-abuse allegations, require a timely final decision, allow third parties to assist or file, provide an emergency route for imminent risk, and permit discipline only when a report is demonstrably made in bad faith. Policy 7-03, the grievance form, PREA education materials, and completed grievance records addressed each procedural safeguard. Implementation was demonstrated through both availability and actual use. Forms and secure submission boxes were accessible; interviewed individuals in confinement understood how to submit a grievance and obtain assistance; staff understood the emergency and third-party routes. The July 27 grievance was accepted promptly, treated as a PREA concern, investigated, followed by written notice, and accompanied by protective measures. The record showed that the reporting person was not required to confront the subject of the complaint, complete an informal process, or satisfy a prohibited procedural barrier. Current materials also distinguished a knowingly false report from a good-faith allegation that could not be substantiated. The policy requirements, accessible submission

	methods, staff and individual knowledge, and documented handling of an actual grievance converge on an operational administrative-remedies process. The evidence demonstrates timely intake, investigation, notice, emergency protection, third-party access, and good-faith-report protection across the applicable provisions. The Auditor determines that the totality of evidence establishes compliance with Standard 115.352, PREA Grievances, and supports a finding of Meets Standard. Standard Finding STANDARD FINDING: MEETS STANDARD

115.353	**Resident access to outside confidential support services and legal representation**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	STANDARD 115.353 — OUTSIDE SUPPORT SERVICES Evidence Reviewed Policy · Policy 7-05, PREA Documentation · Advocates Against Family Violence Memorandum of Understanding · Specialty Contact Form · PREA Intake Orientation · Sexual Assault Awareness Brochure · AAFV memorandum of understanding and recurring facility-access records · ROSE Advocates access and confidentiality information · Community Victim Advocate Questionnaire · Outside Confidential/Emotional Support Provider Questionnaire · Current English and Spanish youth materials Interviews and Questionnaires · Provider questionnaires and facility liaison follow-up

	· Random and targeted youth interviews Observations and Functional Verification · Live test of the confidential-support route and private telephone access PAQ Validation · The PAQ identifies outside confidential emotional-support services and victim-advocate resources, including private telephone access and written notice of confidentiality limits. Provision Analysis 115.353(a) Policy and requirement. Policy 7-05, PREA, states: “Residents shall be provided access to outside victim advocates for emotional support services related to sexual abuse.” Policy 7-05 requires access to outside emotional support services for individuals in confinement who experience sexual abuse. The facility operationalizes this provision through its Memorandum of Understanding with Advocates Against Family Violence. The MOU documents that AAFV provides confidential emotional support services, advocacy services, and outside reporting opportunities for individuals in confinement. Documentation, interviews, and observations. AAFV and ROSE resources provided outside support; the access route was live-tested and known to youth. PAQ validation. The PAQ identifies outside confidential emotional-support services and victim-advocate resources, including private telephone access and written notice of confidentiality limits. The Auditor finds the facility meets the requirements of this provision. 115.353(b) Policy and requirement. Policy 7-05 states: “Residents shall be informed, prior to giving them access, of the extent to which communications with outside support services may be monitored.” The policy requires individuals in confinement be informed about confidentiality limitations and monitoring requirements before using outside support services. The facility operationalizes this requirement through education for individuals in confinement, orientation materials, and communication procedures associated with victim advocacy referrals. Documentation, interviews, and observations. Provider materials disclosed confidentiality and mandatory-reporting limits, and calls were private, free, and unrecorded. PAQ validation. The PAQ identifies outside confidential emotional-support services and victim-advocate resources, including private telephone access and written notice of confidentiality limits.

	The Auditor finds the facility meets the requirements of this provision. 115.353(c) Policy and requirement. Policy 7-05 states: “The facility 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.” The policy requires formal relationships with community-based support organizations capable of providing emotional support services. The facility operationalizes this requirement through its active Memorandum of Understanding with Advocates Against Family Violence. The MOU establishes advocacy services, emotional support, and outside reporting resources for individuals in confinement. Documentation, interviews, and observations. The AAFV agreement and recurring access records documented the facility’s effort to maintain outside emotional-support services; ROSE was an additional 24-hour resource. PAQ validation. The PAQ identifies outside confidential emotional-support services and victim-advocate resources, including private telephone access and written notice of confidentiality limits. The Auditor finds the facility meets the requirements of this provision. Auditor Analysis and Determination Standard 115.353 requires meaningful access to outside confidential emotional-support services, notice of confidentiality and mandatory-reporting limits before communication, and a documented effort to maintain an agreement with a qualified community provider. The standard was therefore assessed through the AAFV memorandum of understanding and recurring access records, ROSE Advocates information, provider questionnaires, current English and Spanish materials, confidentiality disclosures, private telephone capability, functional testing, and interviews. These sources established more than the existence of a telephone number; they documented the provider relationships, access method, privacy protections, and disclosures. Operational verification confirmed practical access. AAFV was established as the documented facility partner, while ROSE Advocates was verified as an additional 24-hour resource. The support route was live-tested and was free, private, and unrecorded. Provider materials explained confidentiality protections and the narrow legal exceptions involving child abuse, vulnerable-adult abuse, and imminent threats. Interviewed individuals in confinement knew that outside support was available, and facility follow-up confirmed how private access was maintained. This evidence resolved the earlier ambiguity between the two provider roles without treating either resource as a substitute for actual access. The agreement, recurring provider access, confidentiality information, functional test, bilingual materials, private telephone capability, and demonstrated awareness converge on a usable outside-support system. The evidence affirmatively establishes the ability to contact qualified community resources and to understand the limits of confidentiality before communication. The Auditor determines that the totality of evidence establishes compliance with every applicable provision of

	Standard 115.353, Outside Support Services, and supports a finding of Meets Standard. Standard Finding STANDARD FINDING: MEETS STANDARD

115.354	**Third-party reporting**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	STANDARD 115.354 — THIRD-PARTY REPORTING Evidence Reviewed Policy · Policy 7-05, PREA · Policy 6-18, Abuse Reporting Documentation · Advocates Against Family Violence Memorandum of Understanding · PREA Intake Orientation · Policy 7-05, PREA · Current English and Spanish orientation and brochure materials · Facility webpage reporting information · Third-party reporting forms and instructions Interviews and Questionnaires · Random and targeted youth interviews · Random staff interviews Observations and Functional Verification · Website and posted third-party reporting options PAQ Validation · The PAQ identifies parents, guardians, attorneys, public defenders, prosecutors, law enforcement, and other trusted persons as third-party reporting

routes.

Provision Analysis

115.354(a)

Policy and requirement. Policy 6-18, Abuse Reporting, states: “Reports of sexual abuse or sexual harassment may be received from residents, staff, family members, attorneys, advocates, or any other third party.” Policy 6-18 permits third-party reporting of sexual abuse and sexual harassment allegations and does not limit reporting to the alleged victim. The facility operationalizes this requirement through staff reporting procedures, victim advocacy resources, reporting forms, education for materials for individuals in confinement, and communication with outside agencies. The AAFV Memorandum of Understanding provides individuals in confinement and outside parties with an additional avenue for reporting concerns related to sexual abuse.

Documentation, interviews, and observations. Current written and online materials provided direct third-party reporting instructions and contact options.

PAQ validation. The PAQ identifies parents, guardians, attorneys, public defenders, prosecutors, law enforcement, and other trusted persons as third-party reporting routes.

The Auditor finds the facility meets the requirements of this provision.

Auditor Analysis and Determination

Policy, public information, youth materials, and interview evidence establish an accessible third-party reporting mechanism and appropriate staff response to reports received from others. The standard-level finding rests on convergence among policy requirements, current documentation, interviews and questionnaires, direct observation and functional verification, and PAQ validation. Current written and online materials provided direct third-party reporting instructions and contact options. Youth understood that a parent or other trusted person could report for them, and staff understood that third-party reports must be handled as any other PREA report. Across 1 applicable provision, the record established both the required controls and their operation in practice.

The material source streams were reconciled at the provision level and collectively support the selected standard-level finding. That conclusion reflects demonstrated operation and corroboration, not the existence of policy language alone.

The Auditor therefore determines that Standard 115.354, Third-Party Reporting, Meets Standard.

Standard Finding

STANDARD FINDING: MEETS STANDARD

115.361	Staff and agency reporting duties
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	STANDARD 115.361 — STAFF REPORTING DUTIES Evidence Reviewed Policy · Policy 7-05, PREA · Policy 6-18, Abuse Reporting Documentation · PREA Training 2022 · PREA Training Acknowledgements · Policy 6-18, Abuse Reporting · Policy 7-05, PREA · Policy 1-07, Incident Reports · Staff reporting acknowledgments · Completed investigation and notification records Interviews and Questionnaires · Twelve random staff interviews · First-responder, supervisory, medical, and investigative questionnaires File Review · Three review-period PREA case groups and the July 27, 2026 allegation file PAQ Validation · The PAQ represents immediate staff reporting of knowledge, suspicion, information, retaliation, and staff neglect, with confidentiality limited to those who need the information to respond or investigate. Provision Analysis 115.361(a) Policy and requirement. Policy 6-18, Abuse Reporting, states: “All staff shall immediately report any knowledge, suspicion, or information regarding an incident of sexual abuse or sexual harassment.” The policy requires immediate reporting of

	sexual abuse and sexual harassment by all staff members. The facility operationalizes this requirement through PREA training, reporting procedures, and supervisory oversight. PREA training materials instruct staff to report immediately and prohibit staff from conducting independent investigations. Documentation, interviews, and observations. All 12 randomly interviewed staff understood immediate mandatory reporting of knowledge, suspicion, retaliation, or staff neglect. PAQ validation. The PAQ represents immediate staff reporting of knowledge, suspicion, information, retaliation, and staff neglect, with confidentiality limited to those who need the information to respond or investigate. The Auditor finds the facility meets the requirements of this provision. 115.361(b) Policy and requirement. Policy 6-18 states: “All staff shall immediately report retaliation against residents or staff who report sexual abuse or sexual harassment.” The policy extends reporting obligations to retaliation concerns involving reporters or participants in investigations. The facility operationalizes this requirement through PREA training and supervisory review processes. Documentation, interviews, and observations. Staff understood that information could be shared only with those who needed it for treatment, protection, investigation, or management. PAQ validation. The PAQ represents immediate staff reporting of knowledge, suspicion, information, retaliation, and staff neglect, with confidentiality limited to those who need the information to respond or investigate. The Auditor finds the facility meets the requirements of this provision. 115.361(c) Policy and requirement. Policy 6-18 states: “All staff shall immediately report any staff neglect or violation of responsibilities that may have contributed to an incident of sexual abuse or sexual harassment.” The policy requires reporting of staff conduct that may contribute to sexual abuse risks. The facility operationalizes this requirement through staff training, incident reporting, and supervisory accountability. Documentation, interviews, and observations. Medical and mental-health personnel described professional confidentiality limits and their duty to inform individuals in confinement before treatment disclosures when applicable. PAQ validation. The PAQ represents immediate staff reporting of knowledge, suspicion, information, retaliation, and staff neglect, with confidentiality limited to those who need the information to respond or investigate. The Auditor finds the facility meets the requirements of this provision.

	115.361(d) Policy and requirement. Policy 6-18 states: “Apart from reporting to designated supervisors and officials, staff shall not reveal any information related to a sexual abuse report to anyone other than those who need to know.” The policy requires confidentiality and limits disclosure to those with a legitimate need to know. The facility operationalizes this requirement through training, reporting protocols, and investigation procedures. Documentation, interviews, and observations. The facility’s juvenile mandatory-reporting procedures required notification to appropriate child-protection or law-enforcement authorities. PAQ validation. The PAQ represents immediate staff reporting of knowledge, suspicion, information, retaliation, and staff neglect, with confidentiality limited to those who need the information to respond or investigate. The Auditor finds the facility meets the requirements of this provision. 115.361(e) Policy and requirement. Policy 6-18 states: “Medical and mental health practitioners shall report sexual abuse and inform residents of reporting limitations and confidentiality requirements.” The policy establishes reporting responsibilities for medical and mental health practitioners while also requiring communication regarding confidentiality limitations. The facility operationalizes this requirement through professional practice standards and specialized PREA training for medical and mental health personnel. Documentation, interviews, and observations. Reported allegations were conveyed to designated facility investigators and leadership for response. PAQ validation. The PAQ represents immediate staff reporting of knowledge, suspicion, information, retaliation, and staff neglect, with confidentiality limited to those who need the information to respond or investigate. The Auditor finds the facility meets the requirements of this provision. Auditor Analysis and Determination Policy, acknowledgments, interviews, and actual case handling demonstrate immediate reporting, appropriate confidentiality, and required notification to designated officials. The standard-level finding rests on convergence among policy requirements, current documentation, interviews and questionnaires, selected file review, and PAQ validation. All 12 random staff understood immediate mandatory reporting and could identify internal and outside routes. The July 27 allegation was reported, separated, documented, investigated, and communicated to leadership without delay. Across 5 applicable provisions, the record established both the required controls and their operation in practice.

	The material source streams were reconciled at the provision level and collectively support the selected standard-level finding. That conclusion reflects demonstrated operation and corroboration, not the existence of policy language alone. The Auditor therefore determines that Standard 115.361, Staff Reporting Duties, Meets Standard. Standard Finding STANDARD FINDING: MEETS STANDARD

115.362	**Agency protection duties**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	STANDARD 115.362 — PROTECTION FROM IMMINENT RISK Evidence Reviewed Policy · Policy 7-05, PREA · Policy 6-18, Abuse Reporting Documentation · Review-period administrative investigation file · Policy 7-05, PREA · Immediate-response and protective-action records Interviews and Questionnaires · Random staff and first-responder interviews · Targeted youth interviews File Review · July 27, 2026, allegation file PAQ Validation · The PAQ represents that staff act immediately when they learn an individual in confinement is at substantial risk of imminent sexual abuse. Provision Analysis 115.362(a)

	Policy and requirement. Policy 6-18, Abuse Reporting, states: Policy 6-18 further states: “Protective actions shall be taken immediately upon receipt of information indicating a resident may be at substantial risk of imminent sexual abuse.” The policy requires immediate action whenever staff learn that an individual in confinement may be subject to a substantial risk of imminent sexual abuse. The facility operationalizes this provision through immediate separation, protective housing adjustments, supervision changes, reporting procedures, and investigative referrals. Investigation files reviewed demonstrate that staff took prompt action to separate involved individuals in confinement, initiate investigations, and implement protective measures when allegations were received. Documentation, interviews, and observations. Staff uniformly described immediate separation, supervision, medical/mental-health notification, and protection. PAQ validation. The PAQ represents that staff act immediately when they learn an individual in confinement is at substantial risk of imminent sexual abuse. The Auditor finds the facility meets the requirements of this provision. Auditor Analysis and Determination Staff knowledge and the actual protective response demonstrate that the agency acts immediately when information presents a potential substantial risk. The standard-level finding rests on convergence among policy requirements, current documentation, interviews and questionnaires, selected file review, and PAQ validation. Staff uniformly described immediate separation, supervision, medical/mental-health notification, and protection. In the July 27 matter, the individual in confinement and staff member were separated, contact was restricted, safety was monitored, and services were offered before the allegation was ultimately found unfounded. Across 1 applicable provision, the record established both the required controls and their operation in practice. The material source streams were reconciled at the provision level and collectively support the selected standard-level finding. That conclusion reflects demonstrated operation and corroboration, not the existence of policy language alone. The Auditor therefore determines that Standard 115.362, Protection from Imminent Risk, Meets Standard. Standard Finding STANDARD FINDING: MEETS STANDARD

115.363	**Reporting to other confinement facilities**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion

STANDARD 115.363 — ALLEGATIONS RECEIVED FROM OTHER FACILITIES

Evidence Reviewed

Policy

· Policy 7-05, PREA

· Policy 6-18, Abuse Reporting

Documentation

· Policy 7-05, PREA

· Reporting and notification procedures

· Annual PREA reports and historical notification records

Interviews and Questionnaires

· PREA Coordinator and investigator questionnaires File Review

· Investigation records involving source-location review

PAQ Validation

· The PAQ represents prompt notification to the head of another confinement facility when an allegation is reported to have occurred there.

Provision Analysis

115.363(a)

Policy and requirement. Policy 6-18, Abuse Reporting, states: “Upon receiving an allegation that a resident was sexually abused while confined at another facility, the Director or designee shall notify the head of the facility where the alleged abuse occurred.” The policy requires notification when the facility receives information that an individual in confinement was sexually abused while confined at another facility. The facility operationalizes this requirement through administrative reporting procedures that require notification to the head of the facility where the alleged abuse occurred. These procedures ensure that allegations are communicated to the facility with jurisdiction over the alleged incident.

Documentation, interviews, and observations. The policy assigns the notification duty and requires documentation.

PAQ validation. The PAQ represents prompt notification to the head of another confinement facility when an allegation is reported to have occurred there.

The Auditor finds the facility meets the requirements of this provision.

115.363(b)

	Policy and requirement. Policy 6-18, Abuse Reporting, states: “Notification shall be provided as soon as possible, but no later than 72 hours after receiving the allegation.” The policy establishes a reporting timeline requiring prompt notification to the facility where the alleged abuse occurred. The facility operationalizes this requirement through administrative notification procedures and supervisory review. This data is significant because no notification events occurred; however, the policy establishes the required reporting timeframe. Documentation, interviews, and observations. No current review-period event required a new notification to another facility. Historical records and coordinator responses demonstrated knowledge of the conditional process. PAQ validation. The PAQ represents prompt notification to the head of another confinement facility when an allegation is reported to have occurred there. The Auditor finds the facility meets the requirements of this provision. 115.363(c) Policy and requirement. Policy 6-18, Abuse Reporting, states: “The facility shall document that notification was provided.” The policy requires documentation of notification whenever an allegation involving another confinement facility is reported. The facility operationalizes this provision through incident reporting and administrative documentation procedures. Documentation, interviews, and observations. The policy assigns the notification duty and requires documentation. PAQ validation. The PAQ represents prompt notification to the head of another confinement facility when an allegation is reported to have occurred there. The Auditor finds the facility meets the requirements of this provision. 115.363(d) Policy and requirement. Policy 6-18, Abuse Reporting, states: “Upon receipt of notification from another facility that a resident was allegedly abused while confined at SWIJDC, the allegation shall be investigated in accordance with PREA requirements.” The policy requires investigation when SWIJDC receives notice from another confinement facility regarding an allegation that occurred while the individual in confinement was housed at SWIJDC. The facility operationalizes this requirement through referral, investigation, and administrative review procedures. Documentation, interviews, and observations. No current review-period event required a new notification to another facility. Historical records and coordinator responses demonstrated knowledge of the conditional process. PAQ validation. The PAQ represents prompt notification to the head of another confinement facility when an allegation is reported to have occurred there. The Auditor finds the facility meets the requirements of this provision.

	Auditor Analysis and Determination The required notification and documentation process is established and understood. No review-period event triggered the conditional duty, and no contrary evidence was identified. The standard-level finding rests on convergence among policy requirements, current documentation, interviews and questionnaires, selected file review, and PAQ validation. The policy assigns the notification duty and requires documentation. No current review-period event required a new notification to another facility. Historical records and coordinator responses demonstrated knowledge of the conditional process. Across 4 applicable provisions, the record established both the required controls and their operation in practice. The material source streams were reconciled at the provision level and collectively support the selected standard-level finding. That conclusion reflects demonstrated operation and corroboration, not the existence of policy language alone. The Auditor therefore determines that Standard 115.363, Allegations Received from Other Facilities, Meets Standard. Standard Finding STANDARD FINDING MEETS STANDARD

115.364	**Staff first responder duties**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	STANDARD 115.364 — FIRST RESPONDER DUTIES Evidence Reviewed Policy · Policy 7-05, PREA · Policy 6-18, Abuse Reporting Documentation · PREA Training 2022 · PREA Training Acknowledgements · Review-period administrative investigation file · Policy 6-18, Abuse Reporting · First-responder procedures and quick-reference materials

	· Completed allegation records Interviews and Questionnaires · Twelve random staff interviews · Security and nonsecurity first-responder questionnaires File Review · July 27, 2026 allegation file PAQ Validation · The PAQ represents first-responder separation, protection, evidence preservation, and immediate notification duties. Provision Analysis 115.364(a) Policy and requirement. Policy 6-18, Abuse Reporting, states: “The first staff member to respond to an allegation of sexual abuse shall take immediate action to protect the victim and preserve evidence.” Policy 6-18 further states: “Staff shall separate the alleged victim and alleged abuser.” The policy requires immediate intervention by first responders to ensure safety of individuals in confinement and evidence preservation. The facility operationalizes this requirement through PREA training and incident response procedures. Investigation files reviewed demonstrate that staff separated involved individuals in confinement, secured the scene, and initiated required notifications following allegations. Documentation, interviews, and observations. All randomly interviewed staff described the required first actions; nonsecurity responders understood the duty to protect and immediately notify security staff. PAQ validation. The PAQ represents first-responder separation, protection, evidence preservation, and immediate notification duties. The Auditor finds the facility meets the requirements of this provision. 115.364(b) Policy and requirement. Policy 6-18 states: “Staff shall request that the alleged victim not take actions that could destroy physical evidence.” The policy requires staff to preserve evidence by instructing alleged victims to avoid actions that may compromise evidentiary value. The facility operationalizes this requirement through first responder training and supervisory response procedures. Documentation, interviews, and observations. The July 27 response included separation, limited contact, prompt notification, documentation, and evidence review. PAQ validation. The PAQ represents first-responder separation, protection, evidence

	preservation, and immediate notification duties. The Auditor finds the facility meets the requirements of this provision. Auditor Analysis and Determination Policy, role-specific questionnaires, unanimous random-staff knowledge, and actual response records corroborate first-responder readiness for both security and nonsecurity staff. The standard-level finding rests on convergence among policy requirements, current documentation, interviews and questionnaires, selected file review, and PAQ validation. All randomly interviewed staff described the required first actions; nonsecurity responders understood the duty to protect and immediately notify security staff. The July 27 response included separation, limited contact, prompt notification, documentation, and evidence review. Across 2 applicable provisions, the record established both the required controls and their operation in practice. The material source streams were reconciled at the provision level and collectively support the selected standard-level finding. That conclusion reflects demonstrated operation and corroboration, not the existence of policy language alone. The Auditor therefore determines that Standard 115.364, First Responder Duties, Meets Standard. Standard Finding STANDARD FINDING MEETS STANDARD

115.365	**Coordinated response**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	STANDARD 115.365 — COORDINATED RESPONSE Evidence Reviewed Policy · Policy 7-05, PREA · Policy 6-18, Abuse Reporting · Policy 6-18a, Abuse Investigation Documentation · Specialty Contact Form

	· Policy 7-05 coordinated response provisions · Abuse-reporting, medical, mental-health, investigation, and incident-review procedures · Completed allegation files Interviews and Questionnaires · First-responder, medical, mental-health, investigator, supervisor, and PREA Coordinator questionnaires File Review · Current investigation and response records PAQ Validation · The PAQ identifies a written coordinated response assigning first-responder, medical, mental-health, investigator, and leadership responsibilities. Provision Analysis 115.365(a) Policy and requirement. Policy 7-05, PREA, states: “The facility shall maintain a coordinated response to allegations of sexual abuse.” Policy 6-18 and Policy 6-18a assign responsibilities for reporting, protection, investigation, medical services, mental health services, victim advocacy, evidence preservation, and administrative review. The facility operationalizes this requirement through coordinated involvement of detention staff, supervisors, investigators, medical and mental health professionals, victim advocates, law enforcement, and prosecutorial authorities. The Specialty Contact Form identifies the individuals and agencies responsible for each response function. Documentation, interviews, and observations. Role-specific questionnaires consistently described a coordinated sequence from protection and evidence preservation through medical/mental-health response, investigation, retaliation monitoring, notification, and review. PAQ validation. The PAQ identifies a written coordinated response assigning first-responder, medical, mental-health, investigator, and leadership responsibilities. The Auditor finds the facility meets the requirements of this provision. Auditor Analysis and Determination The written response framework and role-specific evidence are internally consistent and were demonstrated in actual case handling. The standard-level finding rests on convergence among policy requirements, current documentation, interviews and questionnaires, selected file review, and PAQ validation. Role-specific questionnaires consistently described a coordinated sequence from protection and evidence preservation through medical/mental-health response, investigation, retaliation

	monitoring, notification, and review. Completed case files reflected the same sequence in practice. Across 1 applicable provision, the record established both the required controls and their operation in practice. The material source streams were reconciled at the provision level and collectively support the selected standard-level finding. That conclusion reflects demonstrated operation and corroboration, not the existence of policy language alone. The Auditor therefore determines that Standard 115.365, Coordinated Response, Meets Standard. Standard Finding STANDARD FINDING MEETS STANDARD

115.366	**Preservation of ability to protect residents from contact with abusers**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	STANDARD 115.366 — PRESERVATION OF PROTECTIVE AUTHORITY Evidence Reviewed Policy · Policy 7-05, PREA Documentation · Canyon County personnel policies referenced in PREA policy · Policy 7-05, PREA · Agency Contract Administrator Questionnaire · Current labor/contract information Interviews and Questionnaires · Agency leadership verification PAQ Validation · The PAQ represents that no collective bargaining agreement limits the agency’s ability to remove an alleged staff abuser from contact with individuals in confinement pending investigation.

	Provision Analysis 115.366(a) Policy and requirement. Policy 7-05, PREA, states: “Nothing in any personnel policy or agreement shall restrict the facility’s ability to remove alleged staff abusers from contact with residents pending investigation.” The policy preserves management’s authority to protect individuals in confinement while allegations are investigated. The facility operationalizes this requirement through personnel procedures allowing reassignment, administrative leave, supervision changes, or other protective measures when allegations arise. Documentation, interviews, and observations. No reviewed agreement prevented temporary reassignment, separation, or removal from contact with individuals in confinement. PAQ validation. The PAQ represents that no collective bargaining agreement limits the agency’s ability to remove an alleged staff abuser from contact with individuals in confinement pending investigation. The Auditor finds the facility meets the requirements of this provision. 115.366(b) Policy and requirement. Policy 7-05 maintains the facility’s authority to protect individuals in confinement and implement administrative actions when allegations involve staff misconduct. The facility operationalizes this provision through supervisory authority and personnel practices designed to protect individuals in confinement while investigations are conducted. Documentation, interviews, and observations. Leadership described immediate protective reassignment authority, and the July 27 response demonstrated contact restriction while the allegation was investigated. PAQ validation. The PAQ represents that no collective bargaining agreement limits the agency’s ability to remove an alleged staff abuser from contact with individuals in confinement pending investigation. The Auditor finds the facility meets the requirements of this provision. Auditor Analysis and Determination The agency retained the ability to protect individuals in confinement from contact with an alleged staff abuser, and no contractual restriction inconsistent with the standard was identified. The standard-level finding rests on convergence among policy requirements, current documentation, interviews and questionnaires, and PAQ validation. No reviewed agreement prevented temporary reassignment, separation, or removal from contact with individuals in confinement. Leadership described immediate protective reassignment authority, and the July 27 response demonstrated contact restriction while the allegation was investigated. Across 2

	applicable provisions, the record established both the required controls and their operation in practice. The material source streams were reconciled at the provision level and collectively support the selected standard-level finding. That conclusion reflects demonstrated operation and corroboration, not the existence of policy language alone. The Auditor therefore determines that Standard 115.366, Preservation of Protective Authority, Meets Standard. Standard Finding STANDARD FINDING MEETS STANDARD

115.367	**Agency protection against retaliation**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	STANDARD 115.367 — PROTECTION FROM RETALIATION Evidence Reviewed Policy · Policy 7-05, PREA · Policy 6-18, Abuse Reporting Documentation · Specialty Contact Form · Investigation files · Policy 7-05, PREA · Retaliation Monitor Questionnaire · Retaliation-monitoring records · Investigation and notification records for individuals in confinement Interviews and Questionnaires · Random staff and youth interviews · PREA Coordinator and retaliation-monitor follow-up File Review · July 27, 2026 allegation file

PAQ Validation

· The PAQ identifies a designated retaliation monitor, monitoring for at least 90 days when required, status checks, protective measures, and continued monitoring when warranted.

Provision Analysis

115.367(a)

Policy and requirement. Policy 7-05, PREA, states: “The SWIJDC shall protect all residents and staff who report sexual abuse or sexual harassment or cooperate with investigations from retaliation by other residents or staff.” The policy requires protection of reporters, victims, witnesses, and participants in investigations. The facility operationalizes this requirement through supervisory oversight, separation measures, housing adjustments, monitoring, and administrative review. Investigation files reviewed demonstrate that protective measures were considered following allegations.

Documentation, interviews, and observations. The agency designated staff to monitor retaliation and used protective measures when a report was made.

PAQ validation. The PAQ identifies a designated retaliation monitor, monitoring for at least 90 days when required, status checks, protective measures, and continued monitoring when warranted.

The Auditor finds the facility meets the requirements of this provision.

115.367(b)

Policy and requirement. Policy 7-05 states: “The PREA Coordinator shall be responsible for monitoring retaliation concerns.” The policy assigns responsibility for retaliation monitoring to designated personnel. The facility operationalizes this provision through the PREA Coordinator and other supervisory staff identified in the Specialty Contact Form.

Documentation, interviews, and observations. Monitoring considered housing, discipline, program, work, and other status changes and included periodic contact with the individual in confinement.

PAQ validation. The PAQ identifies a designated retaliation monitor, monitoring for at least 90 days when required, status checks, protective measures, and continued monitoring when warranted.

The Auditor finds the facility meets the requirements of this provision.

115.367(c)

Policy and requirement. Policy 7-05 requires monitoring of individuals in confinement and staff who report sexual abuse or cooperate with investigations. The facility operationalizes this requirement through review of disciplinary actions,

	housing assignments, program participation, work assignments, and interactions involving individuals in confinement when appropriate. Documentation, interviews, and observations. The monitoring process could continue beyond 90 days when information supported a continuing need. PAQ validation. The PAQ identifies a designated retaliation monitor, monitoring for at least 90 days when required, status checks, protective measures, and continued monitoring when warranted. The Auditor finds the facility meets the requirements of this provision. 115.367(d) Policy and requirement. Policy 7-05 requires the facility to continue monitoring for retaliation for an appropriate period following allegations or investigations. The facility operationalizes this requirement through ongoing review and supervisory oversight. This metric is significant because it demonstrates no retaliation allegations were reported while monitoring procedures remained available. Documentation, interviews, and observations. Protection was available to individuals in confinement and staff who reported or cooperated with an investigation. PAQ validation. The PAQ identifies a designated retaliation monitor, monitoring for at least 90 days when required, status checks, protective measures, and continued monitoring when warranted. The Auditor finds the facility meets the requirements of this provision. 115.367(e) Policy and requirement. Policy 7-05 requires prompt action if retaliation is identified. The facility operationalizes this requirement through supervisory intervention, housing changes, separation measures, and administrative review when necessary. Documentation, interviews, and observations. Monitoring could end only when the agency determined the allegation was unfounded; the July 27 matter was monitored while pending and concluded after the unfounded determination. PAQ validation. The PAQ identifies a designated retaliation monitor, monitoring for at least 90 days when required, status checks, protective measures, and continued monitoring when warranted. The Auditor finds the facility meets the requirements of this provision. 115.367(f) Policy and requirement. (f) An agency’s obligation to monitor shall terminate if the agency determines that the allegation is unfounded. Policy 7-05, PREA, Policy 6-18, Abuse Reporting establish the facility process applicable to this requirement.

	Documentation, interviews, and observations. The agency could take immediate protective steps without waiting for the formal monitoring period to begin. PAQ validation. The PAQ identifies a designated retaliation monitor, monitoring for at least 90 days when required, status checks, protective measures, and continued monitoring when warranted. The Auditor finds the facility meets the requirements of this provision. Auditor Analysis and Determination Policy, designated responsibility, monitoring records, interview knowledge, and current case handling demonstrate protection against retaliation and appropriate monitoring. The standard-level finding rests on convergence among policy requirements, current documentation, interviews and questionnaires, selected file review, and PAQ validation. Staff and youth understood that retaliation is prohibited and could identify protective reporting routes. The July 27 matter included safety checks, offered services, contact restrictions, and retaliation monitoring even though the allegation was ultimately found unfounded. Across 6 applicable provisions, the record established both the required controls and their operation in practice. The material source streams were reconciled at the provision level and collectively support the selected standard-level finding. That conclusion reflects demonstrated operation and corroboration, not the existence of policy language alone. The Auditor therefore determines that Standard 115.367, Protection from Retaliation, Meets Standard. Standard Finding STANDARD FINDING MEETS STANDARD

115.368	**Post-allegation protective custody**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	STANDARD 115.368 — POST-ALLEGATION PROTECTIVE CUSTODY Evidence Reviewed Policy · Policy 7-05, PREA · Policy 9-07 Classification

	Documentation · Vulnerability Assessment · Policy 7-05, PREA · Housing and protective-placement procedures · Selected placement records Interviews and Questionnaires · Targeted youth interviews · Supervisory follow-up Observations and Functional Verification · Single-occupancy housing and access to education, recreation, and services PAQ Validation · The PAQ represents that post-allegation protective isolation is used only as a last resort and with the services and review protections required by the standard. Provision Analysis 115.368(a) Policy and requirement. Policy 7-05, PREA, states: “Residents at risk of sexual victimization shall be protected through housing, supervision, classification, and programmatic adjustments whenever possible.” Policy 9-07 requires staff to utilize classification information, vulnerability assessments, supervision practices, and housing decisions to protect individuals in confinement from sexual abuse. The facility operationalizes this provision through classification reviews, housing reassignment, increased supervision, separation of individuals in confinement, and other protective measures designed to maintain safety of individuals in confinement without reliance on involuntary segregated housing. Documentation, interviews, and observations. No individual in confinement was held in segregated housing because of victimization risk on the audit date. PAQ validation. The PAQ represents that post-allegation protective isolation is used only as a last resort and with the services and review protections required by the standard. The Auditor finds the facility meets the requirements of this provision. Auditor Analysis and Determination The facility used less restrictive protection and did not rely on punitive protective custody. The conditional isolation safeguards were established for any future use.

	The standard-level finding rests on convergence among policy requirements, current documentation, interviews and questionnaires, direct observation and functional verification, and PAQ validation. No individual in confinement was held in segregated housing because of victimization risk on the audit date. Single-occupancy rooms, supervision adjustments, and contact restrictions provided less restrictive protective alternatives. Across 1 applicable provision, the record established both the required controls and their operation in practice. The material source streams were reconciled at the provision level and collectively support the selected standard-level finding. That conclusion reflects demonstrated operation and corroboration, not the existence of policy language alone. The Auditor therefore determines that Standard 115.368, Post-Allegation Protective Custody, Meets Standard. Standard Finding STANDARD FINDING MEETS STANDARD

115.371	**Criminal and administrative agency investigations**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	STANDARD 115.371 — INVESTIGATIONS Evidence Reviewed Policy · Policy 6-18a, Abuse Investigation · Policy 7-05, PREA Documentation · Review-period administrative investigation file · Specialty Contact Form · Policy 6-18a, Abuse Investigations · Policy 7-05, PREA · Investigator training records and questionnaires · Administrative investigation reports, statements, video review, credibility assessments, findings, and notification records

	Interviews and Questionnaires · Trained investigator and PREA Coordinator follow-up File Review · Three review-period PREA case groups and the July 27, 2026 allegation file PAQ Validation · The PAQ reports three youth-on-youth sexual-harassment investigations during the review period and identifies trained internal investigators and law-enforcement referral procedures. Provision Analysis 115.371(a) Policy and requirement. Policy 6-18a, Abuse Investigation, states: “Any allegation of sexual abuse that potentially involves criminal behavior shall immediately be turned over to the Caldwell Police Department for investigation.” Policy 6-18a further states: “Allegations of sexual harassment shall be investigated administratively by SWIJDC investigators.” The policy requires prompt investigation of allegations and establishes separate pathways for criminal and administrative investigations depending on the nature of the allegation. The facility operationalizes this requirement through referral of criminal matters to Caldwell Police Department and assignment of administrative investigations to train SWIJDC investigators. Documentation, interviews, and observations. Completed files showed prompt, written, objective administrative investigations of all received reports. PAQ validation. The PAQ reports three youth-on-youth sexual-harassment investigations during the review period and identifies trained internal investigators and law-enforcement referral procedures. The Auditor finds the facility meets the requirements of this provision. 115.371(b) Policy and requirement. Policy 6-18a states: “Investigators shall gather and preserve direct and circumstantial evidence, including physical and documentary evidence.” The policy requires investigations to be thorough, objective, and evidence-based. The facility operationalizes this requirement through investigator training, investigative reports, evidence collection procedures, and documentation review. Investigation files reviewed contained documentation of witness interviews, evidence review, findings, and investigative conclusions. Documentation, interviews, and observations. The facility used investigators with documented juvenile PREA investigation training. PAQ validation. The PAQ reports three youth-on-youth sexual-harassment investigations during the review period and identifies trained internal investigators and law-enforcement referral procedures.

	The Auditor finds the facility meets the requirements of this provision. 115.371(c) Policy and requirement. Policy 6-18a requires investigators to: “Interview alleged victims, suspected perpetrators, and witnesses.” The policy establishes expectations for comprehensive investigation and fact gathering. The facility operationalizes this provision through structured investigative interviews and documentation practices reflected in investigative files. Documentation, interviews, and observations. Files included statements, documentary or video evidence when available, prior-record review, credibility analysis, and written findings. PAQ validation. The PAQ reports three youth-on-youth sexual-harassment investigations during the review period and identifies trained internal investigators and law-enforcement referral procedures. The Auditor finds the facility meets the requirements of this provision. 115.371(d) Policy and requirement. Policy 6-18a requires investigators to assess credibility based upon the totality of evidence and investigative findings. The facility operationalizes this requirement through investigator training and administrative review of investigative reports. Documentation, interviews, and observations. The July 27 investigation continued after the individual in confinement clarified the allegation and was not closed solely because the account changed. PAQ validation. The PAQ reports three youth-on-youth sexual-harassment investigations during the review period and identifies trained internal investigators and law-enforcement referral procedures. The Auditor finds the facility meets the requirements of this provision. 115.371(e) Policy and requirement. Policy 6-18a states: “The departure of the alleged abuser or victim from employment or control of the facility shall not provide a basis for terminating an investigation.” The policy requires investigations to continue regardless of changes in employment or custody status. The facility operationalizes this requirement through investigative procedures requiring completion of investigations whenever sufficient information exists to proceed. Documentation, interviews, and observations. The investigator understood that compelled interviews require consultation with prosecutors when criminal prosecution may be implicated. PAQ validation. The PAQ reports three youth-on-youth sexual-harassment

	investigations during the review period and identifies trained internal investigators and law-enforcement referral procedures. The Auditor finds the facility meets the requirements of this provision. 115.371(f) Policy and requirement. Policy 6-18a requires written reports documenting investigative findings and conclusions. The facility operationalizes this requirement through administrative investigative reports and case documentation maintained by trained investigators. The investigation files reviewed contain written documentation of investigative activity and findings. Documentation, interviews, and observations. Credibility was assessed individually; no individual in confinement was required to take a polygraph or other truth-telling test. PAQ validation. The PAQ reports three youth-on-youth sexual-harassment investigations during the review period and identifies trained internal investigators and law-enforcement referral procedures. The Auditor finds the facility meets the requirements of this provision. 115.371(g) Policy and requirement. Policy 6-18a requires criminal investigations to be conducted by the Caldwell Police Department. The facility operationalizes this provision through immediate referral of potentially criminal allegations to law enforcement. Documentation, interviews, and observations. Administrative reports addressed facts, evidence, credibility, findings, and whether staff action or inaction contributed. PAQ validation. The PAQ reports three youth-on-youth sexual-harassment investigations during the review period and identifies trained internal investigators and law-enforcement referral procedures. The Auditor finds the facility meets the requirements of this provision. 115.371(h) Policy and requirement. Policy 6-18a requires administrative investigations to determine whether staff actions or failures contributed to an incident. The facility operationalizes this requirement through administrative review of policy compliance, supervision practices, reporting requirements, and staff conduct. Documentation, interviews, and observations. The referral framework required criminal investigations to be documented by the law-enforcement agency with available supporting evidence.

	PAQ validation. The PAQ reports three youth-on-youth sexual-harassment investigations during the review period and identifies trained internal investigators and law-enforcement referral procedures. The Auditor finds the facility meets the requirements of this provision. 115.371(i) Policy and requirement. Policy 6-18a requires retention of investigative records consistent with agency record-retention requirements. The facility operationalizes this provision through maintenance of investigative files and associated documentation. Documentation, interviews, and observations. Conduct appearing criminal was subject to prosecution referral; no reviewed matter showed a substantiated criminal allegation that was not referred. PAQ validation. The PAQ reports three youth-on-youth sexual-harassment investigations during the review period and identifies trained internal investigators and law-enforcement referral procedures. The Auditor finds the facility meets the requirements of this provision. 115.371(j) Policy and requirement. Policy 6-18a requires cooperation with criminal investigators and prosecutorial authorities. The facility operationalizes this requirement through established working relationships with Caldwell Police Department and the Canyon County Prosecuting Attorney’s Office. Documentation, interviews, and observations. Written investigative reports were retained under the policy retention schedule. PAQ validation. The PAQ reports three youth-on-youth sexual-harassment investigations during the review period and identifies trained internal investigators and law-enforcement referral procedures. The Auditor finds the facility meets the requirements of this provision. 115.371(k) Policy and requirement. Policy 6-18a requires that substantiated allegations be referred for appropriate administrative action and, when warranted, criminal prosecution. The facility operationalizes this provision through administrative review processes and referral procedures. Documentation, interviews, and observations. Departure from employment or facility control was not a basis for terminating an investigation. PAQ validation. The PAQ reports three youth-on-youth sexual-harassment investigations during the review period and identifies trained internal investigators

	and law-enforcement referral procedures. The Auditor finds the facility meets the requirements of this provision. 115.371(l) Policy and requirement. (l) Any State entity or Department of Justice component that conducts such investigations shall do so pursuant to the above requirements. Policy 6-18a, Abuse Investigation, Policy 7-05, PREA establish the facility process applicable to this requirement. Documentation, interviews, and observations. No State entity or DOJ component conducted a review-period investigation; the conditional requirement was addressed through the established outside-investigation framework. PAQ validation. The PAQ reports three youth-on-youth sexual-harassment investigations during the review period and identifies trained internal investigators and law-enforcement referral procedures. The Auditor finds the facility meets the requirements of this provision. Auditor Analysis and Determination Policy, specialized training, investigator responses, and multiple completed files demonstrate prompt, objective, evidence-based administrative investigation. Conditional criminal-referral and State-entity provisions were evaluated against the established referral framework; no event showed a failure to refer or cooperate. The standard-level finding rests on convergence among policy requirements, current documentation, interviews and questionnaires, selected file review, and PAQ validation. Investigation files were written, fact-specific, and included reports, witness or statements from individuals in confinement, available video or documentary evidence, credibility analysis, findings, protective actions, and notification to individuals in confinement. The July 27 allegation continued to a documented conclusion after the individual in confinement clarified the nature of the concern; the clarification did not cause the investigation to be abandoned. Across 12 applicable provisions, the record established both the required controls and their operation in practice. The material source streams were reconciled at the provision level and collectively support the selected standard-level finding. That conclusion reflects demonstrated operation and corroboration, not the existence of policy language alone. The Auditor therefore determines that Standard 115.371, Investigations, Meets Standard. Standard Finding STANDARD FINDING MEETS STANDARD

115.372	Evidentiary standard for administrative investigations
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	STANDARD 115.372 — EVIDENTIARY STANDARD Evidence Reviewed Policy · Policy 6-18a, Abuse Investigation Documentation · Investigation files · Policy 6-18a, Abuse Investigations · Administrative investigation reports and findings Interviews and Questionnaires · Investigator questionnaire and follow-up File Review · Current investigation files PAQ Validation · The PAQ represents that administrative findings use no evidentiary standard higher than a preponderance of the evidence. Provision Analysis 115.372(a) Policy and requirement. Policy 6-18a, Abuse Investigation, states: “Administrative investigations shall impose no standard higher than a preponderance of the evidence in determining whether allegations of sexual abuse or sexual harassment are substantiated.” The policy requires investigators to utilize a preponderance of the evidence standard when determining whether allegations are substantiated. The facility operationalizes this requirement through investigator training, investigative reports, and administrative review procedures. Investigation files reviewed reflected administrative findings reached through evaluation of available evidence and application of the established evidentiary standard. Documentation, interviews, and observations. Policy and investigator responses identified the preponderance standard. PAQ validation. The PAQ represents that administrative findings use no evidentiary standard higher than a preponderance of the evidence.

	The Auditor finds the facility meets the requirements of this provision. Auditor Analysis and Determination The written and applied evidentiary standard did not exceed preponderance of the evidence. The standard-level finding rests on convergence among policy requirements, current documentation, interviews and questionnaires, selected file review, and PAQ validation. Policy and investigator responses identified the preponderance standard. Completed reports documented reasoning and findings without applying a higher burden. Across 1 applicable provision, the record established both the required controls and their operation in practice. The material source streams were reconciled at the provision level and collectively support the selected standard-level finding. That conclusion reflects demonstrated operation and corroboration, not the existence of policy language alone. The Auditor therefore determines that Standard 115.372, Evidentiary Standard, Meets Standard. Standard Finding STANDARD FINDING MEETS STANDARD

115.373	**Reporting to residents**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	STANDARD 115.373 — REPORTING INVESTIGATION OUTCOMES Evidence Reviewed Policy · Policy 7-05, PREA · Policy 6-18a, Abuse Investigation Documentation · Investigation files · Policy 7-05, PREA · PREA Reporting to Individuals in Confinement Form · Investigation finding notices · Current allegation notification records

	Interviews and Questionnaires · Investigator and PREA Coordinator questionnaires · Targeted youth interview involving a recent harassment report File Review · July 27, 2026 notice of finding and investigation file PAQ Validation · The PAQ represents written notice to individuals in confinement of investigation outcomes and required staff-status or prosecution information when applicable. Provision Analysis 115.373(a) Policy and requirement. Policy 6-18a, Abuse Investigation, states: “Following completion of an investigation, the resident shall be informed whether the allegation was determined to be substantiated, unsubstantiated, or unfounded.” The policy requires notification of investigative outcomes to individuals in confinement who report sexual abuse. The facility operationalizes this provision through investigative closure procedures and documentation of notification to individuals in confinement. Documentation, interviews, and observations. Investigation files contained outcome notification documentation. The individual in confinement in the July 27 matter received written notice of the unfounded finding on July 28, 2026. PAQ validation. The PAQ represents written notice to individuals in confinement of investigation outcomes and required staff-status or prosecution information when applicable. The Auditor finds the facility meets the requirements of this provision. 115.373(b) Policy and requirement. Policy 6-18a requires that when an outside agency conducts the investigation, the facility shall request relevant information necessary to provide notification to the individual in confinement. The facility operationalizes this requirement through communication with Caldwell Police Department and other investigative authorities. Documentation, interviews, and observations. The targeted youth who had reported harassment described prompt response, investigation, follow-up, and offered services. PAQ validation. The PAQ represents written notice to individuals in confinement of investigation outcomes and required staff-status or prosecution information when applicable.

	The Auditor finds the facility meets the requirements of this provision. 115.373(c) Policy and requirement. Policy 6-18a requires notification to individuals in confinement when staff members are no longer employed following an allegation of sexual abuse. The facility operationalizes this requirement through investigative closure and notification procedures when applicable. Documentation, interviews, and observations. No qualifying staff-abuser employment, indictment, conviction, or prosecution involving an alleged abuser who is an individual in confinement event required additional notification during the review period. PAQ validation. The PAQ represents written notice to individuals in confinement of investigation outcomes and required staff-status or prosecution information when applicable. The Auditor finds the facility meets the requirements of this provision. 115.373(d) Policy and requirement. Policy 6-18a requires notification to individuals in confinement when staff members are indicted or convicted on criminal charges related to sexual abuse. The facility operationalizes this provision through communication with investigative authorities and administrative notification procedures. Documentation, interviews, and observations. Investigation files contained outcome notification documentation. The individual in confinement in the July 27 matter received written notice of the unfounded finding on July 28, 2026. PAQ validation. The PAQ represents written notice to individuals in confinement of investigation outcomes and required staff-status or prosecution information when applicable. The Auditor finds the facility meets the requirements of this provision. 115.373(e) Policy and requirement. Policy 6-18a requires notification to individuals in confinement when an individual in confinement alleged to have committed sexual abuse has been indicted or convicted on related charges. The facility operationalizes this requirement through investigative follow-up and notification procedures. Documentation, interviews, and observations. The targeted youth who had reported harassment described prompt response, investigation, follow-up, and offered services. PAQ validation. The PAQ represents written notice to individuals in confinement of

	investigation outcomes and required staff-status or prosecution information when applicable. The Auditor finds the facility meets the requirements of this provision. 115.373(f) Policy and requirement. Policy 6-18a requires documentation of notifications provided under this standard. The facility operationalizes this requirement through maintenance of investigative records and notification documentation. Documentation, interviews, and observations. No qualifying staff-abuser employment, indictment, conviction, or prosecution involving an alleged abuser who is an individual in confinement event required additional notification during the review period. PAQ validation. The PAQ represents written notice to individuals in confinement of investigation outcomes and required staff-status or prosecution information when applicable. The Auditor finds the facility meets the requirements of this provision. Auditor Analysis and Determination Policy, notification forms, completed case records, and evidence from interviews with individuals in confinement demonstrate timely communication of investigative outcomes and a process for conditional follow-up notices. The standard-level finding rests on convergence among policy requirements, current documentation, interviews and questionnaires, selected file review, and PAQ validation. Investigation files contained outcome notification documentation. The individual in confinement in the July 27 matter received written notice of the unfounded finding on July 28, 2026. The targeted youth who had reported harassment described prompt response, investigation, follow-up, and offered services. Across 6 applicable provisions, the record established both the required controls and their operation in practice. The material source streams were reconciled at the provision level and collectively support the selected standard-level finding. That conclusion reflects demonstrated operation and corroboration, not the existence of policy language alone. The Auditor therefore determines that Standard 115.373, Reporting Investigation Outcomes, Meets Standard. Standard Finding STANDARD FINDING MEETS STANDARD

115.376	**Disciplinary sanctions for staff**

	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	STANDARD 115.376 — STAFF DISCIPLINE Evidence Reviewed Policy · Policy 7-05, PREA Documentation · Canyon County Personnel Policies · Employee Standards of Conduct · Policy 7-05, PREA · Employee discipline and reporting procedures · Agency head and supervisory questionnaires Interviews and Questionnaires · Agency leadership verification File Review · Current investigation files PAQ Validation · The PAQ represents discipline up to and including termination for staff sexual abuse and sexual harassment and required law-enforcement/licensing reporting. Provision Analysis 115.376(a) Policy and requirement. Policy 7-05, PREA, states: “Staff shall be subject to disciplinary sanctions up to and including termination for violating agency sexual abuse or sexual harassment policies.” The policy establishes that violations involving sexual abuse or sexual harassment are serious disciplinary matters and may result in termination. The facility operationalizes this requirement through personnel policies, administrative investigations, disciplinary procedures, and supervisory oversight. Documentation, interviews, and observations. Policy makes termination the presumptive sanction for staff sexual abuse and requires sanctions proportionate to misconduct and prior history. PAQ validation. The PAQ represents discipline up to and including termination for staff sexual abuse and sexual harassment and required law-enforcement/licensing

	reporting. The Auditor finds the facility meets the requirements of this provision. 115.376(b) Policy and requirement. Policy 7-05 states: “Termination shall be the presumptive disciplinary sanction for staff who have engaged in sexual abuse.” The policy establishes termination as the presumptive disciplinary outcome when staff engage in sexual abuse. The facility operationalizes this provision through administrative investigations and personnel actions following substantiated findings. Documentation, interviews, and observations. No review-period allegation resulted in a substantiated finding of staff sexual abuse requiring termination or external licensing report. PAQ validation. The PAQ represents discipline up to and including termination for staff sexual abuse and sexual harassment and required law-enforcement/licensing reporting. The Auditor finds the facility meets the requirements of this provision. 115.376(c) Policy and requirement. Policy 7-05 states: “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 policy requires disciplinary actions to be proportional to the misconduct involved. The facility operationalizes this requirement through administrative review, personnel procedures, and supervisory oversight. Documentation, interviews, and observations. Policy makes termination the presumptive sanction for staff sexual abuse and requires sanctions proportionate to misconduct and prior history. PAQ validation. The PAQ represents discipline up to and including termination for staff sexual abuse and sexual harassment and required law-enforcement/licensing reporting. The Auditor finds the facility meets the requirements of this provision. 115.376(d) Policy and requirement. Policy 7-05 states: “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 and relevant licensing bodies unless the activity was clearly not criminal.” The policy requires reporting of qualifying misconduct to law enforcement and professional licensing authorities. The facility operationalizes this requirement through reporting procedures and coordination with investigative agencies.

	Documentation, interviews, and observations. No review-period allegation resulted in a substantiated finding of staff sexual abuse requiring termination or external licensing report. PAQ validation. The PAQ represents discipline up to and including termination for staff sexual abuse and sexual harassment and required law-enforcement/licensing reporting. The Auditor finds the facility meets the requirements of this provision. Auditor Analysis and Determination The required disciplinary framework is established. No qualifying substantiated staff-abuse event occurred during the review period, and no contrary disciplinary practice was identified. The standard-level finding rests on convergence among policy requirements, current documentation, interviews and questionnaires, selected file review, and PAQ validation. Policy makes termination the presumptive sanction for staff sexual abuse and requires sanctions proportionate to misconduct and prior history. No review-period allegation resulted in a substantiated finding of staff sexual abuse requiring termination or external licensing report. Across 4 applicable provisions, the record established both the required controls and their operation in practice. The material source streams were reconciled at the provision level and collectively support the selected standard-level finding. That conclusion reflects demonstrated operation and corroboration, not the existence of policy language alone. The Auditor therefore determines that Standard 115.376, Staff Discipline, Meets Standard. Standard Finding STANDARD FINDING MEETS STANDARD

115.377	**Corrective action for contractors and volunteers**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	STANDARD 115.377 — CONTRACTOR AND VOLUNTEER CORRECTIVE ACTION Evidence Reviewed Policy · Policy 7-05, PREA Documentation

	· PREA Tier 1 Training for Contractors and Volunteers · Contractor/Volunteer PREA Acknowledgement Forms · Policy 7-05, PREA · Volunteer and contractor training and acknowledgment records · Current volunteer/contractor list Interviews and Questionnaires · Volunteer questionnaires and leadership follow-up File Review · Four volunteer packets PAQ Validation · The audit-period data identified four volunteers and no contractor; the current roster identified three volunteers and one contractor. Provision Analysis 115.377(a) Policy and requirement. Policy 7-05, PREA, states: “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.” The policy requires immediate removal from contact with individuals in confinement and referral to law enforcement when a contractor or volunteer engages in sexual abuse. The facility operationalizes this requirement through volunteer screening, contractor oversight, reporting procedures, and supervisory review. Documentation, interviews, and observations. Policy requires removal from contact with individuals in confinement and appropriate reporting when a contractor or volunteer violates sexual-abuse or sexual-harassment rules. PAQ validation. The audit-period data identified four volunteers and no contractor; the current roster identified three volunteers and one contractor. The Auditor finds the facility meets the requirements of this provision. 115.377(b) Policy and requirement. Policy 7-05 states: “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.” The policy requires corrective action and evaluation of continued contact with individuals in confinement when contractors or volunteers violate PREA-related policies. The facility operationalizes this provision through administrative review, corrective action, retraining, removal decisions, and supervisory oversight.

	Documentation, interviews, and observations. No qualifying contractor or volunteer allegation occurred during the review period. PAQ validation. The audit-period data identified four volunteers and no contractor; the current roster identified three volunteers and one contractor. The Auditor finds the facility meets the requirements of this provision. Auditor Analysis and Determination The corrective-action and reporting framework is established, personnel with contact with individuals in confinement were identified and trained, and no qualifying event revealed a failure to act. The standard-level finding rests on convergence among policy requirements, current documentation, interviews and questionnaires, selected file review, and PAQ validation. Policy requires removal from contact with individuals in confinement and appropriate reporting when a contractor or volunteer violates sexual-abuse or sexual-harassment rules. No qualifying contractor or volunteer allegation occurred during the review period. Across 2 applicable provisions, the record established both the required controls and their operation in practice. The material source streams were reconciled at the provision level and collectively support the selected standard-level finding. That conclusion reflects demonstrated operation and corroboration, not the existence of policy language alone. The Auditor therefore determines that Standard 115.377, Contractor and Volunteer Corrective Action, Meets Standard. Standard Finding STANDARD FINDING MEETS STANDARD

115.378	**Interventions and disciplinary sanctions for residents**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	STANDARD 115.378 — INTERVENTIONS AND DISCIPLINE Evidence Reviewed Policy · Policy 7-05, PREA Documentation · Policies governing discipline of individuals in confinement

	· Handbook for individuals in confinement · Policy 7-05, PREA · Procedures governing discipline of individuals in confinement · Investigation records and behavior documentation Interviews and Questionnaires · Supervisory and investigator questionnaires · Random and targeted youth interviews File Review · Current investigation files PAQ Validation · The PAQ represents proportionate sanctions for individuals in confinement following an administrative finding, consideration of mental or cognitive disability, and no discipline for sexual activity unless the activity was coerced or otherwise abusive. Provision Analysis 115.378(a) Policy and requirement. Policy 7-05, PREA, states: “Residents shall 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.” The policy requires formal findings before disciplinary sanctions may be imposed for sexual abuse committed by an individual in confinement. The facility operationalizes this requirement through administrative investigations, disciplinary review procedures, and due process protections. Documentation, interviews, and observations. No individual in confinement reported discipline for making a good-faith report or for consensual conduct. PAQ validation. The PAQ represents proportionate sanctions for individuals in confinement following an administrative finding, consideration of mental or cognitive disability, and no discipline for sexual activity unless the activity was coerced or otherwise abusive. The Auditor finds the facility meets the requirements of this provision. 115.378(b) Policy and requirement. Policy 7-05 states: “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.” The policy requires individualized disciplinary decisions based on the facts and circumstances of each

	case. The facility operationalizes this provision through disciplinary review processes and consideration of factors specific to the individual in confinement. Documentation, interviews, and observations. Investigative and supervisory evidence showed that case findings, age, development, history, and circumstances are considered before intervention or discipline. PAQ validation. The PAQ represents proportionate sanctions for individuals in confinement following an administrative finding, consideration of mental or cognitive disability, and no discipline for sexual activity unless the activity was coerced or otherwise abusive. The Auditor finds the facility meets the requirements of this provision. 115.378(c) Policy and requirement. Policy 7-05 states: “The disciplinary process shall consider whether a resident’s mental disabilities, mental illness, or developmental disabilities contributed to behavior when determining sanctions.” The policy requires consideration of mental health, developmental, and disability-related factors during disciplinary decision making. The facility operationalizes this requirement through classification review, mental health consultation, and individualized case assessment. Documentation, interviews, and observations. Services and behavioral interventions remain available after misconduct findings as appropriate. PAQ validation. The PAQ represents proportionate sanctions for individuals in confinement following an administrative finding, consideration of mental or cognitive disability, and no discipline for sexual activity unless the activity was coerced or otherwise abusive. The Auditor finds the facility meets the requirements of this provision. 115.378(d) Policy and requirement. Policy 7-05 states: “The facility may require participation in interventions designed to address and correct underlying reasons or motivations for abuse.” The policy permits therapeutic interventions when appropriate. The facility operationalizes this provision through counseling services, behavioral interventions, treatment planning, and mental health referrals. Documentation, interviews, and observations. No individual in confinement reported discipline for making a good-faith report or for consensual conduct. PAQ validation. The PAQ represents proportionate sanctions for individuals in confinement following an administrative finding, consideration of mental or cognitive disability, and no discipline for sexual activity unless the activity was coerced or otherwise abusive. The Auditor finds the facility meets the requirements of this provision.

	115.378(e) Policy and requirement. Policy 7-05 states: “A resident may be disciplined for sexual contact with staff only upon a finding that the staff member did not consent to such contact.” The policy recognizes the legal and developmental distinctions applicable to misconduct by an individual in confinement involving staff. The facility operationalizes this requirement through investigative review and disciplinary procedures. Documentation, interviews, and observations. Investigative and supervisory evidence showed that case findings, age, development, history, and circumstances are considered before intervention or discipline. PAQ validation. The PAQ represents proportionate sanctions for individuals in confinement following an administrative finding, consideration of mental or cognitive disability, and no discipline for sexual activity unless the activity was coerced or otherwise abusive. The Auditor finds the facility meets the requirements of this provision. 115.378(f) Policy and requirement. Policy 7-05 states: “Residents shall not be disciplined for reporting sexual abuse made in good faith, even if the allegation is not substantiated.” The policy protects individuals in confinement who report concerns in good faith. The facility operationalizes this provision through disciplinary review procedures and reporting protections. Documentation, interviews, and observations. Services and behavioral interventions remain available after misconduct findings as appropriate. PAQ validation. The PAQ represents proportionate sanctions for individuals in confinement following an administrative finding, consideration of mental or cognitive disability, and no discipline for sexual activity unless the activity was coerced or otherwise abusive. The Auditor finds the facility meets the requirements of this provision. 115.378(g) Policy and requirement. (g) An agency may, in its discretion, prohibit all sexual activity between individuals in confinement and may discipline individuals in confinement for such activity. An agency may not, however, deem such activity to constitute sexual abuse if it determines that the activity is not coerced. Medical and Mental Care Policy 7-05, PREA establish the facility process applicable to this requirement. Documentation, interviews, and observations. No individual in confinement reported discipline for making a good-faith report or for consensual conduct. PAQ validation. The PAQ represents proportionate sanctions for individuals in

	confinement following an administrative finding, consideration of mental or cognitive disability, and no discipline for sexual activity unless the activity was coerced or otherwise abusive. The Auditor finds the facility meets the requirements of this provision. Auditor Analysis and Determination The disciplinary framework is proportionate, individualized, and tied to an administrative finding. Interview and case evidence did not reveal punishment for reporting or an impermissible presumption that all sexual contact involving an individual in confinement constitutes abuse. The standard-level finding rests on convergence among policy requirements, current documentation, interviews and questionnaires, selected file review, and PAQ validation. No individual in confinement reported discipline for making a good-faith report or for consensual conduct. Investigative and supervisory evidence showed that case findings, age, development, history, and circumstances are considered before intervention or discipline. Across 7 applicable provisions, the record established both the required controls and their operation in practice. The material source streams were reconciled at the provision level and collectively support the selected standard-level finding. That conclusion reflects demonstrated operation and corroboration, not the existence of policy language alone. The Auditor therefore determines that Standard 115.378, Interventions and Discipline, Meets Standard. Standard Finding STANDARD FINDING MEETS STANDARD

115.381	**Medical and mental health screenings; history of sexual abuse**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	STANDARD 115.381 — MEDICAL AND MENTAL HEALTH SCREENING Evidence Reviewed Policy · Policy 7-05, PREA Documentation · Vulnerability Assessment

	· Mental Health Referral Procedures · the designated licensed clinical social worker LCSW Documentation · Policy 7-05, PREA · Policy 6-20, Mental Health · Vulnerability Assessment instrument · Assessment referral/review log · Screening and reassessment records Interviews and Questionnaires · Targeted youth interviews involving prior victimization · Medical/mental-health specialty follow-up Observations and Functional Verification · Private referral and service access File Review · Selected screening, referral, and follow-up records PAQ Validation · Onsite population data identified five individuals in confinement who had disclosed prior sexual victimization; selected referral and follow-up records were reviewed. Provision Analysis 115.381(a) Policy and requirement. Policy 7-05, PREA, states: “If screening indicates that a resident has experienced prior sexual victimization, whether in an institutional setting or in the community, staff shall ensure the resident is offered a follow-up meeting with a medical or mental health practitioner.” The policy requires follow-up assessment when prior victimization is disclosed. The facility operationalizes this requirement through vulnerability assessments, classification reviews, and referral to qualified mental health personnel. Documentation, interviews, and observations. Screening and referral records demonstrated offers of medical or mental-health follow-up after qualifying disclosures. PAQ validation. Onsite population data identified five individuals in confinement who had disclosed prior sexual victimization; selected referral and follow-up records were reviewed. The Auditor finds the facility meets the requirements of this provision.

	115.381(b) Policy and requirement. Policy 7-05 states: “If screening indicates that a resident has previously perpetrated sexual abuse, staff shall ensure the resident is offered a follow-up meeting with a mental health practitioner when appropriate.” The policy requires follow-up assessment for individuals in confinement with a history of perpetrating sexual abuse. The facility operationalizes this provision through classification review, behavioral assessment, and mental health referral procedures. Documentation, interviews, and observations. Targeted individuals in confinement with prior victimization confirmed counselor, PREA, nursing, or mental-health follow-up was offered. PAQ validation. Onsite population data identified five individuals in confinement who had disclosed prior sexual victimization; selected referral and follow-up records were reviewed. The Auditor finds the facility meets the requirements of this provision. 115.381(c) Policy and requirement. Policy 7-05 requires follow-up meetings to occur within 14 days of intake screening when qualifying disclosures are identified. The facility operationalizes this requirement through referral tracking and mental health service coordination. Documentation, interviews, and observations. Sensitive information was limited to staff with treatment, safety, or management responsibilities, and informed-consent requirements were incorporated into practice. PAQ validation. Onsite population data identified five individuals in confinement who had disclosed prior sexual victimization; selected referral and follow-up records were reviewed. The Auditor finds the facility meets the requirements of this provision. 115.381(d) Policy and requirement. Policy 7-05 requires information related to sexual victimization or abusiveness be shared only with staff who need the information to make treatment, housing, security, or management decisions. The facility operationalizes this provision through confidentiality procedures, classification reviews, and restricted access to assessment information. Documentation, interviews, and observations. Screening and referral records demonstrated offers of medical or mental-health follow-up after qualifying disclosures. PAQ validation. Onsite population data identified five individuals in confinement who had disclosed prior sexual victimization; selected referral and follow-up records were reviewed.

	The Auditor finds the facility meets the requirements of this provision. Auditor Analysis and Determination The screening-to-referral process, selected records, targeted interviews, and provider verification demonstrate timely offers of follow-up and controlled disclosure of sensitive history. The standard-level finding rests on convergence among policy requirements, current documentation, interviews and questionnaires, direct observation and functional verification, selected file review, and PAQ validation. Screening and referral records demonstrated offers of medical or mental-health follow-up after qualifying disclosures. Targeted individuals in confinement with prior victimization confirmed counselor, PREA, nursing, or mental-health follow-up was offered. Across 4 applicable provisions, the record established both the required controls and their operation in practice. The material source streams were reconciled at the provision level and collectively support the selected standard-level finding. That conclusion reflects demonstrated operation and corroboration, not the existence of policy language alone. The Auditor therefore determines that Standard 115.381, Medical and Mental Health Screening, Meets Standard. Standard Finding STANDARD FINDING MEETS STANDARD

115.382	**Access to emergency medical and mental health services**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	STANDARD 115.382 — EMERGENCY CARE Evidence Reviewed Policy · Policy 7-05, PREA Documentation · Specialty Contact Form · St. Luke's CARES Information · Advocates Against Family Violence MOU · Policy 6-02, Health Appraisal

	· Policy 6-20, Mental Health · Policy 7-05, PREA · Medical Staff Questionnaire · Emergency referral and provider information Interviews and Questionnaires · Medical/mental-health specialty follow-up · Random staff first-responder interviews Observations and Functional Verification · Twenty-four-hour access to medical response and private services PAQ Validation · The PAQ represents immediate, unimpeded emergency medical and crisis-intervention access without financial cost and at the professional judgment of practitioners. Provision Analysis 115.382(a) Policy and requirement. Policy 7-05, PREA, states: “Resident victims of sexual abuse shall receive timely, unimpeded access to emergency medical treatment and crisis intervention services.” The policy requires immediate access to medical and mental health services following sexual abuse. The facility operationalizes this requirement through referral procedures, emergency medical transport, St. Luke’s CARES services, mental health support, and victim advocacy resources. Documentation, interviews, and observations. The medical practitioner confirmed emergency hospital referral, evidence preservation, crisis response, confidentiality, and no-cost care. PAQ validation. The PAQ represents immediate, unimpeded emergency medical and crisis-intervention access without financial cost and at the professional judgment of practitioners. The Auditor finds the facility meets the requirements of this provision. 115.382(b) Policy and requirement. Policy 7-05 states: “Treatment services shall be determined by medical and mental health practitioners according to their professional judgment.” The policy places treatment decisions within the professional judgment of qualified practitioners. The facility operationalizes this provision through use of licensed medical providers, mental health professionals, and forensic examination

	resources. Documentation, interviews, and observations. Staff first responders understood immediate medical and mental-health notification and did not condition care on cooperation with an investigation. PAQ validation. The PAQ represents immediate, unimpeded emergency medical and crisis-intervention access without financial cost and at the professional judgment of practitioners. The Auditor finds the facility meets the requirements of this provision. 115.382(c) Policy and requirement. Policy 7-05 states: “Resident victims of sexual abuse while incarcerated shall be offered timely information about and timely access to emergency contraception and sexually transmitted infection prophylaxis where medically appropriate.” The policy requires access to appropriate post-assault medical care. The facility operationalizes this requirement through referral to St. Luke’s CARES and other qualified medical providers capable of providing emergency medical treatment and follow-up care. Documentation, interviews, and observations. The medical practitioner confirmed emergency hospital referral, evidence preservation, crisis response, confidentiality, and no-cost care. PAQ validation. The PAQ represents immediate, unimpeded emergency medical and crisis-intervention access without financial cost and at the professional judgment of practitioners. The Auditor finds the facility meets the requirements of this provision. 115.382(d) Policy and requirement. Policy 7-05 states: “All treatment services shall be provided to the victim without financial cost regardless of whether the victim names the abuser or cooperates with any investigation.” The policy prohibits charging victims for required treatment services. The facility operationalizes this provision through established referral agreements and funding practices that ensure treatment is provided without cost to the individual in confinement. Documentation, interviews, and observations. Staff first responders understood immediate medical and mental-health notification and did not condition care on cooperation with an investigation. PAQ validation. The PAQ represents immediate, unimpeded emergency medical and crisis-intervention access without financial cost and at the professional judgment of practitioners. The Auditor finds the facility meets the requirements of this provision.

	Auditor Analysis and Determination Policy, practitioner evidence, staff knowledge, and onsite access establish immediate emergency medical and mental-health response without cost to individuals in confinement. The standard-level finding rests on convergence among policy requirements, current documentation, interviews and questionnaires, direct observation and functional verification, and PAQ validation. The medical practitioner confirmed emergency hospital referral, evidence preservation, crisis response, confidentiality, and no-cost care. Staff first responders understood immediate medical and mental-health notification and did not condition care on cooperation with an investigation. Across 4 applicable provisions, the record established both the required controls and their operation in practice. The material source streams were reconciled at the provision level and collectively support the selected standard-level finding. That conclusion reflects demonstrated operation and corroboration, not the existence of policy language alone. The Auditor therefore determines that Standard 115.382, Emergency Care, Meets Standard. Standard Finding STANDARD FINDING MEETS STANDARD

115.383	**Ongoing medical and mental health care for sexual abuse victims and abusers**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	STANDARD 115.383 — ONGOING CARE Evidence Reviewed Policy · Policy 7-05, PREA Documentation · Mental Health Referral Procedures · the designated licensed clinical social worker LCSW Documentation · St. Luke's CARES Information · Advocates Against Family Violence MOU

	· Medical and mental health policies · Medical Staff Questionnaire · Outside provider and victim-advocacy information · Ongoing-care and referral procedures Interviews and Questionnaires · Medical/mental-health specialty follow-up · Targeted youth interviews Observations and Functional Verification · Access to private ongoing medical and mental-health services PAQ Validation · The PAQ represents ongoing care, evaluation, treatment, testing, pregnancy-related services where applicable, and no-cost services consistent with community standards. Provision Analysis 115.383(a) Policy and requirement. Policy 7-05, PREA, states: “The facility shall offer medical and mental health evaluation and, as appropriate, treatment to all residents who have been victimized by sexual abuse in any prison, jail, lockup, or juvenile facility.” The policy requires access to ongoing medical and mental health services for individuals in confinement who have experienced sexual abuse. The facility operationalizes this requirement through qualified mental health providers, referrals to outside medical providers, victim advocacy resources, and ongoing treatment planning when clinically indicated. Documentation, interviews, and observations. The designated practitioner described ongoing evaluation, referral, testing, treatment, and community-provider access based on clinical need. PAQ validation. The PAQ represents ongoing care, evaluation, treatment, testing, pregnancy-related services where applicable, and no-cost services consistent with community standards. The Auditor finds the facility meets the requirements of this provision. 115.383(b) Policy and requirement. Policy 7-05 states: “The evaluation and treatment of such victims shall include, as appropriate, follow-up services, treatment plans, and referrals for continued care following transfer to, or placement in, other facilities, or

	release from custody.” The policy requires continuity of care and follow-up services when individuals in confinement require ongoing treatment. The facility operationalizes this provision through treatment planning, referrals, discharge planning, and coordination with community providers when appropriate. Documentation, interviews, and observations. No individual in confinement reported an in-facility sexual-abuse victimization during the onsite population review that required activation of ongoing post-assault care. PAQ validation. The PAQ represents ongoing care, evaluation, treatment, testing, pregnancy-related services where applicable, and no-cost services consistent with community standards. The Auditor finds the facility meets the requirements of this provision. 115.383(c) Policy and requirement. Policy 7-05 states: “The facility shall provide victims with medical and mental health services consistent with the community level of care.” The policy requires services that are consistent with professional community standards. The facility operationalizes this requirement through referral to licensed medical providers, mental health professionals, St. Luke’s CARES services, and qualified victim advocacy organizations. Documentation, interviews, and observations. Targeted individuals in confinement confirmed access to counseling and health services without charge. PAQ validation. The PAQ represents ongoing care, evaluation, treatment, testing, pregnancy-related services where applicable, and no-cost services consistent with community standards. The Auditor finds the facility meets the requirements of this provision. 115.383(d) Policy and requirement. Policy 7-05 states: “Resident victims of sexually abusive vaginal penetration while incarcerated shall be offered pregnancy testing where medically appropriate.” The policy requires access to pregnancy testing when medically indicated. The facility operationalizes this provision through referrals to qualified medical providers capable of providing appropriate medical evaluation and treatment. Documentation, interviews, and observations. The designated practitioner described ongoing evaluation, referral, testing, treatment, and community-provider access based on clinical need. PAQ validation. The PAQ represents ongoing care, evaluation, treatment, testing, pregnancy-related services where applicable, and no-cost services consistent with community standards. The Auditor finds the facility meets the requirements of this provision.

	115.383(e) Policy and requirement. Policy 7-05 states: “If pregnancy results from conduct described in paragraph (d), victims shall receive timely and comprehensive information and access to lawful pregnancy-related medical services.” The policy requires access to lawful pregnancy-related services when applicable. The facility operationalizes this requirement through referral to licensed medical providers and coordination of necessary healthcare services. Documentation, interviews, and observations. No individual in confinement reported an in-facility sexual-abuse victimization during the onsite population review that required activation of ongoing post-assault care. PAQ validation. The PAQ represents ongoing care, evaluation, treatment, testing, pregnancy-related services where applicable, and no-cost services consistent with community standards. The Auditor finds the facility meets the requirements of this provision. 115.383(f) Policy and requirement. Policy 7-05 states: “Resident victims of sexual abuse while incarcerated shall be offered tests for sexually transmitted infections as medically appropriate.” The policy requires access to STI testing when clinically indicated. The facility operationalizes this requirement through referral to qualified healthcare providers capable of conducting testing and treatment. Documentation, interviews, and observations. Targeted individuals in confinement confirmed access to counseling and health services without charge. PAQ validation. The PAQ represents ongoing care, evaluation, treatment, testing, pregnancy-related services where applicable, and no-cost services consistent with community standards. The Auditor finds the facility meets the requirements of this provision. 115.383(g) Policy and requirement. Policy 7-05 states: “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.” The policy ensures that treatment remains available regardless of investigative participation. The facility operationalizes this requirement through referral procedures and funding practices that eliminate financial barriers to treatment. Documentation, interviews, and observations. The designated practitioner described ongoing evaluation, referral, testing, treatment, and community-provider access based on clinical need. PAQ validation. The PAQ represents ongoing care, evaluation, treatment, testing, pregnancy-related services where applicable, and no-cost services consistent with

	community standards. The Auditor finds the facility meets the requirements of this provision. 115.383(h) Policy and requirement. Policy 7-05 states: “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.” The policy requires mental health assessment and intervention for known individuals in confinement known to have abused other individuals in confinement. The facility operationalizes this provision through mental health referral procedures, behavioral assessments, and treatment recommendations when clinically indicated. Documentation, interviews, and observations. No individual in confinement reported an in-facility sexual-abuse victimization during the onsite population review that required activation of ongoing post-assault care. PAQ validation. The PAQ represents ongoing care, evaluation, treatment, testing, pregnancy-related services where applicable, and no-cost services consistent with community standards. The Auditor finds the facility meets the requirements of this provision. Auditor Analysis and Determination The ongoing-care framework is clinically directed, available without cost, and connected to outside services when necessary. No qualifying event exposed a gap during the review period. The standard-level finding rests on convergence among policy requirements, current documentation, interviews and questionnaires, direct observation and functional verification, and PAQ validation. The designated practitioner described ongoing evaluation, referral, testing, treatment, and community-provider access based on clinical need. No individual in confinement reported an in-facility sexual-abuse victimization during the onsite population review that required activation of ongoing post-assault care. Across 8 applicable provisions, the record established both the required controls and their operation in practice. The material source streams were reconciled at the provision level and collectively support the selected standard-level finding. That conclusion reflects demonstrated operation and corroboration, not the existence of policy language alone. The Auditor therefore determines that Standard 115.383, Ongoing Care, Meets Standard. Standard Finding STANDARD FINDING MEETS STANDARD

115.386	Sexual abuse incident reviews
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	STANDARD 115.386 — INCIDENT REVIEWS Evidence Reviewed Policy · Policy 7-05, PREA Documentation · Incident Review Documentation · Investigation Files · Policy 7-05, PREA · Incident Review Team Questionnaire · Corrected incident-review records · Investigation reports and annual data Interviews and Questionnaires · Incident-review team and PREA Coordinator follow-up Observations and Functional Verification · Review of relevant physical locations and monitoring capability during the site review File Review · Current PREA case and incident-review records PAQ Validation · The PAQ represents a multidisciplinary incident-review process within 30 days for substantiated and unsubstantiated sexual-abuse investigations, excluding unfounded allegations. Provision Analysis 115.386(a) Policy and requirement. Policy 7-05, PREA, states: “The facility shall conduct a sexual abuse incident review at the conclusion of every sexual abuse investigation unless the allegation has been determined to be unfounded.” The policy requires incident reviews following substantiated and unsubstantiated sexual abuse

	investigations. The facility operationalizes this requirement through administrative review procedures conducted after qualifying investigations. Documentation, interviews, and observations. No review-period sexual-abuse investigation ended substantiated or unsubstantiated; therefore, no incident review was required by paragraph (a). Available review records nevertheless demonstrated the process. PAQ validation. The PAQ represents a multidisciplinary incident-review process within 30 days for substantiated and unsubstantiated sexual-abuse investigations, excluding unfounded allegations. The Auditor finds the facility meets the requirements of this provision. 115.386(b) Policy and requirement. Policy 7-05 states: “The review shall ordinarily occur within 30 days of the conclusion of the investigation.” The policy establishes a timeline for incident review completion. The facility operationalizes this requirement through administrative oversight and investigative review procedures. Documentation, interviews, and observations. Corrected review records and the team questionnaire reflected the 30-day completion expectation. PAQ validation. The PAQ represents a multidisciplinary incident-review process within 30 days for substantiated and unsubstantiated sexual-abuse investigations, excluding unfounded allegations. The Auditor finds the facility meets the requirements of this provision. 115.386(c) Policy and requirement. Policy 7-05 states: “The review team shall include upper-level management officials, investigators, medical or mental health practitioners, and other staff as appropriate.” The policy requires a multidisciplinary review team. The facility operationalizes this provision through administrative review structures involving management, investigators, and other relevant personnel. Documentation, interviews, and observations. The review structure included upper-level management and input from supervisors, investigators, and medical or mental-health staff. PAQ validation. The PAQ represents a multidisciplinary incident-review process within 30 days for substantiated and unsubstantiated sexual-abuse investigations, excluding unfounded allegations. The Auditor finds the facility meets the requirements of this provision. 115.386(d) Policy and requirement. Policy 7-05 requires review teams to consider: “Whether the

	allegation or investigation indicates a need to change policy or practice.” The facility operationalizes this requirement through formal review of investigative findings and operational issues. Documentation, interviews, and observations. Review records addressed policy and practice, physical location, staffing, monitoring technology, findings, and recommendations, except for the DOJ-limited subparagraph excluded below. PAQ validation. The PAQ represents a multidisciplinary incident-review process within 30 days for substantiated and unsubstantiated sexual-abuse investigations, excluding unfounded allegations. The Auditor finds the facility meets the requirements of this provision. 115.386(d)(2) — DOJ-Designated Not Audited This provision is designated by DOJ as “Not Audited by the Auditor” and is excluded from compliance determinations. The Auditor did not request documentation, conduct interviews, or assess implementation for this subsection. Its exclusion does not affect the compliance determination for this standard. 115.386(e) Policy and requirement. Policy 7-05 states: “The facility shall implement recommendations for improvement or document the reasons for not doing so.” The policy requires accountability for review findings and recommendations. The facility operationalizes this provision through administrative documentation and management review. Documentation, interviews, and observations. Leadership records required implementation of recommendations or documentation of the reason for not implementing them. PAQ validation. The PAQ represents a multidisciplinary incident-review process within 30 days for substantiated and unsubstantiated sexual-abuse investigations, excluding unfounded allegations. The Auditor finds the facility meets the requirements of this provision. Auditor Analysis and Determination Policy, corrected review records, team responses, investigation files, and site observations establish the required review structure. The prior document-quality defects were resolved before findings were made. DOJ-limited subparagraph 115.386(d)(2) was excluded. The standard-level finding rests on convergence among policy requirements, current documentation, interviews and questionnaires, direct observation and functional verification, selected file review, and PAQ validation. The facility corrected date and readability problems in incident-review records before the onsite audit; the corrected records, rather than the earlier defective copies, controlled the analysis. Review documents considered policy/ practice, physical area, staffing, monitoring technology, and recommendations and were routed to leadership. Across 5 applicable provisions, the record established

	both the required controls and their operation in practice. The 1 DOJ-designated not-audited provision was excluded from the compliance determination and did not supply evidentiary support for the finding. The material source streams were reconciled at the provision level and collectively support the selected standard-level finding. That conclusion reflects demonstrated operation and corroboration, not the existence of policy language alone. The Auditor therefore determines that Standard 115.386, Incident Reviews, Meets Standard. Standard Finding STANDARD FINDING MEETS STANDARD

115.387	**Data collection**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	STANDARD 115.387 — DATA COLLECTION Evidence Reviewed Policy · Policy 7-05, PREA Documentation · Annual PREA Reports · Survey of Sexual Violence Data Collection Materials · Policy 1-19, PREA Data Collection · Policy 7-05, PREA · 2025 Survey of Sexual Violence data workbook · 2025 SWIJDC PREA annual report · Facility Data Collection Reports, Parts One and Two · Investigation and incident-review files Interviews and Questionnaires · PREA Coordinator and agency head questionnaires File Review

	· Three review-period PREA case groups and related source records PAQ Validation · The 12-month data collection reported three youth-on-youth sexual-harassment allegations and no sexual-abuse allegations; the 2025 annual data identified four notifications, consisting of one non-PREA matter, two unsubstantiated matters, and one substantiated matter. Provision Analysis 115.387(a) Policy and requirement. Policy 7-05, PREA, states: “The facility shall collect accurate, uniform data for every allegation of sexual abuse.” The policy requires systematic collection of PREA-related allegation data. The facility operationalizes this requirement through investigative documentation, incident reports, annual PREA reports, and Survey of Sexual Violence reporting. Documentation, interviews, and observations. The facility maintained incident-based data for each allegation using standardized definitions. PAQ validation. The 12-month data collection reported three youth-on-youth sexual-harassment allegations and no sexual-abuse allegations; the 2025 annual data identified four notifications, consisting of one non-PREA matter, two unsubstantiated matters, and one substantiated matter. The Auditor finds the facility meets the requirements of this provision. 115.387(b) Policy and requirement. Policy 7-05 requires data collection to include information necessary for aggregate reporting and analysis. The facility operationalizes this provision through annual PREA reports, investigative documentation, and allegation tracking systems. Documentation, interviews, and observations. The 2025 SSV workbook and annual report aggregated incident data annually. PAQ validation. The 12-month data collection reported three youth-on-youth sexual-harassment allegations and no sexual-abuse allegations; the 2025 annual data identified four notifications, consisting of one non-PREA matter, two unsubstantiated matters, and one substantiated matter. The Auditor finds the facility meets the requirements of this provision. 115.387(c) Policy and requirement. Policy 7-05 requires data collection from incident reports, investigation files, and other available sources. The facility operationalizes this requirement through review of investigative files, incident reports, and

	administrative documentation. Documentation, interviews, and observations. The collected fields were sufficient to answer the current Survey of Sexual Violence categories. PAQ validation. The 12-month data collection reported three youth-on-youth sexual-harassment allegations and no sexual-abuse allegations; the 2025 annual data identified four notifications, consisting of one non-PREA matter, two unsubstantiated matters, and one substantiated matter. The Auditor finds the facility meets the requirements of this provision. 115.387(d) Policy and requirement. Policy 7-05 requires aggregation of PREA data for reporting and review purposes. The facility operationalizes this provision through annual reporting and Survey of Sexual Violence submissions. Documentation, interviews, and observations. Investigation files, reports, and available incident-review documents were used as source records for the annual data. PAQ validation. The 12-month data collection reported three youth-on-youth sexual-harassment allegations and no sexual-abuse allegations; the 2025 annual data identified four notifications, consisting of one non-PREA matter, two unsubstantiated matters, and one substantiated matter. The Auditor finds the facility meets the requirements of this provision. 115.387(e) Policy and requirement. (e) The agency also shall obtain incident-based and aggregated data from every private facility with which it contracts for the confinement of its individuals in confinement. Policy 7-05, PREA establish the facility process applicable to this requirement. Documentation, interviews, and observations. The agency had no private confinement contract from which incident-based data had to be obtained during the review period. PAQ validation. The 12-month data collection reported three youth-on-youth sexual-harassment allegations and no sexual-abuse allegations; the 2025 annual data identified four notifications, consisting of one non-PREA matter, two unsubstantiated matters, and one substantiated matter. The Auditor finds the facility meets the requirements of this provision. 115.387(f) Policy and requirement. (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.

	Policy 7-05, PREA establish the facility process applicable to this requirement. Documentation, interviews, and observations. Policy and annual-data practices supported provision of the prior calendar year’s data to DOJ by June 30 upon request. PAQ validation. The 12-month data collection reported three youth-on-youth sexual-harassment allegations and no sexual-abuse allegations; the 2025 annual data identified four notifications, consisting of one non-PREA matter, two unsubstantiated matters, and one substantiated matter. The Auditor finds the facility meets the requirements of this provision. Auditor Analysis and Determination Standardized data, source investigation records, annual aggregation, and the published annual report were internally reconcilable after separating the non-PREA notification from the three PREA case groups. The facility collects and retains the information necessary for the SSV and DOJ reporting. The standard-level finding rests on convergence among policy requirements, current documentation, interviews and questionnaires, selected file review, and PAQ validation. The facility used standardized categories and maintained incident-based source records supporting its annual aggregation. The 2025 SSV workbook contained year-by-year data and the investigation files supported the current-year classifications. Across 6 applicable provisions, the record established both the required controls and their operation in practice. The material source streams were reconciled at the provision level and collectively support the selected standard-level finding. That conclusion reflects demonstrated operation and corroboration, not the existence of policy language alone. The Auditor therefore determines that Standard 115.387, Data Collection, Meets Standard. Standard Finding STANDARD FINDING MEETS STANDARD

115.388	**Data review for corrective action**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	STANDARD 115.388 — DATA REVIEW AND CORRECTIVE ACTION Evidence Reviewed Policy

	· Policy 7-05, PREA Documentation · Annual PREA Reports · Staffing Plan Assessments · Policy 1-19, PREA Data Collection · Policy 7-05, PREA · 2025 SWIJDC PREA annual report · 2025 SSV year-over-year workbook · Prior published audit and annual reports · Current facility webpage capture Interviews and Questionnaires · Agency head and PREA Coordinator questionnaires Observations and Functional Verification · Public webpage review PAQ Validation · The PAQ represents annual review of aggregated data, identification of problem areas, corrective action, agency-head approval, and public availability. Provision Analysis 115.388(a) Policy and requirement. Policy 7-05, PREA, states: “The facility 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 efforts.” The policy requires review and analysis of PREA data to improve facility operations. The facility operationalizes this requirement through annual PREA reports, staffing plan assessments, incident reviews, and management review processes. Documentation, interviews, and observations. The 2025 annual report compared current and prior-year allegations, described camera and programming improvements, and assessed ongoing prevention efforts. PAQ validation. The PAQ represents annual review of aggregated data, identification of problem areas, corrective action, agency-head approval, and public availability. The Auditor finds the facility meets the requirements of this provision.

	115.388(b) Policy and requirement. Policy 7-05 requires the review process to consider problem areas, corrective actions, and future prevention efforts. The facility operationalizes this provision through annual PREA reports and administrative review of allegations and operational practices. Documentation, interviews, and observations. The public webpage linked annual data, annual reports, and prior audit reports. PAQ validation. The PAQ represents annual review of aggregated data, identification of problem areas, corrective action, agency-head approval, and public availability. The Auditor finds the facility meets the requirements of this provision. 115.388(c) Policy and requirement. Policy 7-05 requires preparation of an annual report assessing PREA efforts and corrective actions. The facility operationalizes this requirement through annual PREA reporting and administrative review. Documentation, interviews, and observations. Agency leadership described use of investigation outcomes and annual data to evaluate policy, physical plant, staffing, supervision, and technology. PAQ validation. The PAQ represents annual review of aggregated data, identification of problem areas, corrective action, agency-head approval, and public availability. The Auditor finds the facility meets the requirements of this provision. 115.388(d) Policy and requirement. Policy 7-05 requires annual reports to be approved by agency leadership and made readily available. The facility operationalizes this provision through publication and administrative approval procedures. Documentation, interviews, and observations. The 2025 annual report compared current and prior-year allegations, described camera and programming improvements, and assessed ongoing prevention efforts. PAQ validation. The PAQ represents annual review of aggregated data, identification of problem areas, corrective action, agency-head approval, and public availability. The Auditor finds the facility meets the requirements of this provision. Auditor Analysis and Determination The annual report, year-over-year data, leadership review, and public posting demonstrate that collected data are used to assess and improve prevention, detection, and response. The standard-level finding rests on convergence among policy requirements, current documentation, interviews and questionnaires, direct

	observation and functional verification, and PAQ validation. The 2025 annual report compared current and prior-year allegations, described camera and programming improvements, and assessed ongoing prevention efforts. The public webpage linked annual data, annual reports, and prior audit reports. Across 4 applicable provisions, the record established both the required controls and their operation in practice. The material source streams were reconciled at the provision level and collectively support the selected standard-level finding. That conclusion reflects demonstrated operation and corroboration, not the existence of policy language alone. The Auditor therefore determines that Standard 115.388, Data Review and Corrective Action, Meets Standard. Standard Finding STANDARD FINDING MEETS STANDARD

115.389	**Data storage, publication, and destruction**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	STANDARD 115.389 — DATA STORAGE, PUBLICATION, AND RETENTION Evidence Reviewed Policy · Policy 7-05, PREA Documentation · Annual PREA Reports · Records Retention Documentation · Policy 1-19, PREA Data Collection · Policy 7-05, PREA · Public annual data and reports · Current facility webpage capture · Records-retention practices Interviews and Questionnaires · PREA Coordinator and agency head questionnaires

	Observations and Functional Verification · Public webpage review PAQ Validation · The PAQ represents secure retention, annual public availability of aggregated data, removal of personal identifiers, and retention for at least 10 years. Provision Analysis 115.389(a) Policy and requirement. Policy 7-05, PREA, states: “The facility shall ensure that data collected pursuant to PREA standards are securely retained.” The policy requires secure storage of PREA-related information. The facility operationalizes this requirement through administrative controls, secure electronic storage, and records management procedures. Documentation, interviews, and observations. The public reports and data contained aggregated information and did not disclose individual in confinement or staff personally identifiable information. PAQ validation. The PAQ represents secure retention, annual public availability of aggregated data, removal of personal identifiers, and retention for at least 10 years. The Auditor finds the facility meets the requirements of this provision. 115.389(b) Policy and requirement. Policy 7-05 requires PREA data to be made available to the public through annual reporting. The facility operationalizes this provision through publication of annual PREA reports. Documentation, interviews, and observations. The facility webpage made annual data and reports readily available. PAQ validation. The PAQ represents secure retention, annual public availability of aggregated data, removal of personal identifiers, and retention for at least 10 years. The Auditor finds the facility meets the requirements of this provision. 115.389(c) Policy and requirement. Policy 7-05 requires removal of personal identifiers before publication. The facility operationalizes this requirement through report review and redaction procedures. Documentation, interviews, and observations. Policy and leadership responses required secure storage and the applicable retention period. PAQ validation. The PAQ represents secure retention, annual public availability of

	aggregated data, removal of personal identifiers, and retention for at least 10 years. The Auditor finds the facility meets the requirements of this provision. 115.389(d) Policy and requirement. Policy 7-05 states: “The facility shall maintain sexual abuse data for at least ten years after the date of collection unless Federal, State, or local law requires otherwise.” The policy establishes retention requirements for PREA data. The facility operationalizes this provision through records retention procedures and secure record storage. Documentation, interviews, and observations. The public reports and data contained aggregated information and did not disclose individual in confinement or staff personally identifiable information. PAQ validation. The PAQ represents secure retention, annual public availability of aggregated data, removal of personal identifiers, and retention for at least 10 years. The Auditor finds the facility meets the requirements of this provision. Auditor Analysis and Determination Secure retention, de-identification, annual publication, and long-term retention are supported by policy, public records, and leadership verification. The standard-level finding rests on convergence among policy requirements, current documentation, interviews and questionnaires, direct observation and functional verification, and PAQ validation. The public reports and data contained aggregated information and did not disclose individual in confinement or staff personally identifiable information. The facility webpage made annual data and reports readily available. Across 4 applicable provisions, the record established both the required controls and their operation in practice. The material source streams were reconciled at the provision level and collectively support the selected standard-level finding. That conclusion reflects demonstrated operation and corroboration, not the existence of policy language alone. The Auditor therefore determines that Standard 115.389, Data Storage, Publication, and Retention, Meets Standard. Standard Finding STANDARD FINDING MEETS STANDARD

115.401	**Frequency and scope of audits**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion

	STANDARD 115.401 — AUDIT FREQUENCY AND SCOPE Evidence Reviewed Documentation · 2020 and 2023 final PREA audit reports · Current audit contract, schedule, and public notice records · Complete facility evidence repository · Video, camera, administrative-round, and electronic data records Interviews and Questionnaires · Twelve random staff interviews · Five random youth interviews · Five targeted youth interviews · Leadership, supervisory, medical, mental-health, investigator, volunteer, advocate, and provider questionnaires and follow-up Observations and Functional Verification · All accessible facility areas, housing units, showers, toilets, classrooms, recreation, medical/mental-health spaces, interview rooms, reporting mechanisms, and monitoring systems File Review · Policies, personnel/volunteer packets, training records, screening/ reassessment records, investigations, incident reviews, grievance records, annual data, and public records PAQ Validation · The current PAQ was evaluated as the facility’s representation and was validated against underlying records, interviews, observations, functional tests, and supplemental evidence. Provision Analysis 115.401(a) Policy and requirement. (a) During the three-year period starting on August 20, 2013, and during each three-year period thereafter, the agency shall ensure that each facility operated by the agency, or by a private organization on behalf of the agency, is audited at least once. The governing facility policies and procedures identified above establish the facility process applicable to this requirement. Documentation, interviews, and observations. Prior final audit reports and the current 2026 audit establish recurring audit coverage of the facility within the

	applicable three-year cycle. PAQ validation. The current PAQ was evaluated as the facility's representation and was validated against underlying records, interviews, observations, functional tests, and supplemental evidence. The Auditor finds the audit process and agency record meet the requirements of this provision. 115.401(b) Policy and requirement. (b) During each one-year period starting on August 20, 2013, the agency shall ensure that at least one-third of each facility type operated by the agency, or by a private organization on behalf of the agency, is audited. The governing facility policies and procedures identified above establish the facility process applicable to this requirement. Documentation, interviews, and observations. The agency operates one juvenile facility; auditing this facility satisfies the annual one-third requirement for the facility type. PAQ validation. The current PAQ was evaluated as the facility's representation and was validated against underlying records, interviews, observations, functional tests, and supplemental evidence. The Auditor finds the audit process and agency record meet the requirements of this provision. 115.401(c) Policy and requirement. (c) The Department of Justice may send a recommendation to an agency for an expedited audit if the Department has reason to believe that a particular facility may be experiencing problems relating to sexual abuse. The recommendation may also include referrals to resources that may assist the agency with PREA-related issues. The governing facility policies and procedures identified above establish the facility process applicable to this requirement. Documentation, interviews, and observations. No DOJ recommendation for an expedited audit was issued. The conditional provision therefore required no additional agency action. PAQ validation. The current PAQ was evaluated as the facility's representation and was validated against underlying records, interviews, observations, functional tests, and supplemental evidence. The Auditor finds the audit process and agency record meet the requirements of this provision. 115.401(d) Policy and requirement. (d) The Department of Justice shall develop and issue an

	audit instrument that will provide guidance on the conduct of and contents of the audit. The governing facility policies and procedures identified above establish the facility process applicable to this requirement. Documentation, interviews, and observations. The audit used the DOJ final standards, official audit guidance, and the current RSAS applicability matrix as controlling instruments. PAQ validation. The current PAQ was evaluated as the facility's representation and was validated against underlying records, interviews, observations, functional tests, and supplemental evidence. The Auditor finds the audit process and agency record meet the requirements of this provision. 115.401(e) Policy and requirement. (e) The agency shall bear the burden of demonstrating compliance with the standards. The governing facility policies and procedures identified above establish the facility process applicable to this requirement. Documentation, interviews, and observations. The agency produced the policies, records, explanations, and access needed to demonstrate compliance; the auditor did not presume compliance from policy alone. PAQ validation. The current PAQ was evaluated as the facility's representation and was validated against underlying records, interviews, observations, functional tests, and supplemental evidence. The Auditor finds the audit process and agency record meet the requirements of this provision. 115.401(f) Policy and requirement. (f) The auditor shall review all relevant agency-wide policies, procedures, reports, internal and external audits, and accreditations for each facility type. The governing facility policies and procedures identified above establish the facility process applicable to this requirement. Documentation, interviews, and observations. Agency-wide and facility policies, procedures, annual reports, prior audit reports, investigation records, and oversight materials were included in the evidence inventory. PAQ validation. The current PAQ was evaluated as the facility's representation and was validated against underlying records, interviews, observations, functional tests, and supplemental evidence. The Auditor finds the audit process and agency record meet the requirements of this provision. 115.401(g)

	Policy and requirement. (g) The audits shall review, at a minimum, a sampling of relevant documents and other records and information for the most recent one-year period. The governing facility policies and procedures identified above establish the facility process applicable to this requirement. Documentation, interviews, and observations. The audit sampled records from the 12-month review period ending May 31, 2026, and considered post-cutoff evidence when it resolved current implementation or a new allegation. PAQ validation. The current PAQ was evaluated as the facility’s representation and was validated against underlying records, interviews, observations, functional tests, and supplemental evidence. The Auditor finds the audit process and agency record meet the requirements of this provision. 115.401(h) Policy and requirement. (h) The auditor shall have access to, and shall observe, all areas of the audited facilities. The governing facility policies and procedures identified above establish the facility process applicable to this requirement. Documentation, interviews, and observations. The auditor was given access to all requested areas and directly observed housing, showers, toilets, education, recreation, medical and mental-health spaces, reporting routes, and monitoring systems. PAQ validation. The current PAQ was evaluated as the facility’s representation and was validated against underlying records, interviews, observations, functional tests, and supplemental evidence. The Auditor finds the audit process and agency record meet the requirements of this provision. 115.401(i) Policy and requirement. (i) The auditor shall be permitted to request and receive copies of any relevant documents (including electronically stored information). The governing facility policies and procedures identified above establish the facility process applicable to this requirement. Documentation, interviews, and observations. The agency provided electronic and paper copies of relevant records, including supplemental and post-onsite evidence. PAQ validation. The current PAQ was evaluated as the facility’s representation and was validated against underlying records, interviews, observations, functional tests, and supplemental evidence. The Auditor finds the audit process and agency record meet the requirements of this provision.

	115.401(j) Policy and requirement. (j) The auditor shall retain and preserve all documentation (including, e.g., video tapes and interview notes) relied upon in making audit determinations. Such documentation shall be provided to the Department of Justice upon request. The governing facility policies and procedures identified above establish the facility process applicable to this requirement. Documentation, interviews, and observations. The evidence repository, interview summaries, observation records, and report-source archive preserve the material relied upon for determinations. PAQ validation. The current PAQ was evaluated as the facility’s representation and was validated against underlying records, interviews, observations, functional tests, and supplemental evidence. The Auditor finds the audit process and agency record meet the requirements of this provision. 115.401(k) Policy and requirement. (k) The auditor shall interview a representative sample of individuals in confinement, individuals in confinement, and individuals in confinement, and of staff, supervisors, and administrators. The governing facility policies and procedures identified above establish the facility process applicable to this requirement. Documentation, interviews, and observations. The auditor interviewed 12 randomly selected staff, five random youth, five targeted youth, leadership, and specialized roles. PAQ validation. The current PAQ was evaluated as the facility’s representation and was validated against underlying records, interviews, observations, functional tests, and supplemental evidence. The Auditor finds the audit process and agency record meet the requirements of this provision. 115.401(l) Policy and requirement. (l) The auditor shall review a sampling of any available videotapes and other electronically available data (e.g., Watch tour) that may be relevant to the provisions being audited. The governing facility policies and procedures identified above establish the facility process applicable to this requirement. Documentation, interviews, and observations. Relevant camera work orders, camera coverage, administrative-round data, staffing data, and electronic facility records were sampled and correlated with observations. PAQ validation. The current PAQ was evaluated as the facility’s representation and

	was validated against underlying records, interviews, observations, functional tests, and supplemental evidence. The Auditor finds the audit process and agency record meet the requirements of this provision. 115.401(m) Policy and requirement. (m) The auditor shall be permitted to conduct private interviews with individuals in confinement, individuals in confinement, and individuals in confinement. The governing facility policies and procedures identified above establish the facility process applicable to this requirement. Documentation, interviews, and observations. All interviews with individuals in confinement were conducted privately. PAQ validation. The current PAQ was evaluated as the facility's representation and was validated against underlying records, interviews, observations, functional tests, and supplemental evidence. The Auditor finds the audit process and agency record meet the requirements of this provision. 115.401(n) Policy and requirement. (n) Individuals in confinement, individuals in confinement, and individuals in confinement shall be permitted to send confidential information or correspondence to the auditor in the same manner as if they were communicating with legal counsel. The governing facility policies and procedures identified above establish the facility process applicable to this requirement. Documentation, interviews, and observations. Bilingual audit notices and confidential correspondence instructions were posted, and individuals in confinement had a legal-mail-equivalent route to the auditor. PAQ validation. The current PAQ was evaluated as the facility's representation and was validated against underlying records, interviews, observations, functional tests, and supplemental evidence. The Auditor finds the audit process and agency record meet the requirements of this provision. 115.401(o) Policy and requirement. (o) Auditors shall attempt to communicate with community-based or victim advocates who may have insight into relevant conditions in the facility. § 115.402 Auditor qualifications. (a) An audit shall be conducted by: (1) A member of a correctional monitoring body that is not part of, or under the authority of, the agency (but may be part of, or authorized by, the relevant State or local government); (2) A member of an auditing entity such as an inspector general's or ombudsperson's office that is external to the agency; or (3) Other outside

	individuals with relevant experience. (b) All auditors shall be certified by the Department of Justice. The governing facility policies and procedures identified above establish the facility process applicable to this requirement. Documentation, interviews, and observations. The auditor obtained information from community victim-advocacy and outside emotional-support providers and tested current access routes. PAQ validation. The current PAQ was evaluated as the facility's representation and was validated against underlying records, interviews, observations, functional tests, and supplemental evidence. The Auditor finds the audit process and agency record meet the requirements of this provision. Auditor Analysis and Determination The audit was conducted using the DOJ standards, current applicability matrix, a 12-month record sample, full site access, private interviews, electronic and documentary evidence, and community-provider outreach. The agency bore the burden of demonstrating compliance, and duplicate records or internal working tools did not receive independent evidentiary weight. The standard-level finding rests on convergence among policy requirements, current documentation, interviews and questionnaires, direct observation and functional verification, selected file review, and PAQ validation. Published prior audit reports and the current audit schedule demonstrate recurring audit coverage of this single juvenile facility within the applicable audit cycles. The agency produced policies, records, electronically stored information, investigation files, and supplemental evidence, and the auditor had access to all areas requested. Across 15 applicable provisions, the record established both the required controls and their operation in practice. The material source streams were reconciled at the provision level and collectively support the selected standard-level finding. That conclusion reflects demonstrated operation and corroboration, not the existence of policy language alone. The Auditor therefore determines that Standard 115.401, Audit Frequency and Scope, Meets Standard. Standard Finding STANDARD FINDING MEETS STANDARD

115.403	**Audit contents and findings**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion

	STANDARD 115.403 — AUDIT REPORT CONTENTS AND FINDINGS Evidence Reviewed Documentation · Auditor conflict-of-interest record · This final provision-by-provision report · Agency website and prior published final reports File Review · Complete evidence and findings reconciliation PAQ Validation · The PAQ was used as facility-entered representation and was not substituted for independent evidence or the auditor’s determination. Provision Analysis 115.403(a) Policy and requirement. (a) Each audit shall include a certification by the auditor that no conflict of interest exists with respect to his or her ability to conduct an audit of the agency under review. The governing facility policies and procedures identified above establish the facility process applicable to this requirement. Documentation, interviews, and observations. Elaine Bridschge is an outside DOJ dual-certified PREA auditor. The conflict-of-interest certification is retained in the audit record. PAQ validation. The PAQ was used as facility-entered representation and was not substituted for independent evidence or the auditor’s determination. The Auditor finds the audit process and agency record meet the requirements of this provision. 115.403(b) Policy and requirement. (b) Audit reports shall state whether agency-wide policies and procedures comply with relevant PREA standards. The governing facility policies and procedures identified above establish the facility process applicable to this requirement. Documentation, interviews, and observations. Each standard section states whether the governing agency and facility policies comply and then separately evaluates implementation. PAQ validation. The PAQ was used as facility-entered representation and was not substituted for independent evidence or the auditor’s determination.

	The Auditor finds the audit process and agency record meet the requirements of this provision. 115.403(c) Policy and requirement. (c) For each PREA standard, the auditor shall determine whether the audited facility reaches one of the following findings: 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). The audit summary shall indicate, among other things, the number of provisions the facility has achieved at each grade level. The governing facility policies and procedures identified above establish the facility process applicable to this requirement. Documentation, interviews, and observations. The report applies only Exceeds Standard, Meets Standard, or Does Not Meet Standard. The final summary is 43 Meets, 0 Exceeds, and 0 Does Not Meet. PAQ validation. The PAQ was used as facility-entered representation and was not substituted for independent evidence or the auditor’s determination. The Auditor finds the audit process and agency record meet the requirements of this provision. 115.403(d) Policy and requirement. (d) Audit reports shall describe the methodology, sampling sizes, and basis for the auditor’s conclusions with regard to each standard provision for each 37232 Federal Register / Vol. 77, No. 119 / Wednesday, June 20, 2012 / Rules and Regulations audited facility, and shall include recommendations for any required corrective action. The governing facility policies and procedures identified above establish the facility process applicable to this requirement. Documentation, interviews, and observations. This final report provides the provision-level evidence and basis for each conclusion. The audit record separately preserves methodology, sample sizes, interviews, observations, file review, PAQ validation, QA, and recommendation analysis. No corrective action is required because no standard is rated Does Not Meet. PAQ validation. The PAQ was used as facility-entered representation and was not substituted for independent evidence or the auditor’s determination. The Auditor finds the audit process and agency record meet the requirements of this provision. 115.403(e) Policy and requirement. (e) Auditors shall redact any personally identifiable individual in confinement or staff information from their reports but shall provide such information to the agency upon request, and may provide such information to

	the Department of Justice. The governing facility policies and procedures identified above establish the facility process applicable to this requirement. Documentation, interviews, and observations. Personally identifiable individual in confinement and line-staff information has been excluded. Confidential source records remain in the audit file. PAQ validation. The PAQ was used as facility-entered representation and was not substituted for independent evidence or the auditor’s determination. The Auditor finds the audit process and agency record meet the requirements of this provision. 115.403(f) Policy and requirement. (f) The agency shall ensure that the auditor’s final report is published on the agency’s Web site if it has one or is otherwise made readily available to the public. § 115.404 Audit corrective action plan. (a) A finding of ‘‘Does Not Meet Standard’’ with one or more standards shall trigger a 180-day corrective action period. (b) The auditor and the agency shall jointly develop a corrective action plan to achieve compliance. (c) The auditor shall take necessary and appropriate steps to verify implementation of the corrective action plan, such as reviewing updated policies and procedures or re-inspecting portions of a facility. The governing facility policies and procedures identified above establish the facility process applicable to this requirement. Documentation, interviews, and observations. The agency has an established public webpage containing prior audit reports and annual data. This final report is ready for OAS submission and publication in accordance with PREA requirements. PAQ validation. The PAQ was used as facility-entered representation and was not substituted for independent evidence or the auditor’s determination. The Auditor finds the audit process and agency record meet the requirements of this provision. Auditor Analysis and Determination Facility factual review was completed with no corrections requested. This final report presents the verified facility facts, evidence descriptions, provision analyses, and findings. The audit record separately retains the auditor certification, methodology, sampling record, source reconciliation, QA record, and publication controls. The standard-level finding rests on convergence among policy requirements, current documentation, selected file review, and PAQ validation. The auditor is an outside DOJ-certified PREA auditor, and the conflict-of-interest certification is retained in the audit record. This final report states policy and operational determinations for every matrix-controlled provision and uses only the three authorized standard findings. Across 6 applicable provisions, the record established both the required controls and their operation in practice.

	The material source streams were reconciled at the provision level and collectively support the selected standard-level finding. That conclusion reflects demonstrated operation and corroboration, not the existence of policy language alone. The Auditor therefore determines that Standard 115.403, Audit Report Contents and Findings, Meets Standard. Standard Finding STANDARD FINDING MEETS STANDARD

Appendix: Provision Findings		
115.311 (a)	**Zero tolerance of sexual abuse and sexual harassment; PREA coordinator**	
	Does the agency have a written policy mandating zero tolerance toward all forms of sexual abuse and sexual harassment?	yes
	Does the written policy outline the agency's approach to preventing, detecting, and responding to sexual abuse and sexual harassment?	yes
115.311 (b)	**Zero tolerance of sexual abuse and sexual harassment; PREA coordinator**	
	Has the agency employed or designated an agency-wide PREA Coordinator?	yes
	Is the PREA Coordinator position in the upper-level of the agency hierarchy?	yes
	Does the PREA Coordinator have sufficient time and authority to develop, implement, and oversee agency efforts to comply with the PREA standards in all of its facilities?	yes
115.311 (c)	**Zero tolerance of sexual abuse and sexual harassment; PREA coordinator**	
	If this agency operates more than one facility, has each facility designated a PREA compliance manager? (N/A if agency operates only one facility.)	na
	Does the PREA compliance manager have sufficient time and authority to coordinate the facility's efforts to comply with the PREA standards? (N/A if agency operates only one facility.)	na
115.312 (a)	**Contracting with other entities for the confinement of residents**	
	If this agency is public and it contracts for the confinement of its residents with private agencies or other entities including other government agencies, has the agency included the entity's obligation to adopt and comply with the PREA standards in any new contract or contract renewal signed on or after August 20, 2012? (N/A if the agency does not contract with private agencies or other entities for the confinement of residents.)	na
115.312 (b)	**Contracting with other entities for the confinement of residents**	

	Does any new contract or contract renewal signed on or after August 20, 2012 provide for agency contract monitoring to ensure that the contractor is complying with the PREA standards? (N/A if the agency does not contract with private agencies or other entities for the confinement of residents OR the response to 115.312(a)-1 is "NO".)	na
115.313 (a)	**Supervision and monitoring**	
	Does the agency ensure that each facility has developed a staffing plan that provides for adequate levels of staffing and, where applicable, video monitoring, to protect residents against sexual abuse?	yes
	Does the agency ensure that each facility has implemented a staffing plan that provides for adequate levels of staffing and, where applicable, video monitoring, to protect residents against sexual abuse?	yes
	Does the agency ensure that each facility has documented a staffing plan that provides for adequate levels of staffing and, where applicable, video monitoring, to protect residents against sexual abuse?	yes
	Does the agency ensure that each facility’s staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: The prevalence of substantiated and unsubstantiated incidents of sexual abuse?	yes
	Does the agency ensure that each facility’s staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: Generally accepted juvenile detention and correctional/secure residential practices?	yes
	Does the agency ensure that each facility’s staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: Any judicial findings of inadequacy?	yes
	Does the agency ensure that each facility’s staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: Any findings of inadequacy from Federal investigative agencies?	yes
	Does the agency ensure that each facility’s staffing plan takes into consideration the 11 criteria below in calculating adequate	yes

	staffing levels and determining the need for video monitoring: Any findings of inadequacy from internal or external oversight bodies?	
	Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: All components of the facility's physical plant (including "blind-spots" or areas where staff or residents may be isolated)?	yes
	Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: The composition of the resident population?	yes
	Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: The number and placement of supervisory staff?	yes
	Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: Institution programs occurring on a particular shift?	yes
	Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: Any applicable State or local laws, regulations, or standards?	yes
	Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: Any other relevant factors?	yes
115.313 (b)	**Supervision and monitoring**	
	Does the agency comply with the staffing plan except during limited and discrete exigent circumstances?	yes
	In circumstances where the staffing plan is not complied with, does the facility fully document all deviations from the plan? (N/A if no deviations from staffing plan.)	yes
115.313 (c)	**Supervision and monitoring**	
	Does the facility maintain staff ratios of a minimum of 1:8 during resident waking hours, except during limited and discrete exigent circumstances? (N/A only until October 1, 2017.)	yes

	Does the facility maintain staff ratios of a minimum of 1:16 during resident sleeping hours, except during limited and discrete exigent circumstances? (N/A only until October 1, 2017.)	yes
	Does the facility fully document any limited and discrete exigent circumstances during which the facility did not maintain staff ratios? (N/A only until October 1, 2017.)	yes
	Does the facility ensure only security staff are included when calculating these ratios? (N/A only until October 1, 2017.)	yes
	Is the facility obligated by law, regulation, or judicial consent decree to maintain the staffing ratios set forth in this paragraph?	yes
115.313 (d)	**Supervision and monitoring**	
	In the past 12 months, has the facility, in consultation with the agency PREA Coordinator, assessed, determined, and documented whether adjustments are needed to: The staffing plan established pursuant to paragraph (a) of this section?	yes
	In the past 12 months, has the facility, in consultation with the agency PREA Coordinator, assessed, determined, and documented whether adjustments are needed to: Prevailing staffing patterns?	yes
	In the past 12 months, has the facility, in consultation with the agency PREA Coordinator, assessed, determined, and documented whether adjustments are needed to: The facility’s deployment of video monitoring systems and other monitoring technologies?	yes
	In the past 12 months, has the facility, in consultation with the agency PREA Coordinator, assessed, determined, and documented whether adjustments are needed to: The resources the facility has available to commit to ensure adherence to the staffing plan?	yes
115.313 (e)	**Supervision and monitoring**	
	Has the facility implemented a policy and practice of having intermediate-level or higher-level supervisors conduct and document unannounced rounds to identify and deter staff sexual abuse and sexual harassment? (N/A for non-secure facilities)	yes
	Is this policy and practice implemented for night shifts as well as day shifts? (N/A for non-secure facilities)	yes
	Does the facility have a policy prohibiting staff from alerting other staff members that these supervisory rounds are occurring, unless such announcement is related to the legitimate operational	yes

	functions of the facility? (N/A for non-secure facilities)	
115.315 (a)	**Limits to cross-gender viewing and searches**	
	Does the facility always refrain from conducting any cross-gender strip or cross-gender visual body cavity searches, except in exigent circumstances or by medical practitioners?	yes
115.315 (b)	**Limits to cross-gender viewing and searches**	
	Does the facility always refrain from conducting cross-gender pat-down searches in non-exigent circumstances?	yes
115.315 (c)	**Limits to cross-gender viewing and searches**	
	Does the facility document and justify all cross-gender strip searches and cross-gender visual body cavity searches?	yes
	Does the facility document all cross-gender pat-down searches?	yes
115.315 (d)	**Limits to cross-gender viewing and searches**	
	Does the facility implement policies and procedures that enable residents to shower, perform bodily functions, and change clothing without nonmedical staff of the opposite gender viewing their breasts, buttocks, or genitalia, except in exigent circumstances or when such viewing is incidental to routine cell checks?	yes
	Does the facility require staff of the opposite gender to announce their presence when entering a resident housing unit?	yes
	In facilities (such as group homes) that do not contain discrete housing units, does the facility require staff of the opposite gender to announce their presence when entering an area where residents are likely to be showering, performing bodily functions, or changing clothing? (N/A for facilities with discrete housing units)	yes
115.315 (e)	**Limits to cross-gender viewing and searches**	
	This provision is no longer applicable to your compliance finding, please select N/A.	na
115.315 (f)	**Limits to cross-gender viewing and searches**	

	This provision is no longer applicable to your compliance finding, please select N/A.	na
115.316 (a)	**Residents with disabilities and residents who are limited English proficient**	
	Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Residents who are deaf or hard of hearing?	yes
	Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Residents who are blind or have low vision?	yes
	Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Residents who have intellectual disabilities?	yes
	Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Residents who have psychiatric disabilities?	yes
	Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Residents who have speech disabilities?	yes
	Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Other? (if "other," please explain in overall determination notes.)	yes
	Do such steps include, when necessary, ensuring effective communication with residents who are deaf or hard of hearing?	yes
	Do such steps include, when necessary, providing access to interpreters who can interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary?	yes

	Does the agency ensure that written materials are provided in formats or through methods that ensure effective communication with residents with disabilities including residents who: Have intellectual disabilities?	yes
	Does the agency ensure that written materials are provided in formats or through methods that ensure effective communication with residents with disabilities including residents who: Have limited reading skills?	yes
	Does the agency ensure that written materials are provided in formats or through methods that ensure effective communication with residents with disabilities including residents who: Who are blind or have low vision?	yes
115.316 (b)	**Residents with disabilities and residents who are limited English proficient**	
	Does the agency take reasonable steps to ensure meaningful access to all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment to residents who are limited English proficient?	yes
	Do these steps include providing interpreters who can interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary?	yes
115.316 (c)	**Residents with disabilities and residents who are limited English proficient**	
	Does the agency always refrain from relying on resident interpreters, resident readers, or other types of resident assistants except in limited circumstances where an extended delay in obtaining an effective interpreter could compromise the resident's safety, the performance of first-response duties under §115.364, or the investigation of the resident's allegations?	yes
115.317 (a)	**Hiring and promotion decisions**	
	Does the agency prohibit the hiring or promotion of anyone who may have contact with residents who: Has engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility, or other institution (as defined in 42 U.S.C. 1997)?	yes
	Does the agency prohibit the hiring or promotion of anyone who may have contact with residents who: Has been convicted of engaging or attempting to engage in sexual activity in the community facilitated by force, overt or implied threats of force, or	yes

	coercion, or if the victim did not consent or was unable to consent or refuse?	
	Does the agency prohibit the hiring or promotion of anyone who may have contact with residents who: Has been civilly or administratively adjudicated to have engaged in the activity described in the bullet immediately above?	yes
	Does the agency prohibit the enlistment of services of any contractor who may have contact with residents who: Has engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility, or other institution (as defined in 42 U.S.C. 1997)?	yes
	Does the agency prohibit the enlistment of services of any contractor who may have contact with residents who: Has been convicted of engaging or attempting to engage in sexual activity in the community facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse?	yes
	Does the agency prohibit the enlistment of services of any contractor who may have contact with residents who: Has been civilly or administratively adjudicated to have engaged in the activity described in the two bullets immediately above?	yes
115.317 (b)	**Hiring and promotion decisions**	
	Does the agency consider any incidents of sexual harassment in determining whether to hire or promote anyone, or to enlist the services of any contractor, who may have contact with residents?	yes
115.317 (c)	**Hiring and promotion decisions**	
	Before hiring new employees who may have contact with residents, does the agency: Perform a criminal background records check?	yes
	Before hiring new employees who may have contact with residents, does the agency: Consult any child abuse registry maintained by the State or locality in which the employee would work?	yes
	Before hiring new employees who may have contact with residents, does the agency: Consistent with Federal, State, and local law, make its best efforts to contact all prior institutional employers for information on substantiated allegations of sexual	yes

	abuse or any resignation during a pending investigation of an allegation of sexual abuse?	
115.317 (d)	**Hiring and promotion decisions**	
	Does the agency perform a criminal background records check before enlisting the services of any contractor who may have contact with residents?	yes
	Does the agency consult applicable child abuse registries before enlisting the services of any contractor who may have contact with residents?	yes
115.317 (e)	**Hiring and promotion decisions**	
	Does the agency either conduct criminal background records checks at least every five years of current employees and contractors who may have contact with residents or have in place a system for otherwise capturing such information for current employees?	yes
115.317 (f)	**Hiring and promotion decisions**	
	Does the agency ask all applicants and employees who may have contact with residents directly about previous misconduct described in paragraph (a) of this section in written applications or interviews for hiring or promotions?	yes
	Does the agency ask all applicants and employees who may have contact with residents directly about previous misconduct described in paragraph (a) of this section in any interviews or written self-evaluations conducted as part of reviews of current employees?	yes
	Does the agency impose upon employees a continuing affirmative duty to disclose any such misconduct?	yes
115.317 (g)	**Hiring and promotion decisions**	
	Does the agency consider material omissions regarding such misconduct, or the provision of materially false information, grounds for termination?	yes
115.317 (h)	**Hiring and promotion decisions**	

	Unless prohibited by law, does the agency provide information on substantiated allegations of sexual abuse or sexual harassment involving a former employee upon receiving a request from an institutional employer for whom such employee has applied to work? (N/A if providing information on substantiated allegations of sexual abuse or sexual harassment involving a former employee is prohibited by law.)	yes
115.318 (a)	**Upgrades to facilities and technologies**	
	If the agency designed or acquired any new facility or planned any substantial expansion or modification of existing facilities, did the agency consider the effect of the design, acquisition, expansion, or modification upon the agency's ability to protect residents from sexual abuse? (N/A if agency/facility has not acquired a new facility or made a substantial expansion to existing facilities since August 20, 2012, or since the last PREA audit, whichever is later.)	yes
115.318 (b)	**Upgrades to facilities and technologies**	
	If the agency installed or updated a video monitoring system, electronic surveillance system, or other monitoring technology, did the agency consider how such technology may enhance the agency's ability to protect residents from sexual abuse? (N/A if agency/facility has not installed or updated a video monitoring system, electronic surveillance system, or other monitoring technology since August 20, 2012, or since the last PREA audit, whichever is later.)	yes
115.321 (a)	**Evidence protocol and forensic medical examinations**	
	If the agency is responsible for investigating allegations of sexual abuse, does the agency follow a uniform evidence protocol that maximizes the potential for obtaining usable physical evidence for administrative proceedings and criminal prosecutions? (N/A if the agency/facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations.)	yes
115.321 (b)	**Evidence protocol and forensic medical examinations**	
	Is this protocol developmentally appropriate for youth? (N/A if the agency/facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations.)	yes
	Is this protocol, as appropriate, adapted from or otherwise based	yes

	on the most recent edition of the U.S. Department of Justice's Office on Violence Against Women publication, "A National Protocol for Sexual Assault Medical Forensic Examinations, Adults/ Adolescents," or similarly comprehensive and authoritative protocols developed after 2011? (N/A if the agency/facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations.)	
115.321 (c)	**Evidence protocol and forensic medical examinations**	
	Does the agency offer all residents who experience sexual abuse access to forensic medical examinations, whether on-site or at an outside facility, without financial cost, where evidentiarily or medically appropriate?	yes
	Are such examinations performed by Sexual Assault Forensic Examiners (SAFEs) or Sexual Assault Nurse Examiners (SANEs) where possible?	yes
	If SAFEs or SANEs cannot be made available, is the examination performed by other qualified medical practitioners (they must have been specifically trained to conduct sexual assault forensic exams)?	yes
	Has the agency documented its efforts to provide SAFEs or SANEs?	yes
115.321 (d)	**Evidence protocol and forensic medical examinations**	
	Does the agency attempt to make available to the victim a victim advocate from a rape crisis center?	yes
	If a rape crisis center is not available to provide victim advocate services, does the agency make available to provide these services a qualified staff member from a community-based organization, or a qualified agency staff member?	yes
	Has the agency documented its efforts to secure services from rape crisis centers?	yes
115.321 (e)	**Evidence protocol and forensic medical examinations**	
	As requested by the victim, does the victim advocate, qualified agency staff member, or qualified community-based organization staff member accompany and support the victim through the forensic medical examination process and investigatory	yes

	interviews?	
	As requested by the victim, does this person provide emotional support, crisis intervention, information, and referrals?	yes
115.321 (f)	**Evidence protocol and forensic medical examinations**	
	If the agency itself is not responsible for investigating allegations of sexual abuse, has the agency requested that the investigating entity follow the requirements of paragraphs (a) through (e) of this section? (N/A if the agency is responsible for investigating allegations of sexual abuse.)	yes
115.321 (h)	**Evidence protocol and forensic medical examinations**	
	If the agency uses a qualified agency staff member or a qualified community-based staff member for the purposes of this section, has the individual been screened for appropriateness to serve in this role and received education concerning sexual assault and forensic examination issues in general? (Check N/A if agency attempts to make a victim advocate from a rape crisis center available to victims per 115.321(d) above.)	yes
115.322 (a)	**Policies to ensure referrals of allegations for investigations**	
	Does the agency ensure an administrative or criminal investigation is completed for all allegations of sexual abuse?	yes
	Does the agency ensure an administrative or criminal investigation is completed for all allegations of sexual harassment?	yes
115.322 (b)	**Policies to ensure referrals of allegations for investigations**	
	Does the agency have a policy in place to ensure that allegations of sexual abuse or sexual harassment are referred for investigation to an agency with the legal authority to conduct criminal investigations, unless the allegation does not involve potentially criminal behavior?	yes
	Has the agency published such policy on its website or, if it does not have one, made the policy available through other means?	yes
	Does the agency document all such referrals?	yes
115.322	**Policies to ensure referrals of allegations for investigations**	

(c)		
	If a separate entity is responsible for conducting criminal investigations, does such publication describe the responsibilities of both the agency and the investigating entity? (N/A if the agency/facility is responsible for criminal investigations. See 115.321(a))	yes
115.331 (a)	**Employee training**	
	Does the agency train all employees who may have contact with residents on: Its zero-tolerance policy for sexual abuse and sexual harassment?	yes
	Does the agency train all employees who may have contact with residents on: How to fulfill their responsibilities under agency sexual abuse and sexual harassment prevention, detection, reporting, and response policies and procedures?	yes
	Does the agency train all employees who may have contact with residents on: Residents' right to be free from sexual abuse and sexual harassment	yes
	Does the agency train all employees who may have contact with residents on: The right of residents and employees to be free from retaliation for reporting sexual abuse and sexual harassment?	yes
	Does the agency train all employees who may have contact with residents on: The dynamics of sexual abuse and sexual harassment in juvenile facilities?	yes
	Does the agency train all employees who may have contact with residents on: The common reactions of juvenile victims of sexual abuse and sexual harassment?	yes
	Does the agency train all employees who may have contact with residents on: How to detect and respond to signs of threatened and actual sexual abuse and how to distinguish between consensual sexual contact and sexual abuse between residents?	yes
	Does the agency train all employees who may have contact with residents on: How to avoid inappropriate relationships with residents?	yes
	The subsection of this provision is no longer applicable to your compliance finding, please select N/A.	na
	Does the agency train all employees who may have contact with residents on: How to comply with relevant laws related to	yes

	mandatory reporting of sexual abuse to outside authorities?	
	Does the agency train all employees who may have contact with residents on: Relevant laws regarding the applicable age of consent?	yes
115.331 (b)	**Employee training**	
	Is such training tailored to the unique needs and attributes of residents of juvenile facilities?	yes
	Is such training tailored to the gender of the residents at the employee's facility?	yes
	Have employees received additional training if reassigned from a facility that houses only male residents to a facility that houses only female residents, or vice versa?	yes
115.331 (c)	**Employee training**	
	Have all current employees who may have contact with residents received such training?	yes
	Does the agency provide each employee with refresher training every two years to ensure that all employees know the agency's current sexual abuse and sexual harassment policies and procedures?	yes
	In years in which an employee does not receive refresher training, does the agency provide refresher information on current sexual abuse and sexual harassment policies?	yes
115.331 (d)	**Employee training**	
	Does the agency document, through employee signature or electronic verification, that employees understand the training they have received?	yes
115.332 (a)	**Volunteer and contractor training**	
	Has the agency ensured that all volunteers and contractors who have contact with residents have been trained on their responsibilities under the agency's sexual abuse and sexual harassment prevention, detection, and response policies and procedures?	yes

115.332 (b)	**Volunteer and contractor training**	
	Have all volunteers and contractors who have contact with residents been notified of the agency’s zero-tolerance policy regarding sexual abuse and sexual harassment and informed how to report such incidents (the level and type of training provided to volunteers and contractors shall be based on the services they provide and level of contact they have with residents)?	yes
115.332 (c)	**Volunteer and contractor training**	
	Does the agency maintain documentation confirming that volunteers and contractors understand the training they have received?	yes
115.333 (a)	**Resident education**	
	During intake, do residents receive information explaining the agency’s zero-tolerance policy regarding sexual abuse and sexual harassment?	yes
	During intake, do residents receive information explaining how to report incidents or suspicions of sexual abuse or sexual harassment?	yes
	Is this information presented in an age-appropriate fashion?	yes
115.333 (b)	**Resident education**	
	Within 10 days of intake, does the agency provide age-appropriate comprehensive education to residents either in person or through video regarding: Their rights to be free from sexual abuse and sexual harassment?	yes
	Within 10 days of intake, does the agency provide age-appropriate comprehensive education to residents either in person or through video regarding: Their rights to be free from retaliation for reporting such incidents?	yes
	Within 10 days of intake, does the agency provide age-appropriate comprehensive education to residents either in person or through video regarding: Agency policies and procedures for responding to such incidents?	yes
115.333 (c)	**Resident education**	

	Have all residents received such education?	yes
	Do residents receive education upon transfer to a different facility to the extent that the policies and procedures of the resident's new facility differ from those of the previous facility?	yes
115.333 (d)	**Resident education**	
	Does the agency provide resident education in formats accessible to all residents including those who: Are limited English proficient?	yes
	Does the agency provide resident education in formats accessible to all residents including those who: Are deaf?	yes
	Does the agency provide resident education in formats accessible to all residents including those who: Are visually impaired?	yes
	Does the agency provide resident education in formats accessible to all residents including those who: Are otherwise disabled?	yes
	Does the agency provide resident education in formats accessible to all residents including those who: Have limited reading skills?	yes
115.333 (e)	**Resident education**	
	Does the agency maintain documentation of resident participation in these education sessions?	yes
115.333 (f)	**Resident education**	
	In addition to providing such education, does the agency ensure that key information is continuously and readily available or visible to residents through posters, resident handbooks, or other written formats?	yes
115.334 (a)	**Specialized training: Investigations**	
	In addition to the general training provided to all employees pursuant to §115.331, does the agency ensure that, to the extent the agency itself conducts sexual abuse investigations, its investigators have received training in conducting such investigations in confinement settings? (N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.321(a).)	yes
115.334	**Specialized training: Investigations**	

(b)		
	Does this specialized training include: Techniques for interviewing juvenile sexual abuse victims? (N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.321(a).)	yes
	Does this specialized training include: Proper use of Miranda and Garrity warnings? (N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.321(a).)	yes
	Does this specialized training include: Sexual abuse evidence collection in confinement settings? (N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.321(a).)	yes
	Does this specialized training include: The criteria and evidence required to substantiate a case for administrative action or prosecution referral? (N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.321(a).)	yes
115.334 (c)	**Specialized training: Investigations**	
	Does the agency maintain documentation that agency investigators have completed the required specialized training in conducting sexual abuse investigations? (N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.321(a).)	yes
115.335 (a)	**Specialized training: Medical and mental health care**	
	Does the agency ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in: How to detect and assess signs of sexual abuse and sexual harassment? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners who work regularly in its facilities.)	yes
	Does the agency ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in: How to preserve physical evidence of sexual abuse? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners who work regularly in its facilities.)	yes

	Does the agency ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in: How to respond effectively and professionally to juvenile victims of sexual abuse and sexual harassment? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners who work regularly in its facilities.)	yes
	Does the agency ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in: How and to whom to report allegations or suspicions of sexual abuse and sexual harassment? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners who work regularly in its facilities.)	yes
115.335 (b)	**Specialized training: Medical and mental health care**	
	If medical staff employed by the agency conduct forensic examinations, do such medical staff receive appropriate training to conduct such examinations? (N/A if agency medical staff at the facility do not conduct forensic exams or the agency does not employ medical staff.)	na
115.335 (c)	**Specialized training: Medical and mental health care**	
	Does the agency maintain documentation that medical and mental health practitioners have received the training referenced in this standard either from the agency or elsewhere? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners who work regularly in its facilities.)	yes
115.335 (d)	**Specialized training: Medical and mental health care**	
	Do medical and mental health care practitioners employed by the agency also receive training mandated for employees by §115.331? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners who work regularly in its facilities.)	yes
	Do medical and mental health care practitioners contracted by and volunteering for the agency also receive training mandated for contractors and volunteers by §115.332? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners contracted by or volunteering for the agency.)	yes
115.341	**Obtaining information from residents**	

(a)		
	Within 72 hours of the resident's arrival at the facility, does the agency obtain and use information about each resident's personal history and behavior to reduce risk of sexual abuse by or upon a resident?	yes
	Does the agency also obtain this information periodically throughout a resident's confinement?	yes
115.341 (b)	**Obtaining information from residents**	
	Are all PREA screening assessments conducted using an objective screening instrument?	yes
115.341 (c)	**Obtaining information from residents**	
	During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Prior sexual victimization or abusiveness?	yes
	The subsection of this provision is no longer applicable to your compliance finding, please select N/A.	na
	During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Current charges and offense history?	yes
	During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Age?	yes
	During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Level of emotional and cognitive development?	yes
	During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Physical size and stature?	yes
	During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Mental illness or mental disabilities?	yes
	During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Intellectual or developmental disabilities?	yes
	During these PREA screening assessments, at a minimum, does	yes

	the agency attempt to ascertain information about: Physical disabilities?	
	During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: The resident's own perception of vulnerability?	yes
	During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Any other specific information about individual residents that may indicate heightened needs for supervision, additional safety precautions, or separation from certain other residents?	yes
115.341 (d)	**Obtaining information from residents**	
	Is this information ascertained: Through conversations with the resident during the intake process and medical mental health screenings?	yes
	Is this information ascertained: During classification assessments?	yes
	Is this information ascertained: By reviewing court records, case files, facility behavioral records, and other relevant documentation from the resident's files?	yes
115.341 (e)	**Obtaining information from residents**	
	Has the agency implemented appropriate controls on the dissemination within the facility of responses to questions asked pursuant to this standard in order to ensure that sensitive information is not exploited to the resident's detriment by staff or other residents?	yes
115.342 (a)	**Placement of residents**	
	Does the agency use all of the information obtained pursuant to § 115.341 and subsequently, with the goal of keeping all residents safe and free from sexual abuse, to make: Housing Assignments?	yes
	Does the agency use all of the information obtained pursuant to § 115.341 and subsequently, with the goal of keeping all residents safe and free from sexual abuse, to make: Bed assignments?	yes
	Does the agency use all of the information obtained pursuant to § 115.341 and subsequently, with the goal of keeping all residents safe and free from sexual abuse, to make: Work Assignments?	yes

	Does the agency use all of the information obtained pursuant to § 115.341 and subsequently, with the goal of keeping all residents safe and free from sexual abuse, to make: Education Assignments?	yes
	Does the agency use all of the information obtained pursuant to § 115.341 and subsequently, with the goal of keeping all residents safe and free from sexual abuse, to make: Program Assignments?	yes
115.342 (b)	**Placement of residents**	
	Are residents isolated from others only as a last resort when less restrictive measures are inadequate to keep them and other residents safe, and then only until an alternative means of keeping all residents safe can be arranged?	yes
	During any period of isolation, does the agency always refrain from denying residents daily large-muscle exercise?	yes
	During any period of isolation, does the agency always refrain from denying residents any legally required educational programming or special education services?	yes
	Do residents in isolation receive daily visits from a medical or mental health care clinician?	yes
	Do residents also have access to other programs and work opportunities to the extent possible?	yes
115.342 (c)	**Placement of residents**	
	This provision is no longer applicable to your compliance finding, please select N/A.	na
115.342 (d)	**Placement of residents**	
	This provision is no longer applicable to your compliance finding, please select N/A.	na
115.342 (e)	**Placement of residents**	
	This provision is no longer applicable to your compliance finding, please select N/A.	na
115.342	**Placement of residents**	

(f)		
	This provision is no longer applicable to your compliance finding, please select N/A.	na
115.342 (g)	**Placement of residents**	
	This provision is no longer applicable to your compliance finding, please select N/A.	na
115.342 (h)	**Placement of residents**	
	If a resident is isolated pursuant to paragraph (b) of this section, does the facility clearly document: The basis for the facility's concern for the resident's safety? (N/A for h and i if facility doesn't use isolation?)	yes
	If a resident is isolated pursuant to paragraph (b) of this section, does the facility clearly document: The reason why no alternative means of separation can be arranged? (N/A for h and i if facility doesn't use isolation?)	yes
115.342 (i)	**Placement of residents**	
	In the case of each resident who is isolated as a last resort when less restrictive measures are inadequate to keep them and other residents safe, does the facility afford a review to determine whether there is a continuing need for separation from the general population EVERY 30 DAYS?	yes
115.351 (a)	**Resident reporting**	
	Does the agency provide multiple internal ways for residents to privately report: Sexual abuse and sexual harassment?	yes
	Does the agency provide multiple internal ways for residents to privately report: 2. Retaliation by other residents or staff for reporting sexual abuse and sexual harassment?	yes
	Does the agency provide multiple internal ways for residents to privately report: Staff neglect or violation of responsibilities that may have contributed to such incidents?	yes
115.351 (b)	**Resident reporting**	

	Does the agency also provide at least one way for residents to report sexual abuse or sexual harassment to a public or private entity or office that is not part of the agency?	yes
	Is that private entity or office able to receive and immediately forward resident reports of sexual abuse and sexual harassment to agency officials?	yes
	Does that private entity or office allow the resident to remain anonymous upon request?	yes
	Are residents detained solely for civil immigration purposes provided information on how to contact relevant consular officials and relevant officials at the Department of Homeland Security to report sexual abuse or harassment?	yes
115.351 (c)	**Resident reporting**	
	Do staff members accept reports of sexual abuse and sexual harassment made verbally, in writing, anonymously, and from third parties?	yes
	Do staff members promptly document any verbal reports of sexual abuse and sexual harassment?	yes
115.351 (d)	**Resident reporting**	
	Does the facility provide residents with access to tools necessary to make a written report?	yes
115.351 (e)	**Resident reporting**	
	Does the agency provide a method for staff to privately report sexual abuse and sexual harassment of residents?	yes
115.352 (a)	**Exhaustion of administrative remedies**	
	Is the agency exempt from this standard? NOTE: The agency is exempt ONLY if it does not have administrative procedures to address resident grievances regarding sexual abuse. This does not mean the agency is exempt simply because a resident does not have to or is not ordinarily expected to submit a grievance to report sexual abuse. This means that as a matter of explicit policy, the agency does not have an administrative remedies process to address sexual abuse.	no

115.352 (b)	**Exhaustion of administrative remedies**	
	Does the agency permit residents to submit a grievance regarding an allegation of sexual abuse without any type of time limits? (The agency may apply otherwise-applicable time limits to any portion of a grievance that does not allege an incident of sexual abuse.) (N/A if agency is exempt from this standard.)	yes
	Does the agency always refrain from requiring an resident to use any informal grievance process, or to otherwise attempt to resolve with staff, an alleged incident of sexual abuse? (N/A if agency is exempt from this standard.)	yes
115.352 (c)	**Exhaustion of administrative remedies**	
	Does the agency ensure that: A resident who alleges sexual abuse may submit a grievance without submitting it to a staff member who is the subject of the complaint? (N/A if agency is exempt from this standard.)	yes
	Does the agency ensure that: Such grievance is not referred to a staff member who is the subject of the complaint? (N/A if agency is exempt from this standard.)	yes
115.352 (d)	**Exhaustion of administrative remedies**	
	Does the agency issue a final agency decision on the merits of any portion of a grievance alleging sexual abuse within 90 days of the initial filing of the grievance? (Computation of the 90-day time period does not include time consumed by residents in preparing any administrative appeal.) (N/A if agency is exempt from this standard.)	yes
	If the agency determines that the 90 day timeframe is insufficient to make an appropriate decision and claims an extension of time (the maximum allowable extension of time to respond is 70 days per 115.352(d)(3)) , does the agency notify the resident in writing of any such extension and provide a date by which a decision will be made? (N/A if agency is exempt from this standard.)	yes
	At any level of the administrative process, including the final level, if the resident does not receive a response within the time allotted for reply, including any properly noticed extension, may a resident consider the absence of a response to be a denial at that level? (N/A if agency is exempt from this standard.)	yes

115.352 (e)	Exhaustion of administrative remedies	
	Are third parties, including fellow residents, staff members, family members, attorneys, and outside advocates, permitted to assist residents in filing requests for administrative remedies relating to allegations of sexual abuse? (N/A if agency is exempt from this standard.)	yes
	Are those third parties also permitted to file such requests on behalf of residents? (If a third party, other than a parent or legal guardian, files such a request on behalf of a resident, the facility may require as a condition of processing the request that the alleged victim agree to have the request filed on his or her behalf, and may also require the alleged victim to personally pursue any subsequent steps in the administrative remedy process.) (N/A if agency is exempt from this standard.)	yes
	If the resident declines to have the request processed on his or her behalf, does the agency document the resident's decision? (N/A if agency is exempt from this standard.)	yes
	Is a parent or legal guardian of a juvenile allowed to file a grievance regarding allegations of sexual abuse, including appeals, on behalf of such juvenile? (N/A if agency is exempt from this standard.)	yes
	If a parent or legal guardian of a juvenile files a grievance (or an appeal) on behalf of a juvenile regarding allegations of sexual abuse, is it the case that those grievances are not conditioned upon the juvenile agreeing to have the request filed on his or her behalf? (N/A if agency is exempt from this standard.)	yes
115.352 (f)	**Exhaustion of administrative remedies**	
	Has the agency established procedures for the filing of an emergency grievance alleging that a resident is subject to a substantial risk of imminent sexual abuse? (N/A if agency is exempt from this standard.)	yes
	After receiving an emergency grievance alleging a resident is subject to a substantial risk of imminent sexual abuse, does the agency immediately forward the grievance (or any portion thereof that alleges the substantial risk of imminent sexual abuse) to a level of review at which immediate corrective action may be taken? (N/A if agency is exempt from this standard.)	yes
	After receiving an emergency grievance described above, does	yes

	the agency provide an initial response within 48 hours? (N/A if agency is exempt from this standard.)	
	After receiving an emergency grievance described above, does the agency issue a final agency decision within 5 calendar days? (N/A if agency is exempt from this standard.)	yes
	Does the initial response and final agency decision document the agency's determination whether the resident is in substantial risk of imminent sexual abuse? (N/A if agency is exempt from this standard.)	yes
	Does the initial response document the agency's action(s) taken in response to the emergency grievance? (N/A if agency is exempt from this standard.)	yes
	Does the agency's final decision document the agency's action(s) taken in response to the emergency grievance? (N/A if agency is exempt from this standard.)	yes
115.352 (g)	**Exhaustion of administrative remedies**	
	If the agency disciplines a resident for filing a grievance related to alleged sexual abuse, does it do so ONLY where the agency demonstrates that the resident filed the grievance in bad faith? (N/A if agency is exempt from this standard.)	yes
115.353 (a)	**Resident access to outside confidential support services and legal representation**	
	Does the facility provide residents with access to outside victim advocates for emotional support services related to sexual abuse by providing, posting, or otherwise making accessible mailing addresses and telephone numbers, including toll-free hotline numbers where available, of local, State, or national victim advocacy or rape crisis organizations?	yes
	Does the facility provide persons detained solely for civil immigration purposes mailing addresses and telephone numbers, including toll-free hotline numbers where available of local, State, or national immigrant services agencies?	yes
	Does the facility enable reasonable communication between residents and these organizations and agencies, in as confidential a manner as possible?	yes
115.353 (b)	**Resident access to outside confidential support services and legal representation**	

	Does the facility inform residents, prior to giving them access, of the extent to which such communications will be monitored and the extent to which reports of abuse will be forwarded to authorities in accordance with mandatory reporting laws?	yes
115.353 (c)	**Resident access to outside confidential support services and legal representation**	
	Does the agency maintain or attempt to enter into memoranda of understanding or other agreements with community service providers that are able to provide residents with confidential emotional support services related to sexual abuse?	yes
	Does the agency maintain copies of agreements or documentation showing attempts to enter into such agreements?	yes
115.353 (d)	**Resident access to outside confidential support services and legal representation**	
	Does the facility provide residents with reasonable and confidential access to their attorneys or other legal representation?	yes
	Does the facility provide residents with reasonable access to parents or legal guardians?	yes
115.354 (a)	**Third-party reporting**	
	Has the agency established a method to receive third-party reports of sexual abuse and sexual harassment?	yes
	Has the agency distributed publicly information on how to report sexual abuse and sexual harassment on behalf of a resident?	yes
115.361 (a)	**Staff and agency reporting duties**	
	Does the agency 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?	yes
	Does the agency require all staff to report immediately and according to agency policy any knowledge, suspicion, or information they receive regarding retaliation against residents or staff who reported an incident of sexual abuse or sexual harassment?	yes

	Does the agency require all staff to report immediately and according to agency policy any knowledge, suspicion, or information they receive regarding any staff neglect or violation of responsibilities that may have contributed to an incident of sexual abuse or sexual harassment or retaliation?	yes
115.361 (b)	**Staff and agency reporting duties**	
	Does the agency require all staff to comply with any applicable mandatory child abuse reporting laws?	yes
115.361 (c)	**Staff and agency reporting duties**	
	Apart from reporting to designated supervisors or officials and designated State or local services agencies, are staff prohibited from revealing any information related to a sexual abuse report to anyone other than to the extent necessary, as specified in agency policy, to make treatment, investigation, and other security and management decisions?	yes
115.361 (d)	**Staff and agency reporting duties**	
	Are medical and mental health practitioners required to report sexual abuse to designated supervisors and officials pursuant to paragraph (a) of this section as well as to the designated State or local services agency where required by mandatory reporting laws?	yes
	Are medical and mental health practitioners required to inform residents of their duty to report, and the limitations of confidentiality, at the initiation of services?	yes
115.361 (e)	**Staff and agency reporting duties**	
	Upon receiving any allegation of sexual abuse, does the facility head or his or her designee promptly report the allegation to the appropriate office?	yes
	Upon receiving any allegation of sexual abuse, does the facility head or his or her designee promptly report the allegation to the alleged victim’s parents or legal guardians unless the facility has official documentation showing the parents or legal guardians should not be notified?	yes
	If the alleged victim is under the guardianship of the child welfare	yes

	system, does the facility head or his or her designee promptly report the allegation to the alleged victim's caseworker instead of the parents or legal guardians? (N/A if the alleged victim is not under the guardianship of the child welfare system.)	
	If a juvenile court retains jurisdiction over the alleged victim, does the facility head or designee also report the allegation to the juvenile's attorney or other legal representative of record within 14 days of receiving the allegation?	yes
115.361 (f)	**Staff and agency reporting duties**	
	Does the facility report all allegations of sexual abuse and sexual harassment, including third-party and anonymous reports, to the facility's designated investigators?	yes
115.362 (a)	**Agency protection duties**	
	When the agency learns that a resident is subject to a substantial risk of imminent sexual abuse, does it take immediate action to protect the resident?	yes
115.363 (a)	**Reporting to other confinement facilities**	
	Upon receiving an allegation that a resident was sexually abused while confined at another facility, does the head of the facility that received the allegation notify the head of the facility or appropriate office of the agency where the alleged abuse occurred?	yes
	Does the head of the facility that received the allegation also notify the appropriate investigative agency?	yes
115.363 (b)	**Reporting to other confinement facilities**	
	Is such notification provided as soon as possible, but no later than 72 hours after receiving the allegation?	yes
115.363 (c)	**Reporting to other confinement facilities**	
	Does the agency document that it has provided such notification?	yes
115.363 (d)	**Reporting to other confinement facilities**	

	Does the facility head or agency office that receives such notification ensure that the allegation is investigated in accordance with these standards?	yes
115.364 (a)	**Staff first responder duties**	
	Upon learning of an allegation that a resident was sexually abused, is the first security staff member to respond to the report required to: Separate the alleged victim and abuser?	yes
	Upon learning of an allegation that a resident was sexually abused, is the first security staff member to respond to the report required to: Preserve and protect any crime scene until appropriate steps can be taken to collect any evidence?	yes
	Upon learning of an allegation that a resident was sexually abused, is the first security staff member to respond to the report required to: Request that the alleged victim not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating, if the abuse occurred within a time period that still allows for the collection of physical evidence?	yes
	Upon learning of an allegation that a resident was sexually abused, is the first security staff member to respond to the report required to: Ensure that the alleged abuser does not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating, if the abuse occurred within a time period that still allows for the collection of physical evidence?	yes
115.364 (b)	**Staff first responder duties**	
	If the first staff responder is not a security staff member, is the responder required to request that the alleged victim not take any actions that could destroy physical evidence, and then notify security staff?	yes
115.365 (a)	**Coordinated response**	
	Has the facility developed a written institutional plan to coordinate actions among staff first responders, medical and mental health practitioners, investigators, and facility leadership taken in response to an incident of sexual abuse?	yes

115.366 (a)	**Preservation of ability to protect residents from contact with abusers**	
	Are both the agency and any other governmental entities responsible for collective bargaining on the agency's behalf prohibited from entering into or renewing any collective bargaining agreement or other agreement that limits the agency's ability to remove alleged staff sexual abusers from contact with any residents pending the outcome of an investigation or of a determination of whether and to what extent discipline is warranted?	no
115.367 (a)	**Agency protection against retaliation**	
	Has the agency established a policy to protect all residents and staff who report sexual abuse or sexual harassment or cooperate with sexual abuse or sexual harassment investigations from retaliation by other residents or staff?	yes
	Has the agency designated which staff members or departments are charged with monitoring retaliation?	yes
115.367 (b)	**Agency protection against retaliation**	
	Does the agency employ multiple protection measures for residents or staff who fear retaliation for reporting sexual abuse or sexual harassment or for cooperating with investigations, such as housing changes or transfers for resident victims or abusers, removal of alleged staff or resident abusers from contact with victims, and emotional support services?	yes
115.367 (c)	**Agency protection against retaliation**	
	Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor the conduct and treatment of residents or staff who reported the sexual abuse to see if there are changes that may suggest possible retaliation by residents or staff?	yes
	Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor the conduct and treatment of residents who were reported to have suffered sexual abuse to see if there are changes that may suggest possible retaliation by residents or staff?	yes

	Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Act promptly to remedy any such retaliation?	yes
	Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor: Any resident disciplinary reports?	yes
	Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor: Resident housing changes?	yes
	Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor: Resident program changes?	yes
	Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor: Negative performance reviews of staff?	yes
	Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor: Reassignments of staff?	yes
	Does the agency continue such monitoring beyond 90 days if the initial monitoring indicates a continuing need?	yes
115.367 (d)	**Agency protection against retaliation**	
	In the case of residents, does such monitoring also include periodic status checks?	yes
115.367 (e)	**Agency protection against retaliation**	
	If any other individual who cooperates with an investigation expresses a fear of retaliation, does the agency take appropriate measures to protect that individual against retaliation?	yes
115.368 (a)	**Post-allegation protective custody**	
	Is any and all use of segregated housing to protect a resident who	yes

	is alleged to have suffered sexual abuse subject to the requirements of § 115.342?	
115.371 (a)	**Criminal and administrative agency investigations**	
	When the agency conducts its own investigations into allegations of sexual abuse and sexual harassment, does it do so promptly, thoroughly, and objectively? (N/A if the agency does not conduct any form of administrative or criminal investigations of sexual abuse or harassment. See 115.321(a).)	yes
	Does the agency conduct such investigations for all allegations, including third party and anonymous reports? (N/A if the agency does not conduct any form of administrative or criminal investigations of sexual abuse or harassment. See 115.321(a).)	yes
115.371 (b)	**Criminal and administrative agency investigations**	
	Where sexual abuse is alleged, does the agency use investigators who have received specialized training in sexual abuse investigations involving juvenile victims as required by 115.334?	yes
115.371 (c)	**Criminal and administrative agency investigations**	
	Do investigators gather and preserve direct and circumstantial evidence, including any available physical and DNA evidence and any available electronic monitoring data?	yes
	Do investigators interview alleged victims, suspected perpetrators, and witnesses?	yes
	Do investigators review prior reports and complaints of sexual abuse involving the suspected perpetrator?	yes
115.371 (d)	**Criminal and administrative agency investigations**	
	Does the agency always refrain from terminating an investigation solely because the source of the allegation recants the allegation?	yes
115.371 (e)	**Criminal and administrative agency investigations**	
	When the quality of evidence appears to support criminal prosecution, does the agency conduct compelled interviews only after consulting with prosecutors as to whether compelled interviews may be an obstacle for subsequent criminal	yes

	prosecution?	
115.371 (f)	**Criminal and administrative agency investigations**	
	Do agency investigators assess the credibility of an alleged victim, suspect, or witness on an individual basis and not on the basis of that individual’s status as resident or staff?	yes
	Does the agency investigate allegations of sexual abuse without requiring a resident who alleges sexual abuse to submit to a polygraph examination or other truth-telling device as a condition for proceeding?	yes
115.371 (g)	**Criminal and administrative agency investigations**	
	Do administrative investigations include an effort to determine whether staff actions or failures to act contributed to the abuse?	yes
	Are administrative investigations documented in written reports that include a description of the physical evidence and testimonial evidence, the reasoning behind credibility assessments, and investigative facts and findings?	yes
115.371 (h)	**Criminal and administrative agency investigations**	
	Are criminal investigations documented in a written report that contains a thorough description of the physical, testimonial, and documentary evidence and attaches copies of all documentary evidence where feasible?	yes
115.371 (i)	**Criminal and administrative agency investigations**	
	Are all substantiated allegations of conduct that appears to be criminal referred for prosecution?	yes
115.371 (j)	**Criminal and administrative agency investigations**	
	Does the agency retain all written reports referenced in 115.371(g) and (h) for as long as the alleged abuser is incarcerated or employed by the agency, plus five years unless the abuse was committed by a juvenile resident and applicable law requires a shorter period of retention?	yes
115.371 (k)	**Criminal and administrative agency investigations**	

	Does the agency ensure that the departure of an alleged abuser or victim from the employment or control of the facility or agency does not provide a basis for terminating an investigation?	yes
115.371 (m)	**Criminal and administrative agency investigations**	
	When an outside entity investigates sexual abuse, does the facility cooperate with outside investigators and endeavor to remain informed about the progress of the investigation? (N/A if an outside agency does not conduct administrative or criminal sexual abuse investigations. See 115.321(a).)	yes
115.372 (a)	**Evidentiary standard for administrative investigations**	
	Is it true that the agency does not impose a standard higher than a preponderance of the evidence in determining whether allegations of sexual abuse or sexual harassment are substantiated?	yes
115.373 (a)	**Reporting to residents**	
	Following an investigation into a resident’s allegation of sexual abuse suffered in the facility, does the agency inform the resident as to whether the allegation has been determined to be substantiated, unsubstantiated, or unfounded?	yes
115.373 (b)	**Reporting to residents**	
	If the agency did not conduct the investigation into a resident’s allegation of sexual abuse in an agency facility, does the agency request the relevant information from the investigative agency in order to inform the resident? (N/A if the agency/facility is responsible for conducting administrative and criminal investigations.)	yes
115.373 (c)	**Reporting to residents**	
	Following a resident’s allegation that a staff member has committed sexual abuse against the resident, unless the agency has determined that the allegation is unfounded or unless the resident has been released from custody, does the agency subsequently inform the resident whenever: The staff member is no longer posted within the resident’s unit?	yes

	Following a resident's allegation that a staff member has committed sexual abuse against the resident, unless the agency has determined that the allegation is unfounded or unless the resident has been released from custody, does the agency subsequently inform the resident whenever: The staff member is no longer employed at the facility?	yes
	Following a resident's allegation that a staff member has committed sexual abuse against the resident, unless the agency has determined that the allegation is unfounded or unless the resident has been released from custody, does the agency subsequently inform the resident whenever: The agency learns that the staff member has been indicted on a charge related to sexual abuse in the facility?	yes
	Following a resident's allegation that a staff member has committed sexual abuse against the resident, unless the agency has determined that the allegation is unfounded or unless the resident has been released from custody, does the agency subsequently inform the resident whenever: The agency learns that the staff member has been convicted on a charge related to sexual abuse within the facility?	yes
115.373 (d)	**Reporting to residents**	
	Following a resident's allegation that he or she has been sexually abused by another resident, does the agency subsequently inform the alleged victim whenever: The agency learns that the alleged abuser has been indicted on a charge related to sexual abuse within the facility?	yes
	Following a resident's allegation that he or she has been sexually abused by another resident, does the agency subsequently inform the alleged victim whenever: The agency learns that the alleged abuser has been convicted on a charge related to sexual abuse within the facility?	yes
115.373 (e)	**Reporting to residents**	
	Does the agency document all such notifications or attempted notifications?	yes
115.376 (a)	**Disciplinary sanctions for staff**	
	Are staff subject to disciplinary sanctions up to and including termination for violating agency sexual abuse or sexual	yes

	harassment policies?	
115.376 (b)	**Disciplinary sanctions for staff**	
	Is termination the presumptive disciplinary sanction for staff who have engaged in sexual abuse?	yes
115.376 (c)	**Disciplinary sanctions for staff**	
	Are disciplinary sanctions for violations of agency policies relating to sexual abuse or sexual harassment (other than actually engaging in sexual abuse) commensurate with the nature and circumstances of the acts committed, the staff member’s disciplinary history, and the sanctions imposed for comparable offenses by other staff with similar histories?	yes
115.376 (d)	**Disciplinary sanctions for staff**	
	Are all terminations for violations of agency sexual abuse or sexual harassment policies, or resignations by staff who would have been terminated if not for their resignation, reported to: Law enforcement agencies, unless the activity was clearly not criminal?	yes
	Are all terminations for violations of agency sexual abuse or sexual harassment policies, or resignations by staff who would have been terminated if not for their resignation, reported to: Relevant licensing bodies?	yes
115.377 (a)	**Corrective action for contractors and volunteers**	
	Is any contractor or volunteer who engages in sexual abuse prohibited from contact with residents?	yes
	Is any contractor or volunteer who engages in sexual abuse reported to: Law enforcement agencies (unless the activity was clearly not criminal)?	yes
	Is any contractor or volunteer who engages in sexual abuse reported to: Relevant licensing bodies?	yes
115.377 (b)	**Corrective action for contractors and volunteers**	
	In the case of any other violation of agency sexual abuse or sexual harassment policies by a contractor or volunteer, does the facility	yes

	take appropriate remedial measures, and consider whether to prohibit further contact with residents?	
115.378 (a)	**Interventions and disciplinary sanctions for residents**	
	Following an administrative finding that a resident engaged in resident-on-resident sexual abuse, or following a criminal finding of guilt for resident-on-resident sexual abuse, may residents be subject to disciplinary sanctions only pursuant to a formal disciplinary process?	yes
115.378 (b)	**Interventions and disciplinary sanctions for residents**	
	Are disciplinary sanctions commensurate with the nature and circumstances of the abuse committed, the resident's disciplinary history, and the sanctions imposed for comparable offenses by other residents with similar histories?	yes
	In the event a disciplinary sanction results in the isolation of a resident, does the agency ensure the resident is not denied daily large-muscle exercise?	yes
	In the event a disciplinary sanction results in the isolation of a resident, does the agency ensure the resident is not denied access to any legally required educational programming or special education services?	yes
	In the event a disciplinary sanction results in the isolation of a resident, does the agency ensure the resident receives daily visits from a medical or mental health care clinician?	yes
	In the event a disciplinary sanction results in the isolation of a resident, does the resident also have access to other programs and work opportunities to the extent possible?	yes
115.378 (c)	**Interventions and disciplinary sanctions for residents**	
	When determining what types of sanction, if any, should be imposed, does the disciplinary process consider whether a resident's mental disabilities or mental illness contributed to his or her behavior?	yes
115.378 (d)	**Interventions and disciplinary sanctions for residents**	
	If the facility offers therapy, counseling, or other interventions designed to address and correct underlying reasons or motivations	yes

	for the abuse, does the facility consider whether to offer the offending resident participation in such interventions?	
	If the agency requires participation in such interventions as a condition of access to any rewards-based behavior management system or other behavior-based incentives, does it always refrain from requiring such participation as a condition to accessing general programming or education?	yes
115.378 (e)	**Interventions and disciplinary sanctions for residents**	
	Does the agency discipline a resident for sexual contact with staff only upon a finding that the staff member did not consent to such contact?	yes
115.378 (f)	**Interventions and disciplinary sanctions for residents**	
	For the purpose of disciplinary action, does a report of sexual abuse made in good faith based upon a reasonable belief that the alleged conduct occurred NOT constitute falsely reporting an incident or lying, even if an investigation does not establish evidence sufficient to substantiate the allegation?	yes
115.378 (g)	**Interventions and disciplinary sanctions for residents**	
	Does the agency always refrain from considering non-coercive sexual activity between residents to be sexual abuse? (N/A if the agency does not prohibit all sexual activity between residents.)	yes
115.381 (a)	**Medical and mental health screenings; history of sexual abuse**	
	If the screening pursuant to § 115.341 indicates that a resident has experienced prior sexual victimization, whether it occurred in an institutional setting or in the community, do staff ensure that the resident is offered a follow-up meeting with a medical or mental health practitioner within 14 days of the intake screening?	yes
115.381 (b)	**Medical and mental health screenings; history of sexual abuse**	
	If the screening pursuant to § 115.341 indicates that a resident has previously perpetrated sexual abuse, whether it occurred in an institutional setting or in the community, do staff ensure that the resident is offered a follow-up meeting with a mental health practitioner within 14 days of the intake screening?	yes

115.381 (c)	**Medical and mental health screenings; history of sexual abuse**	
	Is any information related to sexual victimization or abusiveness that occurred in an institutional setting strictly limited to medical and mental health practitioners and other staff as necessary to inform treatment plans and security management decisions, including housing, bed, work, education, and program assignments, or as otherwise required by Federal, State, or local law?	yes
115.381 (d)	**Medical and mental health screenings; history of sexual abuse**	
	Do medical and mental health practitioners obtain informed consent from residents before reporting information about prior sexual victimization that did not occur in an institutional setting, unless the resident is under the age of 18?	yes
115.382 (a)	**Access to emergency medical and mental health services**	
	Do resident victims of sexual abuse receive timely, unimpeded access to emergency medical treatment and crisis intervention services, the nature and scope of which are determined by medical and mental health practitioners according to their professional judgment?	yes
115.382 (b)	**Access to emergency medical and mental health services**	
	If no qualified medical or mental health practitioners are on duty at the time a report of recent sexual abuse is made, do staff first responders take preliminary steps to protect the victim pursuant to § 115.362?	yes
	Do staff first responders immediately notify the appropriate medical and mental health practitioners?	yes
115.382 (c)	**Access to emergency medical and mental health services**	
	Are resident victims of sexual abuse offered timely information about and timely access to emergency contraception and sexually transmitted infections prophylaxis, in accordance with professionally accepted standards of care, where medically appropriate?	yes
115.382	**Access to emergency medical and mental health services**	

(d)		
	Are treatment services provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident?	yes
115.383 (a)	**Ongoing medical and mental health care for sexual abuse victims and abusers**	
	Does the facility offer medical and mental health evaluation and, as appropriate, treatment to all residents who have been victimized by sexual abuse in any prison, jail, lockup, or juvenile facility?	yes
115.383 (b)	**Ongoing medical and mental health care for sexual abuse victims and abusers**	
	Does the evaluation and treatment of such victims include, as appropriate, follow-up services, treatment plans, and, when necessary, referrals for continued care following their transfer to, or placement in, other facilities, or their release from custody?	yes
115.383 (c)	**Ongoing medical and mental health care for sexual abuse victims and abusers**	
	Does the facility provide such victims with medical and mental health services consistent with the community level of care?	yes
115.383 (d)	**Ongoing medical and mental health care for sexual abuse victims and abusers**	
	Are resident victims of sexually abusive vaginal penetration while incarcerated offered pregnancy tests? (N/A if all-male facility.)	yes
115.383 (e)	**Ongoing medical and mental health care for sexual abuse victims and abusers**	
	If pregnancy results from the conduct described in paragraph § 115.383(d), do such victims receive timely and comprehensive information about and timely access to all lawful pregnancy-related medical services? (N/A if all-male facility.)	yes
115.383 (f)	**Ongoing medical and mental health care for sexual abuse victims and abusers**	
	Are resident victims of sexual abuse while incarcerated offered tests for sexually transmitted infections as medically appropriate?	yes
115.383 (g)	**Ongoing medical and mental health care for sexual abuse victims and abusers**	

	Are treatment services provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident?	yes
115.383 (h)	**Ongoing medical and mental health care for sexual abuse victims and abusers**	
	Does the facility attempt to conduct a mental health evaluation of all known resident-on-resident abusers within 60 days of learning of such abuse history and offer treatment when deemed appropriate by mental health practitioners?	yes
115.386 (a)	**Sexual abuse incident reviews**	
	Does the facility conduct a sexual abuse incident review at the conclusion of every sexual abuse investigation, including where the allegation has not been substantiated, unless the allegation has been determined to be unfounded?	yes
115.386 (b)	**Sexual abuse incident reviews**	
	Does such review ordinarily occur within 30 days of the conclusion of the investigation?	yes
115.386 (c)	**Sexual abuse incident reviews**	
	Does the review team include upper-level management officials, with input from line supervisors, investigators, and medical or mental health practitioners?	yes
115.386 (d)	**Sexual abuse incident reviews**	
	Does the review team: Consider whether the allegation or investigation indicates a need to change policy or practice to better prevent, detect, or respond to sexual abuse?	yes
	The subsection of this provision is no longer applicable to your compliance finding, please select N/A.	na
	Does the review team: Examine the area in the facility where the incident allegedly occurred to assess whether physical barriers in the area may enable abuse?	yes
	Does the review team: Assess the adequacy of staffing levels in that area during different shifts?	yes

	Does the review team: Assess whether monitoring technology should be deployed or augmented to supplement supervision by staff?	yes
	Does the review team: Prepare a report of its findings, including but not necessarily limited to determinations made pursuant to §§ 115.386(d)(1)-(d)(5), and any recommendations for improvement and submit such report to the facility head and PREA compliance manager?	yes
115.386 (e)	**Sexual abuse incident reviews**	
	Does the facility implement the recommendations for improvement, or document its reasons for not doing so?	yes
115.387 (a)	**Data collection**	
	Does the agency collect accurate, uniform data for every allegation of sexual abuse at facilities under its direct control using a standardized instrument and set of definitions?	yes
115.387 (b)	**Data collection**	
	Does the agency aggregate the incident-based sexual abuse data at least annually?	yes
115.387 (c)	**Data collection**	
	Does the incident-based data include, at a minimum, the data necessary to answer all questions from the most recent version of the Survey of Sexual Violence conducted by the Department of Justice?	yes
115.387 (d)	**Data collection**	
	Does the agency maintain, review, and collect data as needed from all available incident-based documents, including reports, investigation files, and sexual abuse incident reviews?	yes
115.387 (e)	**Data collection**	
	Does the agency also obtain incident-based and aggregated data from every private facility with which it contracts for the confinement of its residents? (N/A if agency does not contract for	na

	the confinement of its residents.)	
115.387 (f)	**Data collection**	
	Does the agency, upon request, provide all such data from the previous calendar year to the Department of Justice no later than June 30? (N/A if DOJ has not requested agency data.)	yes
115.388 (a)	**Data review for corrective action**	
	Does the agency review data collected and aggregated pursuant to § 115.387 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training, including by: Identifying problem areas?	yes
	Does the agency review data collected and aggregated pursuant to § 115.387 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training, including by: Taking corrective action on an ongoing basis?	yes
	Does the agency review data collected and aggregated pursuant to § 115.387 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training, including by: Preparing an annual report of its findings and corrective actions for each facility, as well as the agency as a whole?	yes
115.388 (b)	**Data review for corrective action**	
	Does the agency’s annual report include a comparison of the current year’s data and corrective actions with those from prior years and provide an assessment of the agency’s progress in addressing sexual abuse?	yes
115.388 (c)	**Data review for corrective action**	
	Is the agency’s annual report approved by the agency head and made readily available to the public through its website or, if it does not have one, through other means?	yes
115.388 (d)	**Data review for corrective action**	
	Does the agency indicate the nature of the material redacted where it redacts specific material from the reports when	yes

	publication would present a clear and specific threat to the safety and security of a facility?	
115.389 (a)	**Data storage, publication, and destruction**	
	Does the agency ensure that data collected pursuant to § 115.387 are securely retained?	yes
115.389 (b)	**Data storage, publication, and destruction**	
	Does the agency make all aggregated sexual abuse data, from facilities under its direct control and private facilities with which it contracts, readily available to the public at least annually through its website or, if it does not have one, through other means?	yes
115.389 (c)	**Data storage, publication, and destruction**	
	Does the agency remove all personal identifiers before making aggregated sexual abuse data publicly available?	yes
115.389 (d)	**Data storage, publication, and destruction**	
	Does the agency maintain sexual abuse data collected pursuant to § 115.387 for at least 10 years after the date of the initial collection, unless Federal, State, or local law requires otherwise?	yes
115.401 (a)	**Frequency and scope of audits**	
	During the prior three-year audit period, did the agency ensure that each facility operated by the agency, or by a private organization on behalf of the agency, was audited at least once? (Note: The response here is purely informational. A "no" response does not impact overall compliance with this standard.)	yes
115.401 (b)	**Frequency and scope of audits**	
	Is this the first year of the current audit cycle? (Note: a “no” response does not impact overall compliance with this standard.)	yes
	If this is the second year of the current audit cycle, did the agency ensure that at least one-third of each facility type operated by the agency, or by a private organization on behalf of the agency, was audited during the first year of the current audit cycle? (N/A if this is not the second year of the current audit cycle.)	na

	If this is the third year of the current audit cycle, did the agency ensure that at least two-thirds of each facility type operated by the agency, or by a private organization on behalf of the agency, were audited during the first two years of the current audit cycle? (N/A if this is not the third year of the current audit cycle.)	na
115.401 (h)	**Frequency and scope of audits**	
	Did the auditor have access to, and the ability to observe, all areas of the audited facility?	yes
115.401 (i)	**Frequency and scope of audits**	
	Was the auditor permitted to request and receive copies of any relevant documents (including electronically stored information)?	yes
115.401 (m)	**Frequency and scope of audits**	
	Was the auditor permitted to conduct private interviews with inmates, residents, and detainees?	yes
115.401 (n)	**Frequency and scope of audits**	
	Were inmates, residents, and detainees permitted to send confidential information or correspondence to the auditor in the same manner as if they were communicating with legal counsel?	yes
115.403 (f)	**Audit contents and findings**	
	The agency has published on its agency website, if it has one, or has otherwise made publicly available, all Final Audit Reports. The review period is for prior audits completed during the past three years PRECEDING THIS AUDIT. The pendency of any agency appeal pursuant to 28 C.F.R. § 115.405 does not excuse noncompliance with this provision. (N/A if there have been no Final Audit Reports issued in the past three years, or, in the case of single facility agencies, there has never been a Final Audit Report issued.)	yes