PREA Facility Audit Report: Final

Name of Facility: Sununu Youth Services Center
Facility Type: Juvenile
Date Interim Report Submitted: 05/11/2022
Date Final Report Submitted: 05/12/2022

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: Andrew George LeClair	**Date of Signature:** 05/12/2022

AUDITOR INFORMATION	
Auditor name:	LeClair, Andy
Email:	andy@lawofficeagl.com
Start Date of On-Site Audit:	06/15/2021
End Date of On-Site Audit:	07/08/2021

FACILITY INFORMATION	
Facility name:	Sununu Youth Services Center
Facility physical address:	1056 River Road, Manchester, New Hampshire - 03104
Facility mailing address:	

Primary Contact	
Name:	Rhonda Chasse
Email Address:	Rhonda.M.Chasse@dhhs.nh.gov
Telephone Number:	603 665-8524

Superintendent/Director/Administrator	
Name:	Rhonda Chasse
Email Address:	Rhonda.M.Chasse@dhhs.nh.gov
Telephone Number:	603 665-8524

Facility PREA Compliance Manager	
Name:	George Dovas
Email Address:	george.j.dovas@dhhs.nh.gov
Telephone Number:	O: (603) 665-1526

Facility Health Service Administrator On-Site	
Name:	Steven Abbott
Email Address:	Steven.B.Abbott@dhhs.nh.gov
Telephone Number:	603 665-1580

Facility Characteristics	
Designed facility capacity:	144
Current population of facility:	15
Average daily population for the past 12 months:	14
Has the facility been over capacity at any point in the past 12 months?	No
Which population(s) does the facility hold?	Both females and males
Age range of population:	11-17
Facility security levels/resident custody levels:	Secure
Number of staff currently employed at the facility who may have contact with residents:	95
Number of individual contractors who have contact with residents, currently authorized to enter the facility:	5
Number of volunteers who have contact with residents, currently authorized to enter the facility:	0

AGENCY INFORMATION	
Name of agency:	New Hampshire Division for Children, Youth, and Families
Governing authority or parent agency (if applicable):	
Physical Address:	129 Pleasant Street, Concord, New Hampshire - 03301
Mailing Address:	
Telephone number:	

Agency Chief Executive Officer Information:	
Name:	
Email Address:	
Telephone Number:	

Agency-Wide PREA Coordinator Information			
Name:	James Panzer	**Email Address:**	james.panzer@dhhs.nh.gov

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:	
34	
Number of standards not met:	
9	• 115.315 - Limits to cross-gender viewing and searches • 115.317 - Hiring and promotion decisions • 115.321 - Evidence protocol and forensic medical examinations • 115.333 - Resident education • 115.341 - Obtaining information from residents • 115.351 - Resident reporting • 115.353 - Resident access to outside confidential support services and legal representation • 115.372 - Evidentiary standard for administrative investigations • 115.378 - Interventions and disciplinary sanctions for residents

POST-AUDIT REPORTING INFORMATION

GENERAL AUDIT INFORMATION

On-site Audit Dates

1. Start date of the onsite portion of the audit:	2021-06-15
2. End date of the onsite portion of the audit:	2021-07-08

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:	The auditor contacted the facility's designated local advocate group: YWCA New Hampshire. YWCA of NH was founded in 1920 and is an agency dedicated to victims' rights and services and only employs staff that are qualified and receive training concerning sexual assault and forensic examination issues in general. YWCA provides confidential services to victims at no charge and are available to female and male children, adolescents, adults, and elders. A representative of YWCA indicated that they have a memorandum of understanding with the facility. Throughout this audit it was revealed that this relationship is being reformed and efforts have been made to expand the use and scope of services offered by YWCA (e.g., reporting lines). The auditor also contacted Justice Detention International (JDI). A representative of JDI informed this auditor that JDI had not received any information regarding SYSC.

AUDITED FACILITY INFORMATION

14. Designated facility capacity:	144
15. Average daily population for the past 12 months:	14
16. Number of inmate/resident/detainee housing units:	9
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

36. Enter the total number of inmates/residents/detainees in the facility as of the first day of onsite portion of the audit:	15

37. 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:	15
38. 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:	2
39. 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:	0
40. 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
41. 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
42. 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:	1
43. 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:	2
44. 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
45. 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:	2
46. 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:	1
47. 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:	1

48. 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):	Based upon the resident population at the facility on the first day of the onsite portion of the audit, the PREA Auditor Handbook (August 2017) specifies that a minimum of 10 resident interviews must be conducted; a minimum number of five random resident and five targeted resident interviews are required. The random residents were selected across all housing units and utilizing random methodology employed by this auditor. The methodology employed for this audit was selection of the resident name from a roster provided by the facility based on a numerical cadence chosen by the auditor. The auditor made adjustments to the random sample to reflect a diverse interview pool by selecting the name above the randomly identified selection. The auditor was given complete discretion to select interviewees independently without input from the facility. Interviews were conducted using the Interview Guide for Residents developed by the Department of Justice. Targeted residents were identified from listings of residents provided by the facility at the beginning of the onsite portion of the audit. The auditor interviewed identified residents until the mandatory minimum number of interviews was conducted for this audit. Interviews were conducted using the Interview Guide for Residents that includes questions for targeted residents.
Staff, Volunteers, and Contractors Population Characteristics on Day One of the Onsite Portion of the Audit	
49. 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:	95
50. 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:	0
51. 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:	5
52. 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:	No text provided.

INTERVIEWS

Inmate/Resident/Detainee Interviews

Random Inmate/Resident/Detainee Interviews

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

54. 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
55. How did you ensure your sample of RANDOM INMATE/RESIDENT/DETAINEE interviewees was geographically diverse?	Based upon the resident population at the facility on the first day of the onsite portion of the audit, the PREA Auditor Handbook (August 2017) specifies that a minimum of 10 resident interviews must be conducted; a minimum number of five random resident and five targeted resident interviews are required. This auditor compared his random sample to a resident list that include bed/housing assignment, DOB, and gender to ensure the auditor was interviewing a geographically diverse cross-section of the program.
56. Were you able to conduct the minimum number of random inmate/resident/detainee interviews?	◉ Yes ○ No
57. 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):	The random residents were selected across all housing units and utilizing random methodology employed by this auditor. The methodology employed for this audit was selection of the resident name from a roster provided by the facility based on a numerical cadence chosen by the auditor. The auditor made adjustments to the random sample to reflect a diverse interview pool by selecting the name above the randomly identified selection. The auditor was given complete discretion to select interviewees independently without input from the facility. Interviews were conducted using the Interview Guide for Residents developed by the Department of Justice.
Targeted Inmate/Resident/Detainee Interviews	
58. 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".	

59. Enter the total number of interviews conducted with youthful inmates or youthful/juvenile detainees using the "Youthful Inmates" protocol:	10
60. Enter the total number of interviews conducted with inmates/residents/detainees with a physical disability using the "Disabled and Limited English Proficient Inmates" protocol:	2
61. 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:	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).	During resident and staff interviews, this auditor attempted to corroborate facility reports that no residents of any given targeted groups were available for interview. No residents were discovered.
62. 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).	During resident and staff interviews, this auditor attempted to corroborate facility reports that no residents of any given targeted groups were available for interview. No residents were discovered.
63. 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).	During resident and staff interviews, this auditor attempted to corroborate facility reports that no residents of any given targeted groups were available for interview. No residents were discovered.
64. 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:	1
65. 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
66. 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).	During resident and staff interviews, this auditor attempted to corroborate facility reports that no residents of any given targeted groups were available for interview. No residents were discovered.
67. 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:	2
68. 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:	1
69. 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:	1
70. Provide any additional comments regarding selecting or interviewing targeted inmates/residents/detainees (e.g., any populations you oversampled, barriers to completing interviews):	Targeted residents were identified from listings of residents provided by the facility at the beginning of the onsite portion of the audit. The auditor interviewed identified residents until the mandatory minimum number of interviews was conducted for this audit. Interviews were conducted using the Interview Guide for Residents that includes questions for targeted residents.

Staff, Volunteer, and Contractor Interviews

Random Staff Interviews

71. Enter the total number of RANDOM STAFF who were interviewed:	12
72. 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
73. Were you able to conduct the minimum number of RANDOM STAFF interviews?	◉ Yes ○ No
74. Provide any additional comments regarding selecting or interviewing random staff (e.g., any populations you oversampled, barriers to completing interviews, barriers to ensuring representation):	The random staff were selected across all shifts and housing units. The methodology employed for this audit was selection of one person from each shift during the dates of this auditor's audit. The auditor utilized this methodology as a selection based on the staff roster proved as a numerical selection was not feasible. The staff roster included part-time/relief staff and staff who were currently out on vacation time, etc. Additionally, due to the COVID-19 pandemic and staff availability, many staff worked multiple shifts during the onsite portion of this audit. The auditor was given complete discretion to select interviewees independently without input from the facility (except for the purposes of identifying specific staff that perform specialized functions). Random interviews were conducted using the Interview Guide for a Random Sample of Staff developed by the Department of Justice. All staff in this facility perform specialized functions (e.g., 1st Responders and Staff who Supervise Residents in Segregated Housing). As a result, all random staff interviewed were additionally interviewed utilizing the specialized protocol that was applicable to their job responsibility.

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.

75. Enter the total number of staff in a SPECIALIZED STAFF role who were interviewed (excluding volunteers and contractors):	20
76. Were you able to interview the Agency Head?	◉ Yes ○ No

77. Were you able to interview the Warden/Facility Director/Superintendent or their designee?	◉ Yes ○ No
78. Were you able to interview the PREA Coordinator?	◉ Yes ○ No
79. 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)

80. 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
If "Other," provide additional specialized staff roles interviewed:	Grievance staff, Staff responsible for training other staff, Data analyst/keeper of electronic resident files, & Maintenance personnel.
81. Did you interview VOLUNTEERS who may have contact with inmates/residents/detainees in this facility?	○ Yes ◉ No
82. 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
83. Provide any additional comments regarding selecting or interviewing specialized staff.	The auditor was given complete discretion to select interviewees independently without input from the facility (except for the purposes of identifying specific staff that perform specialized functions). Specialized staff were interviewed utilizing the Interview Guide for Specialized Staff developed by the Department of Justice. All staff in this facility perform specialized functions (e.g., 1st Responders and Staff who Supervise Residents in Segregated Housing). As a result, all random staff interviewed were additionally interviewed utilizing the specialized protocol that was applicable to their job responsibility.

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.

84. Did you have access to all areas of the facility?	◉ Yes ○ No
Was the site review an active, inquiring process that included the following:	
85. 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
86. 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
87. Informal conversations with inmates/residents/detainees during the site review (encouraged, not required)?	◉ Yes ○ No

88. Informal conversations with staff during the site review (encouraged, not required)?	◉ Yes ○ No
89. 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 arrived at the Facility on June 15, 2021, to begin the onsite portion of the audit. The final day of the onsite portion of this audit was July 8, 2021 (as outlined above). An introduction and security in-brief were conducted with SYSC administration and leadership, which included: the Agency PREA Coordinator, Facility Director, and other facility administrators, case management staff, and direct care staff. During this introduction, the auditor reviewed the onsite PREA audit process, methodology, and other logistical information. This occurred on June 15, 2021. After the introduction, agency staff members escorted the PREA auditor throughout the facility. The auditor observed daily operations to include: intake/booking process, classification, record storage area, resident education process, grievance system, staff and cross-gender announcements when entering a resident bedroom and housing unit of the opposite gender, and phone systems. This auditor requested that staff demonstrate a mock intake and showed this auditor where the resident would come in from, what information they would receive, and where the resident would wait during this process. While touring the facility, this auditor observed escorting staff announcing their presence when entering an access door to get into the resident's housing unit of the opposite gender. This auditor was able to test the functioning of the phone system throughout the facility and test reporting lines posted throughout the facility. While conducting the site review, the auditor reviewed: privacy issues, supervision practices and ratios, programming and education areas, work areas, camera placement and the location of any blind spots, the food service area, storage areas, as well as the basement and roof. This auditor was able to observe a life skills resident group being facility by staff in the library/group room. This auditor was able to locate camera placements throughout the facility and review the and manipulate the display settings in the control center. All areas of the facility were observed to be monitored. This auditor observed the roof access and had staff employ key control measures to provide this auditor with access to the roof. During the site review, the auditor conducted informal interviews with residents and staff. The informal interviews covered a wide-range of topics; the overwhelming response and feeling while engaging with residents and staff at the program was that they felt like they resided and worked in a sexually safe environment. PREA-related education materials were observed in the intake/booking area, centrally located throughout the facility, and in the dining area. This auditor observed the grievance box system and asked residents how they would write a grievance or submit a written report of an incident during resident interviews.

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.

90. 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

91. Provide any additional comments regarding selecting additional documentation (e.g., any documentation you oversampled, barriers to selecting additional documentation, etc.).	Document Sampling and Review The facility provided the auditor the requested listings of documents, files and records. From this information, the auditor selected and reviewed a variety of files, records and documents summarized in the following table and discussed in detail below: Personnel and Training Files. The auditor reviewed nine personnel records that included staff hired within the past 12 months as well as existing staff members. Additionally, the auditor reviewed staff who received promotions in the last year. The sample included a variety of job functions and post assignments, including both supervisory and line staff. Files for volunteer and contractors who have contact with inmates were sampled randomly across functional service areas. The methodology employed for this audit was selection of the staff name from a roster provided by the facility based on a numerical cadence chosen by the auditor. The auditor made adjustments to the random sample to reflect a diverse interview pool by selecting the name above the randomly identified selection. Effort was made to corroborate information obtained during staff interviews by reviewing personnel and training files of those staff previously interviewed. At no time did facility or agency representatives impact the auditor's sample of audited materials. Resident Files. Based on the resident population on the first day of the onsite phase of the audit, a total of 10 resident interviews were required. A total of six resident files were reviewed by the auditor. Six resident records were sampled across all housing units in the facility. There were no resident files of residents that had reported sexual abuse available for the auditor to review. The auditor randomly selected resident files to review. Additionally, the auditor attempted to corroborate information obtained during resident interviews by reviewing files of those residents that were previously interviewed. At no time did facility or agency representatives impact the auditor's sample of audited materials. Grievances. In the past year, the facility reported receiving no grievances. The auditor attempted to discover the existence of reported grievance during random resident and staff interviews. No grievances were made available for the auditor to review. Incident Reports. The facility reported there were 13 incident reports alleging sexual harassment and no incidents alleging sexual abuse for the 12 months prior to the audit. The auditor reviewed all identified incident reports. Investigative files. The Agency provided the auditor with a list of PREA-related allegations from the previous twelve months. There was a total of 13 administrative investigative files listed. While onsite, this auditor was given access to the investigative files storage room to review. The auditor reviewed all files within the past 12-months and reviewed the months between the completion of the PAQ and the onsite portion of the audit. This auditor discovered five investigations of conduct defined by the PREA Standards as Sexual Abuse. All sexual abuse investigative files were reviewed. Additionally, 10 investigations involving sexual harassment were also reviewed.

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.

92. 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	3	0	3	0
Staff-on-inmate sexual abuse	2	0	3	0
Total	6	0	6	0

93. 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	8	0	8	0
Staff-on-inmate sexual harassment	2	0	2	0
Total	10	0	10	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.

94. 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

You indicated that you are unable to provide information for one or more of the fields above. Explain why this information could not be provided.	None of the above-listed investigations were referred for prosecution as a result there is no data to report on the remaining fields.

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

	Ongoing	Unfounded	Unsubstantiated	Substantiated
Inmate-on-inmate sexual abuse	0	1	2	0
Staff-on-inmate sexual abuse	0	2	0	0
Total	0	3	2	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.

96. 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

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

	Ongoing	Unfounded	Unsubstantiated	Substantiated
Inmate-on-inmate sexual harassment	0	1	1	6
Staff-on-inmate sexual harassment	0	0	2	0
Total	0	1	3	6

Sexual Abuse and Sexual Harassment Investigation Files Selected for Review

Sexual Abuse Investigation Files Selected for Review

98. Enter the total number of SEXUAL ABUSE investigation files reviewed/sampled:	5
99. 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	
100. Enter the total number of INMATE-ON-INMATE SEXUAL ABUSE investigation files reviewed/sampled:	3
101. 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)
102. 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	
103. Enter the total number of STAFF-ON-INMATE SEXUAL ABUSE investigation files reviewed/sampled:	2
104. 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)
105. 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	
106. Enter the total number of SEXUAL HARASSMENT investigation files reviewed/sampled:	10

107. 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	
108. Enter the total number of INMATE-ON-INMATE SEXUAL HARASSMENT investigation files reviewed/sampled:	8
109. 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)
110. 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	
111. Enter the total number of STAFF-ON-INMATE SEXUAL HARASSMENT investigation files reviewed/sampled:	2
112. 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)
113. 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)
114. Provide any additional comments regarding selecting and reviewing sexual abuse and sexual harassment investigation files.	The Agency provided the auditor with a list of PREA-related allegations from the previous twelve months. There was a total of 13 administrative investigative files listed. While onsite, this auditor was given access to the investigative files storage room to review. The auditor reviewed all files within the past 12-months and reviewed the months between the completion of the PAQ and the onsite portion of the audit. This auditor discovered five investigations of conduct defined by the PREA Standards as Sexual Abuse. All sexual abuse investigative files were reviewed. Additionally, 10 investigations involving sexual harassment were also reviewed.

SUPPORT STAFF INFORMATION

DOJ-certified PREA Auditors Support Staff

115. 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

116. 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

121. 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

115.311: Zero tolerance of sexual abuse and sexual harassment; PREA Coordinator.

The following evidence was analyzed in making the compliance determination:

1. Documents: (Policies, directives, forms, files, records, etc.)

a. Sununu Youth Services Center Pre-Audit Questionnaire (PAQ) responses

b. Sexual Assault and Sexual Harassment Policy 2055 (effective August 2017)

c. PREA General Provisions Policy 2040 (effective February 2022)

d. Addressing Rules Violations Policy 2100 (effective December 2020)

e. Agency Organizational Chart

f. Facility Organizational Chart

2. Interviews

a. Agency PREA Coordinator

b. Facility PREA Compliance Manager

3. Site Review Observations:

a. Observations during on-site review of physical plant

Findings (By Provision):

115.311(a):

The Sununu Youth Services Center (hereafter "The Facility") facility within the New Hampshire Division for Children, Youth and Families (hereafter "DCYF" indicated compliance in the Pre-Audit Questionnaire (hereafter "PAS") and provided the auditor with Policy 2055 Sexual Assault and Sexual Harassment. Section I(A) of Policy 2055 establishes, "The Sununu Youth Services Center (SYSC) establishes zero tolerance towards all forms of sexual abuse, sexual harassment, and/or other forms of sexual misconduct. Sexual or sexualized behavior or sexual harassment from staff-to-staff, staff-to-youth, or youth-to-youth is expressly prohibited (115.311(a))" (p. 4).

Policy 2055 indicates the Purpose of 2055 is to "outline[] the SYSC approach to preventing, detecting, and responding to such conduct according to the provisions of the Prison Rape Elimination Act of 2003 (PREA)" (p. 1). However, the policy fails to delineate what procedures within the policy are associated with "preventing" or "detecting" sexual abuse and sexual harassment. A search of this document only reveals these two terms once within the 26-page policy (within the aforementioned document). Sections V(A) and VIII(C)(3) outline the agency's approach to responding to sexual abuse and sexual harassment.

Policy 2055 includes a "Definitions" section that defines, among other terms, "Sexual Abuse," "Sexual Harassment," and "Sexual Misconduct." (p.2–4).

Section I(H) of Policy 2055 establishes presumptive and available sanctions for staff, contractors, or volunteers (p. 5). Policy 2055 does not, however, include possible sanctions for youth found to have participated in prohibited behaviors.

Based upon the review and analysis of all the available evidence, and following a period of corrective action, the auditor has

determined that the agency is fully compliant with this provision. Please see the below "Final Audit Report Reassessment" for review.

115.311(b):

During the pre-onsite portion of this audit, the Facility acknowledged compliance in this provision in its PAQ response. The facility reported that the agency employs an upper-level, agency-wide PREA Coordinator. The agency provided this auditor with an organizational chart of the Agency. The PREA Coordinator is defined as a Program Specialist IV. The Agency's organizational chart reveals that this staff person reports to the Administrator I within the DCYF General Counsel and Legislative Liaison's Office.

During the onsite portion of this audit, the auditor interviewed the PREA Coordinator. In response to whether they felt that they had enough time to manage all PREA-related responsibilities, the PREA Coordinator responded in the affirmative. The PREA Coordinator reported that there is one PREA Compliance Manager within the Facility and that he has regular interaction with that person. The PREA Coordinator reported that he ensures that if any modifications or updates are made – or issues are revealed – that any changes adhere to the PREA standards. Further elaborating that he is an active participant on the PREA Resource Center and Federal Register Listservs.

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is fully compliant with this provision.

115.311(c):

During the pre-onsite portion of this audit, the Facility acknowledged compliance in this provision in its PAQ response. The facility reported that the agency has a designated PREA Compliance Manager. The agency provided this auditor with an organizational chart of the Facility. The PREA Compliance Manager is defined as Administrator II. The Facility's organizational chart reveals that this staff person reports to the SYSC Administrator/Facility Director of Operations.

During the onsite portion of this audit, the auditor interviewed the PREA Compliance Manager. In response to whether they felt that they had enough time to manage all PREA-related responsibilities, this staff person responded in the affirmative and indicated that their PREA-related responsibilities are at the forefront of their job responsibilities as a whole.

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is fully compliant with this provision.

Interim Report Corrective Action:

Develop a policy clearly outlining how the Facility will implement the agency's approach to preventing and detecting to sexual abuse and sexual harassment.
Develop and Implement policy and procedures that include sanctions for youth who have participated in prohibited behaviors.

Recommendations:

1. Amend the excerpt in Section I(A) to indicate "The … (SYSC) mandates zero tolerance . . ."

Final Audit Report Reassessment:

During the post-onsite audit portion of this audit, the auditor identified that the agency was not fully compliant with provision (a) of this standard. The Agency provided the auditor with "SYSC PREA Audit Corrective Action Specific Findings" on February 18, 2022. Follow-up to this corrective action plan was received on March 25, 2022. The Agency developed the

following corrective action plan with respect to this provision:

115.311 Corrective Action #1: The Department historically relied on Policy 2055 to implement a number of PREA regulations, and included that the policy "…outlines SYSC's approach to detection and prevention planning in accordance to the provisions of the Prison Rape Elimination Act of 2003 (PREA) (28 CFR Part 115)." Prior to engagement in this audit, the DCYF Policy Unit had identified a need to deconstruct Policy 2055 into a number of more targeted policies. The unit put this work on hold during the period of the audit in order to ensure the final product would be responsive to the audit findings. The result is that Policy 2055 has been re-written into five individual policies, including 2040 PREA General Provisions. The new policy clarifies which actions the SYSC takes to prevent sexual abuse and harassment versus the actions that are intended to detect sexual abuse and harassment.

New policy 2040 will follow standard implementation protocol. All Policy Directive (PD) releases are emailed to supervisors to review and discuss with staff. Staff are required to read the policy and sign the PD Receipt form confirming that they have read, understood, and will adhere to the policy within 30 days. Additionally, at each annual performance evaluation, supervisors and staff discuss the Professionalism and Ethics Policy, which makes clear the staff requirement to understand and abide by all State laws, DHHS Policy, and DCYF Division policies.

Going forward, the PREA Compliance Manager will review audit logs for PREA-specific policies and will ensure monitoring of new policy implementation.

115.311 Corrective Action #2: The policy was also amended to include a citation to the policy 2100 Addressing Rules Violations as the process for imposing sanctions on youth, which delineates the facility practices for determining behavioral intervention focused consequences.

115:311(a), Recommendation #1: The language of Policy 2040 has been updated to meet the recommended verbiage of "mandating" zero tolerance in lieu of "establishing" zero tolerance.

During the post-corrective action period, this auditor reviewed the newly revised/created policies to verify the Agency's stated efforts. Upon clarification by the auditor, the Facility confirmed that these policies were implemented on February 16, 2022 (prior to the completion of the 180-day corrective action period).

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency has been able to remedy any previously reported deficiency and is fully compliant with this standard.

115.312	Contracting with other entities for the confinement of residents
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	115.312: Contracting with other entities for the confinement of residents. The following evidence was analyzed in making the compliance determination: 1. Documents: (Policies, directives, forms, files, records, etc.) a. Sununu Youth Services Center Pre-Audit Questionnaire (PAQ) responses 2. Interviews a. Facility Director 3. Site Review Observations: a. Observations during on-site review of physical plant Findings (By Provision): 115.212(a)–(c): During the pre-onsite portion of this audit, the Facility reported in its Pre-Audit Questionnaire (PAQ) responses that the agency has not entered into or renewed a contract for the confinement of residents on or after August 20, 2012 or since its last PREA audit. During the onsite portion of this audit, this auditor interviewed the Facility Director to review the information provided by the facility in its PAQ responses. The Facility Director corroborated the information provided and informed the auditor that DCYF has not contracted with other agencies for the confinement of residents over the reporting timeframe. Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is fully compliant with this provision.

115.313	Supervision and monitoring
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	115.313: Supervision and monitoring The following evidence was analyzed in making the compliance determination: 1. Documents: (Policies, directives, forms, files, records, etc.) a. Sununu Youth Services Center Pre-Audit Questionnaire (PAQ) responses b. SYSC Staffing Plan and Master Schedule Policy 2071 (effective February 2019) c. SYSC Staffing Plan – Final Draft d. SYSC Staffing Plan Assessment (signed 2/16/2022) e. Weight Room Log f. Residential Staffing Report g. Staffing Plan Deviations Log (as a result of COVID-19 Protocols) h. Unannounced rounds – Shift Summary Report 2. Interviews a. Facility Director b. PREA Coordinator c. Intermediate or Higher-Level Facility Staff 3. Site Review Observations: a. Observations during on-site review of physical plant Findings (By Provision): 115.313(a): During the pre-onsite portion of this audit, the Facility indicated compliance in this provision in its PAQ responses. The Facility provided this auditor SYSC Staffing Plan and Master Schedule Policy 2071. The Facility reported its average daily population of 14 since its last PREA Audit. The Facility further reported its average daily population of 30 on which the staffing plan was predicated. A review of Policy 2071 reveals that Section I(B)(1)–(11) lists this standard's 11 required criteria that a staffing plan must take into consideration (see p. 2). During the on-site portion of this audit, this auditor interviewed the agency PREA Coordinator and the Facility Director. The Facility Director indicated SYSC has a staffing plan that provides adequate staffing levels to protect residents against sexual abuse. The Facility further indicated that video monitoring is part of the Facility's staffing plan. When this auditor inquired as to whether the staffing plan was documented and what factors the Facility considers, the Facility Director referred me to Policy 2071. The Facility Director reported that to check for compliance with the staffing plan, this person looks at the schedule (titled, "Residential Staffing Report"), communication logs, shift logs, and makes random spot checks to make sure the Facility is in compliance (that are not documented and are part of the Director's routine for ensuring compliance with the Residential Staffing Report). A review of the Residential Staffing Reports provided and Policy 2071 establish that the current "staffing plan" is akin to a master schedule that indicate placement and schedules of staff that have been allocated to the facility. The auditor was not provided a plan that contained a documented objective analysis of what staff and video monitoring are needed to protect the facility population from sexual abuse. "A PREA-compliant staffing plan is a written document that reflects the results of an

objective analysis of the facility's staffing needs to ensure sexual safety. The staffing plan must identify the personnel and any video monitoring technology necessary to safely and securely operate a facility in a manner that protects against sexual abuse. The staffing plan must describe the numbers and types of positions and video monitoring equipment needed, and the manner in which they would be deployed within each facility to meet the facility's mission to protect . . . residents from sexual abuse" ("Developing and Implementing A PREA-Compliant Staffing Plan" (p. 4) found at https://www.prearesourcecenter.org/sites/default/files/library/staffingplanfinalwbjalogosubmt.pdf). However, in calculating staffing levels, as required by this standard, the facility has demonstrated that is considers: the physical layout of the facility, the composition of the resident population, the prevalence of substantiated and unsubstantiated incidents of sexual abuse, and other related factors.

Based upon the review and analysis of all the available evidence, and following a period of corrective action, the auditor has determined that the agency is fully compliant with this provision. Please see the below "Final Audit Report Reassessment" for review.

115.313(b):

During the pre-onsite portion of this audit, the Facility indicated that this standard was not applicable.

During the on-site portion of this audit, this auditor interviewed the Facility Director. The Facility Director indicated that the only deviations of the staff plan were the result of the creation of the COVID-19 Quarantine requirement created as part of the Facility's COVID-19 protocols to protect against the spread of the virus within the Facility. The Facility Director repotted that as a result the Facility established a log of any deviations that included a reason why. A review of this log corroborated the Facility Director's report.

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is compliant with this provision.

115.313(c):

During the pre-onsite portion of this audit, the Facility indicated compliance in this provision and indicated that the Facility maintains staff ratios of a minimum of 1:8 during resident waking hours and 1:16 during resident sleeping hours.

During the on-site portion of this audit, this auditor interviewed the Facility Director. The Facility Director reported that due to current utilization, the Facility averages two staff for every three to four residents. The Facility Director further indicated that the facility maintains the above-referenced ratios.

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is fully compliant with this provision.

115.313(d):

During the pre-onsite portion of this audit, the Facility indicated compliance in this provision.

During the on-site portion of this audit, this auditor interviewed the agency PREA Coordinator. The PREA Coordinator indicated that during the Facility's PREA preparatory meetings, the annual assessment of the Staffing Plan was discussed and that the Agency is mindful of the fact that these process needs to be completed.

As established in subsection (a), the facilities provided staffing patterns are not an objective-based PREA-compliant staffing plan. As a result, over the past 12 months, the facility cannot assess, determine, and document whether adjustments are

needed to that staffing plan. Furthermore, the Facility has not evidenced that this procedure is in place; a procedure for a review that assesses, determines, and documents whether adjustments are needed to prevailing staffing patterns, to the facility's deployment of video monitoring systems, and whether additional resources are needed to ensure adequate staffing levels.

Additionally, during the facility review it was revealed that the weight room located on the basement level of the "old building" – adjacent to the current facility – does not have electronic monitoring capabilities. This is a three-story building that currently houses staff and State Police temporary offices. The officers are locked but once in the building one can walk freely throughout the various floors. Administration informed this auditor that only trusted youth go to the weight room with two staff. However, during formal and informal staff interviews, it was revealed that staff can and have taken youth alone to the weight room. It is this auditor's opinion that this is a substantial monitoring issue that could be manipulated.

Based upon the review and analysis of all the available evidence, and following a period of corrective action, the auditor has determined that the agency is fully compliant with this provision. Please see the below "Final Audit Report Reassessment" for review.

115.313(e):

During the pre-onsite portion of this audit, the Facility indicated compliance in this provision and provided this auditor with Policy 2071. Section (I)(E) establishes, "SYSC staffing plan shall include the practice of having intermediate-level or higher-level supervisors conduct and document unannounced rounds to identify and deter staff sexual abuse and sexual harassment . . . Such unannounced rounds shall be implemented for all shifts: day, evening, and night, and documented in the YouthCenter SYSC Shift Summary Report, Form 2371" (p. 3). Policy 2071 further indicates in bold that, "Staff are prohibited from alerting other staff members that these supervisory rounds are occurring unless such announcement is related to the legitimate operational functions of the SYSC."

During the onsite portion of this audit, this Auditor interviewed Intermediate or Higher-level Security Staff tasked with the responsibility of completing unannounced rounds. The Facility indicated that the Supervisor on shift would be responsible for conducting these rounds. All supervisors interviewed indicated that as part of their shift responsibilities, they conduct unannounced rounds and that they look back to the prior shift to ensure one was completed. Furthermore, these staff indicated that they would change the times and route taken from day-to-day so that staff could not anticipate when an unannounced round would occur. Also, while onsite, this auditor was able to review shift summary reports that evidenced completion of these rounds.

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is fully compliant with this provision.

Interim Report Corrective Action:

1. Develop a Staffing Plan that provides for an objective analysis of what staff and video monitoring are needed to protect the facility population from sexual abuse, pursuant to 115.313(a).

2. Develop a supervision and monitoring plan for the weight room.

3. Develop a procedure to objectively assess whether adjustments are needed to the staffing plan as defined by 115.313(d).

Final Audit Report Reassessment:

During the post-onsite audit portion of this audit, the auditor identified that the agency was not fully compliant with provisions (a) and (d) of this standard. The Agency provided the auditor with "SYSC PREA Audit Corrective Action Specific Findings" on February 18, 2022. The Agency developed the following corrective action plan with respect to this provision:

115.313 Corrective Action #1: A Staffing Plan was developed and finalized consistent with 115.313(a) on February 7, 2022.

115:313 Corrective Action #2: Utilization of the weight room was temporarily suspended pending the implementation of a protocol. The weight room was again open for youth as of October 5, 2021 consistent with the following:

Effective Tuesday, October 5, 2021, the Trusted Weight Room will reopen for youth to access. Youth must have the appropriate level and trust status to access the gym. The following protocol to follow is below:

1. Staff wanting to take youth to the Trusted Weight Room must contact the Supervisor-on-Duty (SOD) to make sure staffing levels are appropriate to maintain safety and security for all at SYSC. The SOD will review the staffing schedule to insure the appropriate gender ratio per compliance with PREA Standards and Guidelines.

2. Two staff must accompany youth to the Trusted Weight Room.

3. Staff and youth will enter the Administration Building (first door/closest to the main building) and proceed downstairs to the gym door.

4. At the bottom of the stairs, there is a new sign in/sign out sheet on the table. Staff members must sign-in their full names and the full names of the youth accessing the gym. Youth are not to sign in themselves. Staff will add the Date, time-in, time-out and initial the sheet. I attached a copy of the "Trusted Weight Room Visitor Checklist above. Please leave the signed visitor checklist on the clipboard. Do not remove it.

5. Staff must remain in the same room and monitor the youth at all times.

6. Once the youth finish their workouts, staff are to make sure the weight room is picked-up and clean before exiting the weight room.

7. Staff must accompany youth back into the main building and back to their respective unit floors.

8. Staff, who were with youth at the gym, must perform a personal, "pat-down" search of youth when they first enter their floors. (In camera view)

SYSC staff, including JPPOs, may continue to access the Trusted Weight Room, for personal use for exercising; staff still need to fill out their name, document "N/A" under youth names, Date, Time-in, Time out and their Initials. Please make sure you keep the weight room clean when exiting the area.

A copy of the sign-in/sign-out sheet is attached as "Weight Room Log." The facility director or the PREA Compliance Manager will conduct random monthly audits to ensure that the youth and staff who utilize the weight room are in compliance with above sign in procedures.

The door at the top of the 2nd flight of stairs for the entrance into the SYSC Administrative Building has also been locked to eliminate any opportunity for any youth to have contact with the general public without SYSC staff being present.

115:313 Corrective Action #3: As directed in the new Staffing Plan outlined above, and consistent with 115.313(d), a process and form was created for the facility administrator to conduct an annual staffing assessment. The form is included in the Staffing Plan. The most recent assessment was completed on February 7, 2022 and is attached hereto.

During the post-corrective action period, this auditor reviewed the Staffing Plan to ensure the Plan includes all necessary modules pursuant to this standard. Additionally, the Facility effectuated an annual review and provided the auditor with a signed annual assessment documenting that review. Lastly, the updated supervision and monitoring plan adequately addresses the concerns raised by this auditor during the facility site review.

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency has been able to remedy any previously reported deficiency and is fully compliant with this standard.

115.315	Limits to cross-gender viewing and searches
	Auditor Overall Determination: Does Not Meet Standard
	Auditor Discussion

115.315: Limits to cross-gender viewing and searches.

The following evidence was analyzed in making the compliance determination:

1. Documents: (Policies, directives, forms, files, records, etc.)

a. Sununu Youth Services Center Pre-Audit Questionnaire (PAQ) responses

b. Searches Policy 2058 (effective February 2019)

c. Youth Hygiene Policy 2403 (effective July 2014)

d. Nursing Services at Admission Policy 2279 (effective August 2017)

e. Clinical/Medical Watch Report (Form 2054)

f. SYSC Daily Roll Call Form

g. Training Curriculum and Rosters

2. Interviews

a. Random Staff

b. Random Youth

c. Non-medical staff involved in strip or visual searches

d. PREA Coordinator/Director of Operations

3. Site Review Observations:

a. Observations during on-site review of physical plant

Findings (By Provision):

115.315(a):

During the pre-onsite portion of this audit, the Facility indicated compliance with this provision in its PAQ responses and reported the facility does not conduct cross-gender strip or cross-gender visual body cavity searches of residents. The Facility provided this Auditor Policy 2058: Searches. Section IV(B)(3)(a) establishes, "[a]n Unclothed Search shall be conducted with two staff members of the same gender as the youth searched . . . Cross-gendered Unclothed Searches by SYSC staff (including a search of anal or genital openings) are prohibited" (p. 9). The facility indicated that over the past 12 months, there have not been any cross-gender strip or cross-gender visual body cavity searches of residents.

During the on-site portion of this audit, this auditor was informed that there was no cross-gender strip or cross-gender visual body cavity search logs to review. To corroborate the information provided in the PAQ (that there have been no cross-gender strip or visual body cavity searches conducted), this auditor asked all random Youth whether they had been or know of another youth that had been the subject of a strip search or visual body cavity search by a staff person of the opposite gender. Out of 10 Youth interviewed, all of them responded that they have only been searched by staff of the same gender. All 12 staff interviewed reported that they were not allowed to conduct these types of searches on a youth of the opposite gender. Of the 12 staff interviewed, all 12 reported that they qualify as "non-medical staff" that conduct unclothed visual searches as required by policy. All reported the same procedure to conduct these types of searches: the youth enters the visual search room alone, one staff is positioned within site of the youth outside of the room visible on camera, another staff observes from an area of the room where they cannot see inside the room but can only maintain line of site of the staff performing the search.

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is compliant with this provision.

115.315(b):

During the pre-onsite portion of this audit, the Facility indicated compliance with this provision in its PAQ responses and reported the facility does not permit cross-gender pat-down searches of residents, absent exigent circumstances. The Facility provided this Auditor Policy 2058: Searches. Section III(C) establishes, “Staff shall not conduct cross-gender Pat-Frisk Searches (115.315 (b)) except in exigent circumstances” (p. 8). The facility indicated that over the past 12 months, there have not been any cross-gender pat-down searches of residents.

During the onsite portion of this audit, this auditor interviewed 12 staff members and asked them whether they were permitted to pat-down search a youth of the opposite gender. All staff indicated that this is prohibited. Also, while onsite, this auditor interviewed 10 youth. All youth reported to this auditor that they have never been pat down by a staff by the opposite gender or were aware of that occurring.

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is compliant with this provision.

115.315(c):

During the pre-onsite portion of this audit, the Facility indicated compliance with this provision and provided this auditor with Policy 2058: Searches. Section I(H) establishes, “Staff shall document and justify all cross-gender Pat-Frisk Searches . . . Although PREA Standards authorize cross-gendered searches, best practices at the SYSC prohibit cross-gendered searches of any kind . . . Exceptions require direct and explicit authorization from the SYSC Administrator and documentation of the justification and exigent circumstances on a YouthCenter, Non- Disciplinary: Cross Gender Search Form 2094” (p. 7).

As reported in subsection (a) of this standard, there were no logs to review as the Facility reported none of these searches have been performed.

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is fully compliant with this provision.

115.315(d):

During the pre-onsite portion of this audit, the Facility indicated compliance with this provision and provided this auditor with Policy 2403: Youth Hygiene. Section I establishes, “Committed or detained youth may shower, perform bodily functions, and change clothing without non-medical staff of the opposite gender viewing their breasts, buttocks, or genitalia, except in exigent circumstances” (p. 2). The policy further establishes, “Staff of the opposite gender must announce their presence when entering an SYSC housing unit or areas where youth may be showering, performing bodily functions, or changing clothes” (p. 2).

During the onsite portion of this audit, this auditor interviewed 10 youth and 12 staff. Of the 10 residents interviewed, six indicated staff of the opposite gender do not announce their presence when entering a resident housing unit, 2 indicated “some” staff do, and two indicated that staff announce their presence. Out of 12 staff interviewed, the majority of staff indicated that staff of the opposite gender announce their presence as required; others, however, a number of staff indicated that they know or have witnessed not all staff doing so.

Additionally, both youth and staff commented with appreciation a recent change to the youth bathrooms that allow a youth to use the bathroom while the door remained locked and that did not require the need for staff to unlock the door to exit. This was reported almost unanimously by everyone mentioned above. However, what was brought to this auditor's attention was that while a youth was on "A-watch" (one-to-one staff observation) the door to the bathroom needs to be kept open. Although many times, it was reported, that the youth will likely be in one of the stabilization units while on this watch, both staff and youth reported that watches can – and have – continue past the period of stabilization and while the youth is on the main unit. There is no privacy barrier available to allow the youth to perform bodily functions without non-medical staff of the opposite gender viewing their buttocks or genitalia.

This auditor also made observations and engaged informal conversations with residents and staff while conducting the facility tour. This auditor observed my escorting staff announcing their presence when entering a housing area.

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is not fully compliant with this provision. Please see the below "Final Audit Report Reassessment" for review.

115.315(e):

During the pre-onsite portion of this audit, the Facility indicated compliance with this provision and provided this auditor with Policy 2279: Nursing Services at Admission. Section III(C) establishes, "[t] he Nursing Screening shall include a determination of a youth's gender; however, the nurse shall not search or physically examine any youth, including transgendered or intersex youth, for the sole purpose of determining the youth's genital status. If the youth's genital status is unknown, it may be determined during conversations with the youth, by reviewing medical records, or, if necessary, by learning that information as part of a broader medical examination conducted in private by a medical practitioner" (p. 2). Additionally, Policy 2058: Searches, establishes: "Youth shall not be searched or physically examined for the sole purpose of determining the youth's genital status." The facility indicated that no searches for the sole purpose of determining the youth's genital status has occurred in the past 12 months.

During the onsite portion of this audit, this auditor conducted 12 staff interviews. All staff reported that they are prohibited from searching or physically examining a transgender or intersex resident for the sole purpose of determining the resident's genital status. The facility reported that there were no transgender or intersex residents residing in the program on the first day of the onsite portion of this audit. This auditor attempted to verify this information by asking staff whether or not they were aware of a current resident in the facility that identified as either transgender or intersex to which this auditor was told there were not any present.

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is fully compliant with this provision.

115.315(f):

During the pre-onsite portion of this audit, the Facility indicated that 100% of its staff is trained on conducting cross-gender pat-down searches and searches of transgender and intersex residents in a professional and respectful manner, consistent with security needs. Section I(E) of Policy 2058: Searches, establishes "Two staff of the same gender as the youth being searched shall conduct or be present during the search or the youth's assigned treatment team shall establish search procedures for intersex or transgendered youth. For intersex or transgendered youth requiring a search before their treatment team is assigned, staff must consult with the youth, and the Supervisor On-Duty for the conduct of the search" (p. 6).

During the onsite portion of this audit, this auditor interviewed 12 random staff. Seven staff revealed that they have not received training in how to physically conduct searches of transgender and intersex residents in a professional and respectful manner. All 12 staff identified that upon hire and annually, they receive the online training developed. No staff indicated the above-referenced excerpt from Policy 2058 during this auditor's interviews.

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is fully compliant with this provision. Please see the below "Final Audit Report Reassessment" for review.

Interim Report Corrective Action:

Develop policies and implement procedures that require and ensures staff of the opposite gender to announce their presence when entering a housing unit.
Develop or expand existing policy and protocols to allow residents that are on one-to-one watches the ability to perform bodily functions without being viewed by staff of the opposite gender.
Develop and implement training to conduct searches of transgender and intersex residents in a professional and respectful manner, consistent with security needs; and ensure staff are trained in existing Facility policy as it applies to conducting pat-down searches of transgender or intersex youth.

Final Audit Report Reassessment:

During the post-onsite audit portion of this audit, the auditor identified that the agency was not fully compliant with provision (d) and (f) of this standard. The Agency provided the auditor with "SYSC PREA Audit Corrective Action Specific Findings" on February 18, 2022. Follow-up to this corrective action plan was received on March 25, 2022. The Agency developed the following corrective action plan with respect to this provision:

115.315 Corrective Action #1: Policy 2403 Youth Hygiene requires all staff of the opposite gender to announce their presence when entering an SYSC housing unit or areas where youth may be showering, performing bodily functions, or changing clothes. Posters have posted on all doors (unit doors) reminding staff to announce their presence prior to entering the unit. Going forward, supervisors and the PREA Compliance Manager will be tasked with monitoring compliance by randomly observing the units during their shifts, and verifying compliance by speaking with the youth at the facility.

115:315 Corrective Action #2: DCYF Form 2054 Clinical/Medical Watch Report has been amended to clarify that any youth on A-watch needing to use the bathroom (for toileting or showering) shall have a same sex staff monitoring them while in the bathroom or be sent to the Medical Department. This form is required to be initialed by staff and signed by both the Unit Manager and Clinical/Medical Staff. A revised DCYF Policy 2054 Suicide Prevention scheduled for release in April will also address toileting for residents on A-watch.

115:315 Corrective Action #3: The DCYF Training Coordinator, in conjunction with Granite State College's Child Welfare Education Partnership (CWEP), has included the Cross Gender Pat searches video from the National PREA Resource Center into its yearly training. This training includes information and training about transgender and intersex searches.

Staff are required to attend an annual full day Aggression Management & Handcuff/Search training. This training was modified to include information regarding transgender or intersex youth searches.

Additionally, SYSC's Daily Roll Call form has been updated to include refresher training information and allow more frequent review of specific training topic. This platform will be utilized for a review of search protocol on any occasions transgender or intersex youth enter SYSC.

Upon auditor follow-up and request, the Facility provided the auditor with a training roster and post-test scored for all staff in the facility for the Cross Gender Pat Search training referenced in Corrective Action #3. The facility representative confirmed that all staff completed this training by February 15, 2022.

During the post-corrective action period, this auditor was unable to verify that the Facility sufficiently corrected the previously identified non-complaint areas. Specifically, in subsection (d), this auditor noted despite the Facility reportedly having practices in place at the time of the onsite portion of this audit requiring staff of the opposite gender to announce his/her presence, the vast majority of residents indicated they do not; only two residents indicated that staff of the opposite gender announce his/her/their presence. Due to the Facility providing this auditor with their Corrective Action response on February 18, 2022 (one day prior to the 180-day corrective action period expiring), this auditor was unable to re-interview residents to ensure that this practice was corrected. The auditor is satisfied, however, that the concern raised while a youth is on an A-watch has been adequately addressed.

	Additionally, the facility provided this auditor with training rosters for all staff for the Cross Gender Pat Search training that was completed within the required timeframe. Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is not compliant with this standard as it failed to adequately demonstrate compliance with provision (d) of this standard.

115.316	Residents with disabilities and residents who are limited English proficient
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	115.316: Residents with disabilities and residents who are limited English proficient. The following evidence was analyzed in making the compliance determination: 1. Documents: (Policies, directives, forms, files, records, etc.) a. Sununu Youth Services Center Pre-Audit Questionnaire (PAQ) responses b. Basic Rights for Committed and Detained Youth Policy 2058 (effective February 2019) 2. Interviews a. Agency Head b. Residents with disabilities c. Resident who are limited English proficient d. Random Staff 3. Site Review Observations: a. Observations during on-site review of physical plant Findings (By Provision): 115.316(a): During the pre-onsite portion of this audit, the Facility indicated compliance and provided this auditor with Policy 2058: Basic Rights for Committed and Detained Youth. Section V(A)(1) establishes, "Youth with disabilities (including, for example, youth who are deaf or hard of hearing, those who are blind or have low vision, or those who have intellectual, psychiatric, or speech disabilities), shall have an equal opportunity to participate in, or benefit from, all aspects of the SYSC programming including efforts to prevent, detect, and respond to sexual abuse and sexual harassment" (p. 4). During the onsite portion of this audit, this auditor interviewed the designated Agency Head – the Director of the Division of Children, Youth and Families of the Department of Health and Human Services. The Division Director reported that SYSC has established procedures to provide residents with disabilities and residents who are limited English proficient 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. He further communicated that the services provided by the Facility are youth-oriented and the needs of every youth are identified at the time of intake. The facility provided this auditor with a list of three youth that classified as Disabled and/or Limited English Proficient Residents in the Specialized Resident ID Form during the pre-onsite portion of this audit. As of the start of the onsite portion of this audit, two youth had discharged and the only youth remaining was classified as limited English proficient. Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is compliant with this provision. 115.316(b): During the pre-onsite portion of this audit, the Facility indicated compliance and provided this auditor with Policy 2058: Basic Rights for Committed and Detained Youth. Section V(A)(2) establishes, "[t]he SYSC shall ensure meaningful access to all aspects of the SYSC's efforts to prevent, detect, and respond to sexual abuse and sexual harassment to youth who are

limited English proficient, including steps to provide interpreters who can interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary" (p. 4). The Facility also reported that SYSC utilizes the Department of Health and Human Services' Language Bank for youth with Limited English Proficiency. Language Bank posters were posted throughout the intake area of the Facility.

The facility provided this auditor with a list of three youth that classified as Disabled and/or Limited English Proficient Residents in the Specialized Resident ID Form during the pre-onsite portion of this audit. As of the start of the onsite portion of this audit, two youth had discharged and the only youth remaining was classified as limited English proficient.

During the onsite portion of this audit, this auditor interviewed the youth classified as limited English proficient. Although this youth's first language was not English, this youth is able to understand English and reported that the Facility re-reads and explains things slowly in order for this youth to understand what is being discussed.

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is compliant with this provision. The auditor is recommending to the agency a best practice to engage an interpreter services or other professional organization to translate important information/notices to allow the youth to educate themselves on essential topics so that the youth does not need to rely on staff for this information as that very fact can prevent access to this information depending on the youth.

115.316(c):

During the pre-onsite portion of this audit, the Facility indicated compliance and provided this auditor with Policy 2058: Basic Rights for Committed and Detained Youth. Section V(A)(3) establishes, "SYSC shall not rely on youth interpreters, youth readers, or other types of youth assistants except in limited circumstances where an extended delay in obtaining an effective interpreter could compromise a youth's safety, the performance of first- responder duties as described in Policy 2055 "Sexual Abuse and Sexual Harassment," or the investigation of a youth's allegations . . . [y]outh-to-youth interpreters shall not be used for sexual assault or sexual harassment investigations. The SYSC Director or designee shall ensure Language Bank Services are accessible in these circumstances" (p. 5). The facility indicated that they would document the use of the use of resident interpreters but reported that the facility has not utilized resident interpreters, readers, or any other type of resident assistants over the past twelve months.

During the onsite portion of this audit, this auditor interviewed 12 staff. All staff reported that under no circumstances would the agency ever allow the use of resident interpreters, resident readers, or other types of resident assistants to assist disabled residents or residents with limited English proficiency when making an allegation of sexual abuse or sexual harassment. All staff were also aware of the availability of the Language Line.

No youth reported the use of a resident interpreter, reader, or other type of resident assistant that the facility classified as having a physical disability; who are blind, deaf, or hard of hearing; who are limited English proficient; or with a cognitive disability.

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is compliant with this provision.

Recommendations:

1. Engage an interpreter services or other professional organization to translate important information/notices to allow the youth to educate themselves on essential topics so that the youth does not need to rely on staff for this information.

115.317	Hiring and promotion decisions
	Auditor Overall Determination: Does Not Meet Standard
	Auditor Discussion

115.317: Hiring and promotion decisions.

The following evidence was analyzed in making the compliance determination:

1. Documents: (Policies, directives, forms, files, records, etc.)

a. Sununu Youth Services Center Pre-Audit Questionnaire (PAQ) responses

b. Hiring, Promoting, Corrective and Disciplinary Actions for SYSC Personnel, Contractors, and Volunteers Policy 2476 (effective June 2014)

c. DCYF Central Registry Checks for Child Abuse and Neglect

d. Department of Safety Criminal Record Checks

e. Bureau of Elderly and Adult Services Checks for Abuse and Neglect

f. Personnel files or persons hire or promoted in the past 12 months

g. Application for Employment

h. Hiring, Promoting, Corrective and Disciplinary Actions for SYSC Personnel, Contractors, and Volunteers Policy 2476 (effective February 2022)

i. New Procedures 2476.1 Required Background Checks effective February 2022)

j. SYSC PREA Employment Questionnaire (February 2022)

k. PREA Criminal, BEAS and Central Registry Checks Template

2. Interviews

a. Administrative/Human Resources Staff

b. Informal interviews with staff during site review

c. Facility Director

3. Site Review Observations:

a. Observations during on-site review of physical plant

Findings (By Provision):

115.317(a):

During the pre-onsite portion of this audit, the Facility indicated compliance with this provision and provided this auditor with Policy 2476: Hiring, Promoting, Corrective and Disciplinary Actions for SYSC Personnel, Contractors, and Volunteers. Section I(B)(2)(a)-(c) establishes, "DCYF shall not hire or promote anyone who may have contact with youth, and shall not enlist the services of any contractor who may have contact with these youth, 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) (115.317(a1)); (b) 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 (115.317(a2)); or (c) Has been civilly or administratively adjudicated for engaging in the activity described in (b) above (115.317(a3))" (p. 3)

During the onsite portion of this audit, this auditor conducted nine personnel file reviews selected by this auditor at random. Of these nine personnel two files contained a 1) DCYF Central Registry check for child abuse and neglect, 2) Bureau of Elderly and Adult Services check for abuse and neglect, and 3) Department of Safety criminal record check prior to the

employee's date of hire (however, for one of these employee's, the checks came back after the employee's offer letter was sent out). Two files had none of the above-referenced checks contained in them. Three files had completed that were completed after the staff person was hired (ranging from one week to 1 month after the employee's date of hire). One file had partial completion of the above-referenced checks. And the last file evidenced the above-referenced checks as a result of this employee's promotion but no other checks were done.

No personnel file contained administrative adjudication checks (i.e., institutional reference checks). The application for employment does not contain any relevant questions that is required under this provision that would trigger these checks.

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is not fully compliant with this provision. Please see the below "Final Audit Report Reassessment" for review.

115.317(b):

During the pre-onsite portion of this audit, the Facility indicated compliance with this provision and provided this auditor with Policy 2476: Hiring, Promoting, Corrective and Disciplinary Actions for SYSC Personnel, Contractors, and Volunteers. Section I(B)(5) establishes, "DCYF 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 youth" (p. 4).

During the post-onsite portion of this audit, this auditor interviewed human resources staff. This staff person reported that the Human Resources does not have a role in hiring or promotion of employees. The process is handled at the local level. Upon inquiry, the Facility Director reported that the HR Department conducts all background checks and that requests are made at the Facility-level to have these checks completed when considering a candidate for promotion.

Of the nine personnel files reviewed, three were of employees that had been promoted. As noted in subsection(a), only one of those files contained the background checks. Furthermore, these checks would not be responsive to this provision as they do not report on any prior incidents of sexual harassment. Additionally, as reported in subsection (a), the Facility does not conduct institutional reference checks and therefore would not be aware of any incident of sexual harassment that occurred at a prior institution or facility.

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is not fully compliant with this provision. Please see the below "Final Audit Report Reassessment" for review.

115.317(c):

During the pre-onsite portion of this audit, the Facility indicated compliance with this provision and provided this auditor with Policy 2476: Hiring, Promoting, Corrective and Disciplinary Actions for SYSC Personnel, Contractors, and Volunteers as outlined in subsection (a) of this standard. The Facility indicated in the past 12 months 23 persons hired had criminal background record checks completed.

As outlined in subsection (a) of this standard, During the onsite portion of this audit, this auditor conducted nine personnel file reviews selected by this auditor at random. Of these nine personnel two files contained a 1) DCYF Central Registry check for child abuse and neglect, 2) Bureau of Elderly and Adult Services check for abuse and neglect, and 3) Department of Safety criminal record check prior to the employee's date of hire (however, for one of these employee's, the checks came back after the employee's offer letter was sent out). Two files had none of the above-referenced checks contained in them. Three files had completed that were completed after the staff person was hired (ranging from one week to 1 month after the employee's date of hire). One file had partial completion of the above-referenced checks. And the last file evidenced the above-referenced checks as a result of this employee's promotion but no other checks were done.

No personnel file contained administrative adjudication checks (i.e., institutional reference checks). The application for

employment does not contain any relevant questions that is required under this provision that would trigger these checks.

During the post-onsite portion of this audit, this auditor interviewed human resources staff. This staff person reported that the facility performs criminal records checks and a review of the child abuse registry for the state on all newly hired employees, regardless of their level of contact with residents. HR does not have a role in background checks for contractors. That this process is handled at the local level.

An audit of personnel records revealed that agency failed to conduct necessary criminal records and institutional reference checks as outlined above.

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is not fully compliant with this provision. Please see the below "Final Audit Report Reassessment" for review.

115.317(d):

During the pre-onsite portion of this audit, the Facility indicated compliance with this provision and provided this auditor with Policy 2070: SYSC Visitors and the Visitation Routine. Section III(E) establishes, "[a]ll contractors visiting the SYSC must be approved in compliance with Policy 2476 PREA Standards – Hiring, Promoting, Corrective, and Disciplinary Actions based on the Prison Rape Elimination Act of 2003 (PREA). 1. DCYF shall not hire or enlist the services of any contractor who may have contact with committed or detained youth, 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) (115.317(a1)); (b) 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 (115.317(a2)); or (c) Has been civilly or administratively adjudicated to engage in the activity described in (b) above (115.317(a3)).The facility reported that in the past 12 months, there were three contracts for services where those contractors would have contact with resident.

During the onsite portion of this audit, this auditor interviewed human resources staff. This staff person reported that Human Resources does not have a role in background checks for contractors. The Facility Director indicated that all background checks are completed through the Human Resources Department. No contractor personnel files were made available to the auditor at the time of writing the interim audit report.

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is not fully compliant with this provision. Please see the below "Final Audit Report Reassessment" for review.

115.317(e):

During the pre-onsite portion of this audit, the Facility indicated compliance with this provision and provided this auditor with Policy 2476: Hiring, Promoting, Corrective and Disciplinary Actions for SYSC Personnel, Contractors, and Volunteers. Section I(B)(6) establishes, "DCYF shall either conduct criminal background records checks at least every five years of current employees and contractors who may have contact with youth, or have in place a system for otherwise capturing such information for current employees" (p. 4).

As noted in subsection (a) of this standard, this auditor conducted nine personnel file reviews while onsite. Of these nine files, four were of employee employed for greater than five years. No file contained criminal background records checks pursuant to this standard. No other system was disclosed to this auditor that would otherwise capture such information.

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is not fully compliant with this provision. Please see the below "Final Audit Report Reassessment" for review.

115.317(f):

During the onsite portion of this audit, this auditor interviewed human resources staff. This staff person reported that the State of New Hampshire job application removed the option for self-disclosure of criminal offenses effective September 2020. The Agency's performance evaluation form does not currently have a space for self-disclosure of criminal offenses or misconduct as described in subsection (a) of this standard. The human resources staff further indicated that an affirmative duty to disclose any such misconduct is located in the DHHS has a policy titled, "Reporting Criminal Convictions and Certain Arrests."

During the onsite portion of this audit, this auditor conducted nine personnel file reviews selected at random. Some files had performance evaluations located within. The Management Evaluation Form had an excerpt related to PREA but responsive to this standard (it was of managerial expectations to ensure compliance in the PREA standards). No other evaluation was evidenced to contain the required language as indicated by the human resource staff.

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is not fully compliant with this provision. Please see the below "Final Audit Report Reassessment" for review.

115.317(g):

During the pre-onsite portion of this audit, the Facility indicated compliance with this provision and provided this auditor with Policy 2476: Hiring, Promoting, Corrective and Disciplinary Actions for SYSC Personnel, Contractors, and Volunteers. Section I(B)(6) establishes, "[m]aterial omissions regarding such misconduct, or the provision of materially false information, shall be grounds for termination" (p. 4).

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is compliant with this provision as Agency has a policy responsive to this provision.

115.317(h):

During the onsite portion of this audit, this auditor interviewed human resources staff. This staff person reported that HR does not have a role in providing reference checks. The process is handled at the local level. The Facility Director informed this auditor that the Facility does not disclose this information.

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is not fully compliant with this provision. Please see the below "Final Audit Report Reassessment" for review.

Interim Report Corrective Action:

1. Establish or improve procedures that ensures required checks are conducted prior to the employee's date of hire.

2. Establish or improve procedures that ensures questions pertaining to the need to complete administrative adjudication checks are included on the employment application.

3. Establish or improve procedures that ensures prior incidents of sexual harassment are considered when determining whether to promote or hire anyone.

4. Establish or improve procedures that ensures required checks are conducted for all contractors who may have contact with residents.

5. Establish or improve procedures that ensures required checks are conducted at least every five years for current employees or contractors.

6. Establish or improve procedures that ensures that the agency will 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 has engaged in

the prohibited behaviors.

7. Establish and implement procedures that ensures that the agency makes its best efforts to contact all prior institutional employers for information on substantiated allegations of sexual abuse or any resignation during a pending investigation of an allegation of sexual abuse.

8. Establish and implement procedures that ensures the agency provides information on substantiated allegations of sexual abuse or sexual harassment involving a former employee upon receiving a request from an institutional employer for whom such employee has applied to work. Alternatively, provide information that this disclosure is prohibited by law, including but not limited to the statute.

Final Audit Report Reassessment:

During the post-onsite audit portion of this audit, the auditor identified that the agency was not fully compliant with provisions (a)–(f) and (h) of this standard. The Agency provided the auditor with "SYSC PREA Audit Corrective Action Specific Findings" on February 18, 2022. Follow-up to this corrective action plan was received on March 25, 2022. The Agency developed the following corrective action plan with respect to this provision:

115.317 Corrective Action #1: New Procedures 2476.1, Sec I, A-D, Sec II, A-G have been established and implemented that ensure all required checks are conducted prior to the employee's date of hire.

115.317 Corrective Action #2: New Procedures 2476.1, Sec II, B have been established and implemented that ensure questions pertaining to the need to complete administrative adjudication checks are included on the employment application.

New Form 2478 establishes a SYSC PREA Employment Questionnaire. The applicant as part of the application/interview process completes the questionnaire. Current SYSC employees will also be asked to provide answers to the questions on the form during their yearly performance review and as part of the promotion process.

115.317 Corrective Action #3: New Procedures 2476.1, Sec III, A-B have been established and implemented that ensure prior incidents of sexual harassment are considered when determining whether to promote or hire anyone.

115.317 Corrective Action #4: New Procedures 2476.1, Sec I, A-D, Sec II, A-G Sec have been established and implemented that ensure required checks are conducted for all contractors who may have contact with residents.

115.317 Corrective Action #5: New Procedures 2476.1, Sec V, A-C have been established and implemented that ensure required checks are conducted at least every five years for current employees or contractors.

115.317 Corrective Action #6: New Procedures 2476.1, Sec III, A-B, Sec IV, A-C have been established and implemented that ensure that the agency will 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 has engaged in the prohibited behaviors.

115.317 Corrective Action #7: New Procedures 2476.1, Sec II, D have been established and implemented that ensure that the agency makes its best efforts to contact all prior institutional employers for information on substantiated allegations of sexual abuse or any resignation during a pending investigation of an allegation of sexual abuse.

115.317 Corrective Action #8: The department is currently engaging in statewide discussions involving a rule change in order to adhere to this requirement. Absent consent by the individual, Administrative Rule Per 1501 prohibits DCYF from disclosing information about substantiated allegations of sexual abuse or sexual harassment involving former staff to employers outside New Hampshire state government. When the rule change has been completed, it will be reflected in the written policy and

	procedures that ensures the agency provides information on substantiated allegations of sexual abuse or sexual harassment involving a former employee upon receiving a request from an institutional employer for whom such employee has applied to work. 115.317 Corrective Action #9: Additionally correlates to all of the corrective actions and provides an additional check and balance. New Procedures 2476.1, Sec VI, A-B have been established and implemented that ensure that an annual review is conducted by the PREA Compliance Manager of at least 10 staff and contractor records to ensure all required background checks have been appropriately performed, the results duly recorded and any required disciplinary actions have been appropriately carried out, in a timely fashion. 115.317 Corrective Action #10: Additionally correlates to corrective action #1. New Procedures 2476.1, Sec II, C have been established and implemented that ensure that if an applicant has resided outside of New Hampshire at any point in the past 5 years, staff completing the background checks shall advise the applicant to submit an out of state abuse/neglect background check and a criminal history background check in the state(s) where they have previously resided. In following up with the corrective action plan submitted by the facility, this auditor requested, and allowed the facility additional time to provide examples of checks (that were in existence prior to 2/19/2022 as the auditor does not have the authority to enlarge the corrective action period), "Please provide examples of completed checks (each kind)." The facility provided this auditor with an example of three types of background checks for one employee. These checks were dated March 19, 2022 (outside the permissible timeframe for this audit and corrective action period). These checks were: BEAS State Registry Consent Form, NH Child Abuse and Neglect Central Registry, and State of New Hampshire Criminal Records Unit check. Each form had a hand written notation indicating "SYSC-Promotion" on the top of the form. This auditor took this to mean that these checks were evidencing implementation of corrective action #3. No other checks were provided to the auditor as part of the Facility's corrective action response and follow-up. The auditor had an additional inquiry as to corrective action #8. The facility further elaborated that "there are currently no established plans to address [corrective action #8]." During the post-corrective action period, this auditor reviewed the newly revised policies, standard operating procedures, and corrective action measures to verify the Facility's/Agency's stated efforts. It should be noted that significant policy improvements have been made. The Facility, however, failed to provide any copies of completed checks evidencing that these updated hiring processes have been implemented/completed prior to the corrective action period expired (February 19, 2022). Furthermore, as identified in Interim Report Corrective Action #8, "Alternatively, provide information that this disclosure is prohibited by law, including but not limited to the statute." The Facility provided that Administrative Rule 1501 prohibits disclosure absent consent of the applicant/employee. However, as noted above, the Facility indicated there are currently no established plans to address this provision, to include, but would not be limited to, any efforts that they've established a consent form for new applicants, nor have they provided this auditor any efforts to obtain existing employees' consent. Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is not compliant with this standard.

115.318	Upgrades to facilities and technologies
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	115.318: Upgrades to facilities and technology. The following evidence was analyzed in making the compliance determination: 1. Documents: (Policies, directives, forms, files, records, etc.) a. Sununu Youth Services Center Pre-Audit Questionnaire (PAQ) responses b. Facility Site Plans 2. Interviews a. Agency Head or Designee b. Facility Director 3. Site Review Observations: a. Observations during on-site review of physical plant Findings (By Provision): 115.318(a): During the pre-onsite portion of this audit, the Facility indicated that Agency/Facility has not acquired a new facility or made a substantial expansion or modification to existing facilities since the last PREA audit. A NOT APPLICABLE determination has been made for this provision due to the fact that the agency/facility has not acquired a new facility or made a substantial expansion to existing facilities since the last PREA audit. Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is compliant with this provision as the agency considers the effect of the design, acquisition, expansion, or modification upon the agency's ability to protect residents from sexual abuse. 115.318(b): During the pre-onsite portion of this audit, the Facility indicated that they 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. During the onsite portion of this audit, the auditor interviewed the Facility Director and designated Agency Head. Both individuals identified that the leading motivation in updated the monitoring system was to protect the residents from abuse, including sexual abuse, and for the Facility to be able to adequately review reports and allegations of any type of incident alleged to have occurred within the facility. Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is compliant with this provision as the agency considers how the installation of or upgrading of its video monitoring system may enhance the agency's ability to protect residents from sexual abuse.

115.321	Evidence protocol and forensic medical examinations
	Auditor Overall Determination: Does Not Meet Standard
	Auditor Discussion

115.321: Evidence protocol and forensic medical examinations.

The following evidence was analyzed in making the compliance determination:

1. Documents: (Policies, directives, forms, files, records, etc.)

a. Sununu Youth Services Center Pre-Audit Questionnaire (PAQ) responses

b. State of New Hampshire Office of the Attorney General Sexual Assault: An Acute Care Protocol for Medical/Forensic Evaluation (Ninth Edition, 2018)

c. Sexual Assault and Sexual Harassment Policy 2055 (effective August 2017)

d. Memorandum of Understanding (MOU) with the YWCA of New Hampshire (signed 4/8/2021)

e. MOU with New Hampshire State Police (signed 4/6/2014)

f. 2088 PREA Investigations (effective February 2022)

g. 2055 PREA – Immediate Response to Sexual Abuse and First Responder Duties (effective February 2022)

2. Interviews

a. Random Staff

b. SAFE/SANE Community-based Provider

c. YWCA of NH Representative

d. Residents who Reported a Sexual Abuse

3. Site Review Observations:

a. Observations during on-site review of physical plant

Findings (By Provision):

115.321(a):

During the pre-onsite portion of this audit, the Facility indicated compliance with this provision and provided this auditor with the State of New Hampshire Office of the Attorney General Sexual Assault: An Acute Care Protocol for Medical/Forensic Evaluation (Ninth Edition, 2018). The facility indicated in the PAQ that the agency/facility is responsible for conducting administrative sexual abuse investigations but any criminal investigations are conducted by the New Hampshire State Police.

During the onsite portion of this audit, this auditor interviewed 12 randomly selected staff. Of the twelve no one made reference to the above-mentioned sexual assault protocol. Seven staff indicated that they did not know or understood the agency's protocol for obtaining usable physical evidence if a resident alleges sexual abuse. Additionally, there was inconsistency and a general lack of knowledge as to who were the facility investigators by the randomly selected staff interviewed.

While on site this auditor made observations. It should be noted that the New Hampshire State Police have set up investigatory offices in an adjacent building to the Facility as a result of past allegations and current criminal investigations. This auditor observed the location of these office spaces. No investigators were available to interview while this auditor was onsite.

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is not fully compliant with this provision. Please see the below "Final Audit Report Reassessment" for review.

115.321(b):

During the pre-onsite portion of this audit, the Facility indicated compliance with this provision and provided this auditor with the State of New Hampshire Office of the Attorney General Sexual Assault: An Acute Care Protocol for Medical/Forensic Evaluation (Ninth Edition, 2018). A review of this protocol establishes that is developmentally appropriate for youth (see pages 15, 16, 20, and Appendix E).

During the pre-onsite portion of this audit, the Facility indicated the protocol was adapted from or otherwise based on the most recent edition of the DOJ's Office on Violence Against Women publication, "A National Protocol for Sexual Assault Medical Forensic Examinations, Adults/Adolescents," or similarly comprehensive and authoritative protocols developed after 2011. However, a review of this manual establishes the following: "In 1989, the New Hampshire Attorney General's Office formed the Sexual Assault Protocol Committee representing the medical, legal, law enforcement, victim advocacy and forensic science communities, to establish a New Hampshire protocol and kit. The Committee took great care to make recommendations based upon the physical and emotional needs of the sexual assault victim, reasonably balanced with the basic requirements of the legal system. The result was the publication of Sexual Assault: A Protocol for Medical and Forensic Examination, and a standardized evidence collection kit to be used in all of the hospitals in the state. This project was completed in June 1989. Recognizing that forensic science is a field in continual evolution, the Protocol is continually being revised in an effort to improve evidence collection outcomes for patients who have experienced sexual assault." The auditor is cannot make a compliance determination based on the information provided by the Facility.

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is not fully compliant with this provision. Please see the below "Final Audit Report Reassessment" for review.

115.321(c):

During the pre-onsite portion of this audit, the Facility indicated compliance with this provision and provided this auditor with Sexual Assault and Sexual Harassment Policy 2055 (effective August 2017). Section VIII(B) establishes, "[w] here evidentiary or medically appropriate, youth experiencing sexual abuse shall have access to forensic medical examinations without financial cost. Adolescent youth must consent to forensic medical examinations and must not be mandated to comply." (p. 20). Section VIII(B)(1) further establishes, "Sexual Assault Nurse Examiners (SANE) or other qualified medical practitioners shall conduct all forensic medical examinations. No Sexual Assault Evidence Collection Kit shall be administered at the SYSC and youth recommended for forensic examinations that consent must be transported to the Elliot Hospital as authorized by the SYSC Medical Department and Supervisor On-Duty" (p. 20). The Facility reported that over the past 12 months, no forensic medical exams were conducted.

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is compliant with this provision.

115.321(d)-(e):

During the pre-onsite portion of this audit, the Facility indicated compliance with this provision and provided this auditor with a Memorandum of Understanding between the Facility and the YWCA of New Hampshire. The MOU stablishes that YWCA "[p]rovide resident victims of sexual assault support services comparable to those received by victims of sexual assault who are not detained; [and] [o]ffer resident victims of sexual harassment, sexual abuse, or sexual assault access to community crisis center advocates in a manner that respects all security and confidentiality concerns of the respective parties" (p. 2).

Section VIII(C) of Sexual Assault and Sexual Harassment Policy 2055, establishes, "[t]he SYSC has entered into a Memorandum of Understanding with the Manchester YWCA Crisis Services to provide victim advocacy services" (p. 21). The Policy is silent as to the circumstance if and when a rape crisis center is not available to provide victim advocate services, the facility provides a qualified staff member from a community-based organization or a qualified agency staff

member as required by this provision.

During the pre-onsite portion of this audit, this auditor interviewed an executive-level representative of the YWCA of New Hampshire. This representative reported that the MOU between the Facility and YWCA had been in existence for greater than five years but prior to signing the renewed MOU in April of 2021, had not heard from the Facility for a couple years (when the prior MOU needed to be signed). This representative also reported that they had never been – nor had ever been invited to tour – to the Facility. Lastly, this representative reported that YWCA had not been contacted by a youth at the Facility over the past 12 months.

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is not fully compliant with this provision. Please see the below "Final Audit Report Reassessment" for review.

115.321(f):

During the pre-onsite portion of this audit, the Facility indicated compliance with this provision and provided this auditor with a Memorandum of Understanding between the Facility and the New Hampshire State Police. The MOU establishes, "[t]he following representatives from the . . . Sununu Youth Services Center and the New Hampshire State Police have read PREA Standards: 115.321 . . . and agree to adhere to the referenced standards."

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is compliant with this provision.

115.321(g): the auditor is not required to audit this provision.

115.321(h):

During the pre-onsite portion of this audit, this auditor interviewed an executive-level representative of the YWCA of New Hampshire. A review of YWCA of New Hampshire's website (www.ywcanh.org) reveals its Vision is to "create a thriving community free from violence and oppression. We will create an individualized experience for victims on their path of transformation." An interview with an executive-level representative of the YWCA of New Hampshire revealed that YWCA of NH was founded in 1920 and is an agency dedicated to victims' rights and services and only employs staff are qualified and receive training concerning sexual assault and forensic examination issues in general.

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is compliant with this provision.

Interim Report Corrective Action:

1. Establish or improve existing procedures that ensures staff are trained and understand the Facility's evidence collection protocols.

2. Provide information that the protocol was adapted or otherwise based on the most recent edition of the applicable US DOJ's authoritative protocol; or, in the alternative, develop evidence protocol based on the aforementioned authority.

3. Establish a relationship with a victim advocate organization that ensures youth have access to its services.

4. Establish or improve existing procedures to ensure if and when a rape crisis center is not available to provide victim advocate services, the facility provides a qualified staff member from a community-based organization or a qualified agency staff member

Final Audit Report Reassessment:

During the post-onsite audit portion of this audit, the auditor identified that the agency was not fully compliant with provisions (a), (b), (d), and (e) of this standard. The Agency provided the auditor with "SYSC PREA Audit Corrective Action Specific Findings" on February 18, 2022. Follow-up to this corrective action plan was received on March 25, 2022. The Agency developed the following corrective action plan with respect to this provision:

115.321 Corrective Action #1: The agency evidence collection protocol has been updated and Policy 2088 Sec. VIII, B and Updated Policy 2055 at Section I, E have been created/updated to direct that SYSC no longer collects physical evidence when there has been an allegation of sexual abuse. Before the end of February 2022, a Detective from the New Hampshire State Police, will be providing a two –hour training to all SYSC Supervisors and the PREA Compliance Manager regarding the appropriate protocol for securing the scene (including the youth, area or objects) when there has been an allegation of sexual abuse.

115.321 Corrective Action #2: As the agency's policies have been updated to reflect that the SYSC does not collect physical evidence when there has been an allegation of sexual abuse, this should alleviate the concerns in Corrective Action #2. Physical evidence at SYSC will be collected by the investigating agency.

115:321 Corrective Action #3: On January 25, 2022, members of the SYSC audit team met with representatives of YWCA of New Hampshire to engage in the initial steps to solidifying the relationship between the YWCA and SYSC. It was through this meeting that it was learned that the YWCA is able and willing to offer a variety of training topics to the staff and residents at SYSC. A tour of SYSC for members of YWCA has been scheduled for February 18, 2022. Additionally on February 23, 2022, members of the YWCA will be meeting with the SYSC Training Coordinator to formulate future training opportunities/partnerships between the two organizations.

115:321 Corrective Action #4: requires that the facility to establish/improve procedures to provide victim advocacy services in the event that a rape-crisis center in not available. The YWCA of New Hampshire is a member agency of the New Hampshire Coalition Against Sexual Violence. The NH Coalition is comprised of 13 member programs (including the YWCA, whose catchment area includes SYSC) throughout the state that provide services to survivors of sexual assault, domestic violence, stalking and sexual harassment. Services are free, confidential, and available to everyone regardless of gender, age, health status (including HIV-positive), physical, mental or emotional ability, sexual orientation, gender identity/expression, socio-economic status, race, national origin, immigration status or religious or political affiliation. Included in the services provided by Coalition members are victim support services available in person through a 24-hour hotline. The YWMC of New Hampshire has established a REACH Program that provides a Crisis Hotline that is available to SYSC residents. This service is available 24/7. Upon placing a phone call to REACH, an advocate will contact the caller within 10 minutes. If, in the unlikely event that the YWCA Crisis Hotline is unavailable, the on-call administrator would be able to reach out to the SYSC on-call clinician to assess the next appropriate steps.

Upon follow-up, the facility reported that the "The training outlined in the corrective action plan in response to 115.321 has been tentatively scheduled for some time between 3/31/2022 – 4/6/2022. There are no training certificates/logs available at this time." Furthermore, it was reported that the revised policy and procedures were implemented on February 16, 2022.

During the post-corrective action period, this auditor reviewed the newly revised/created policies to verify the Agency's stated efforts. The auditor was able to verify that Policy 2055 establishes that, "Staff responding to a report of the sexual abuse of a youth will . . . NOT collect evidence." Further, Policy 2088 establishes that "No sexual assault evidence collection kit shall be administered at SYSC." Both of these policies have an effective date of February 2022. The Facility failed to evidence that staff were trained in the policies and practices (as outlined above) as these trainings were tentatively scheduled for a time period after the close of the requisite timeframe.

The Facility reported steps to solidify its relationship with YWCA that in turn would provide the facility the opportunity to attempt to make available to the victim of sexual abuse a victim advocate from a rape crisis center. The auditor is encouraged by the progress; however, the auditor cannot make compliance determination at this time as the facility failed to evidence that they are in a position to attempt to make available this service to residents who reported a sexual abuse. A

	review of the auditor's interview notes revealed not a single resident during the onsite portion of the audit identified any familiarity with YWCA or any service available outside of the Facility for dealing with sexual abuse. As identified in prior standards, the auditor was unable to re-interview anyone in an effort to collect additional information that may provide information as to any change in this process. Based upon the review and analysis of all the available evidence, the auditor has determined that the agency has not evidenced compliance with this standard.

115.322	Policies to ensure referrals of allegations for investigations
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	115.322: Policies to ensure referrals of allegations for investigations The following evidence was analyzed in making the compliance determination: 1. Documents: (Policies, directives, forms, files, records, etc.) a. Sununu Youth Services Center Pre-Audit Questionnaire (PAQ) responses b. Sexual Assault and Sexual Harassment Policy 2055 (effective August 2017) c. Agency Website: https://www.dhhs.nh.gov/djjs/institutional/prea.htm d. Administrative Investigative Files 2. Interviews a. Agency Head or Designee b. Investigative Staff 3. Site Review Observations: a. Observations during on-site review of physical plant Findings (By Provision): 115.322(a)-(c): During the pre-onsite portion of the facility indicated compliance in its PAQ responses and provided this auditor with applicable facility policies and protocols. During the onsite portion of this audit this auditor interviewed staff and/or residents (as outlined above) having first-hand knowledge as to operations and practices within the facility as it pertains to this provision. All interviewees corroborated those practices within the facility adhere to the procedures previously provided to the auditor. Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is compliant with this provision. 115.322(d) &(e): the auditor is not required to audit these provisions.

115.331	Employee training
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	115.331: Employee training. The following evidence was analyzed in making the compliance determination: 1. Documents: (Policies, directives, forms, files, records, etc.) a. Sununu Youth Services Center Pre-Audit Questionnaire (PAQ) responses b. Sexual Assault and Sexual Harassment Policy 2055 (effective August 2017) c. 2040 PREA General Provisions (effective February 2022) d. SYSC Daily Roll Call Information Sheet (Sample) e. Section 3 of Online Training (re: Mandatory Reporting Law and Consent) f. Personnel Files/Training Records g. Training Curriculum 2. Interviews a. Random Staff 3. Site Review Observations: a. Observations during on-site review of physical plant Findings (By Provision): 115.331(a): During the pre-onsite portion of this audit, the Facility provided Policy 2055: Sexual Assault and Sexual Harassment in support of their compliance in this standard in its Pre-Audit Questionnaire (PAQ) responses. Section XIII(A)(1) establishes, "[a]ll staff that may have contact with youth shall be trained on: 1. The SYSC zero tolerance policy for sexual abuse and sexual harassment (115.331(a1)); 2. How staff can fulfill their responsibilities under SYSC sexual abuse and sexual harassment prevention, detection, reporting, and response policies and procedures (115.331(a2)); 3. The right of youth to be free from sexual abuse and sexual harassment (115.331(a3)); 4. The right of youth and employees to be free from retaliation for reporting sexual abuse and sexual harassment (115.331(a4)); 5. The dynamics of sexual abuse and sexual harassment in juvenile facilities (115.331(a5)); 6. The common reactions of youth victims of sexual abuse and sexual harassment (115.331(a6)); 7. How staff can detect and respond to signs of threatened and actual sexual abuse and how to distinguish between consensual sexual contact and sexual abuse between youth (115.331(a7)); 8. How staff can avoid inappropriate relationships with youth (115.331(a8)); 9. How staff can communicate effectively and professionally with youth, including lesbian, gay, bisexual, transgender, intersex, or gender nonconforming youth (115.331(a9)); 10. How staff can comply with relevant laws related to mandatory reporting of sexual abuse to outside authorities (115.331(a10)); and 11. Relevant laws regarding the applicable age of consent (115.331(a11))" (p. 23-24). The Training Director provided this Auditor with access to the Facility's online curriculum that was developed in collaboration with the Child Welfare Education Partnership at Granite State College. This auditor was provided with a sign-on and access to the training as a participant. This auditor reviewed the online portal and spot-checked portions of the training. With respect to requirements 115.331(a)(3): Residents' right to be free from sexual abuse and sexual harassment. The training fails to appropriately cover this right. Instead, the training provides, "Youth have the right to be safe at all times." During the onsite portion of this audit, the auditor interviewed 12 randomly selected staff chosen randomly by the auditor. Out of all staff only one staff was able to identify what NH's mandatory reporting law was. Nine staff unequivocally informed this writer that they were not trained on this topic or could not tell this auditor whether they were mandatory reporters in the

State or what their responsibilities were under the law. Additionally, the majority of staff were not able to tell this auditor what the applicable age of consent was in NH.

Based upon the review and analysis of all the available evidence, and following a period of corrective action, the auditor has determined that the agency is fully compliant with this provision. Please see the below "Final Audit Report Reassessment" for review.

115.331(b)-(d):

During the pre-onsite portion of the facility indicated compliance in its PAQ responses and provided this auditor with applicable facility policies and protocols.

During the onsite portion of this audit this auditor interviewed staff and/or residents (as outlined above) having first-hand knowledge as to operations and practices within the facility as it pertains to this provision. All interviewees corroborated those practices within the facility adhere to the procedures previously provided to the auditor.

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is compliant with this provision.

Interim Report Corrective Action:

Train all staff on: Residents' right to be free from sexual abuse and sexual harassment, how to comply with relevant laws related to mandating reporting of sexual abuse to outside authorities, and Relevant laws regarding the applicable age of consent.

Final Audit Report Reassessment:

During the post-onsite audit portion of this audit, the auditor identified that the agency was not fully compliant with provision (a) of this standard. The Agency provided the auditor with "SYSC PREA Audit Corrective Action Specific Findings" on February 18, 2022. The Agency developed the following corrective action plan with respect to this provision:

115.331 Corrective Action #1: Section 3 of the SYSC's PREA training describes New Hampshire's Mandatory Reporting law, codified as RSA 169-C:29 and outlines the laws and rules regarding consent within the facility. All staff who have not had PREA Training in 2022 will receive a refresher by February 15, 2022. This refresher will include the Resident's right to be free of sexual abuse and sexual harassment, how to comply with relevant laws related to mandating reporting of sexual abuse to outside authorities, and relevant laws regarding the applicable age of consent. Going forward, all staff at SYSC will be required to attend an annual PREA training to ensure retention of this information. This training requirement will be monitored by the SYSC Training Coordinator.

Also, the agency added to Section 3 of SYSC's PREA training is the following True/False question:

NH Law requires any person who suspects that a child under age 18 has been abused or neglected must report that suspicion immediately to DCYF.

TRUE OR FALSE Answer = TRUE

SYSC has also updated their Daily Roll Call form to include an area called SYSC Training Corner to assist staff with retaining the information that they have already been trained on. Abbreviated training information to staff will be given every 7 days. Staff will acknowledge having received this training information by signing off on the Roll Call form. This form will then be scanned in and saved in a Roll Call folder

The agency has also revised and created Policy 2040, which outlines the agency's position regarding the ability to consent to any type of sexualized behavior while at SYSC. This policy specifically states at Sec. 1 (A) that Sexual or sexualized behavior, sexual harassment, and sexual misconduct between youth-to-youth, youth-to-staff, or staff-to-staff is expressly prohibited at the facility.

	New policy 2040 will follow implementation protocol for all new policies. All Policy Directive (PD) releases are emailed to supervisors to review and discuss with staff. Staff are required to read the policy and sign the PD Receipt form confirming that they have read, understood, and will adhere to the policy within 30 days. Additionally, at each annual performance evaluation, supervisors and staff discuss the Professionalism and Ethics Policy, which makes clear the staff requirement to understand and abide by all State laws, DHHS Policy, and DCYF Division policies. Going forward, the PREA Compliance Manager will review audit logs for PREA-specific policies and will ensure monitoring of new policy implementation. During the post-corrective action period, this auditor reviewed the newly revised/created policies to verify the Agency's stated efforts. Upon reviewing section 3 of the existing PREA training, the previously identified corrective action was rescinded. During the pre-audit portion of this audit, this auditor was directed to a different portion of the aforementioned training that did not contain these excerpts. This auditor is encouraged with the additional improvements aimed at staff retention of this material/information. Based upon the review and analysis of all the available evidence, the auditor has determined that the agency has been able to remedy any previously reported deficiency and is fully compliant with this standard.

115.332	Volunteer and contractor training
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	115.332: Volunteer and contractor training. The following evidence was analyzed in making the compliance determination: 1. Documents: (Policies, directives, forms, files, records, etc.) a. Sununu Youth Services Center Pre-Audit Questionnaire (PAQ) responses b. Sexual Assault and Sexual Harassment Policy 2055 (effective August 2017) c. Volunteer and contractor training records 2. Interviews a. Volunteer(s) or Contractor(s) who may have Contact with Residents 3. Site Review Observations: a. Observations during on-site review of physical plant Findings (By Provision): 115.332(a)-(c): During the pre-onsite portion of the facility indicated compliance in its PAQ responses and provided this auditor with applicable facility policies and protocols. During the onsite portion of this audit this auditor interviewed staff and/or residents (as outlined above) having first-hand knowledge as to operations and practices within the facility as it pertains to this provision. All interviewees corroborated those practices within the facility adhere to the procedures previously provided to the auditor. Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is compliant with this provision.

115.333	Resident education
	Auditor Overall Determination: Does Not Meet Standard
	Auditor Discussion
	115.333: Resident education The following evidence was analyzed in making the compliance determination: Documents: (Policies, directives, forms, files, records, etc.) a. Sununu Youth Services Center Pre-Audit Questionnaire (PAQ) responses Residential Orientation Policy 2027 (effective February 2019) Youth Handbook Form 2035: Juvenile PREA Intake Orientation Resident Confidential Case Files Form 2594 – PREA Posters Form 2095: A Guide to Preventing and Reporting Sexual Abuse, and Sexual Harassment Form 2035: Juvenile PREA Intake Orientation (revised) Interviews Intake Staff Random Residents Site Review Observations: Observations during on-site review of physical plant PREA education materials/posted PREA Notices Findings (By Provision): 115.333(a)-(b): During the pre-onsite portion of this audit, the Facility provided Policy 2055: Sexual Assault and Sexual Harassment in support of their compliance in this standard in its Pre-Audit Questionnaire (PAQ) responses. Section XIII(A)(1) establishes, "[t]he unit Youth Counselor (YC) assigned to assist with the admissions process shall conduct a general orientation of the facility's procedures, rules, programs, and services, including the following topics: . . . [a]ge and developmentally appropriate information explaining the SYSC's zero-tolerance policy regarding sexual abuse and sexual harassment and how to report incidents or suspicions of sexual abuse or sexual harassment" (p. 2). Additionally, the Facility provided a master copy of Form 2035: Juvenile PREA Intake Orientation. Completed and signed copies were found in all confidential resident case file reviews this auditor completed. The Facility reported that over the past 12 months 71 unique clients had 93 entries in the Facility that were given this information at intake. During the onsite portion of the audit, the auditor interviewed the interviewed intake staff. Intake Staff in this facility include Youth Counselors and the Supervisor-on-Duty. All intake staff informed this auditor that they complete the orientation checklist as one of the first items completed upon a youth's arrival to the Facility. Ten youth were formally interviewed during the onsite portion of this audit. During random and targeted youth interviews, residents were asked specifically if they received information or 1) your right to not be sexually abused or sexually harassed, 2) how to report sexual abuse or sexual harassment, 3) your right not to be punished for reporting sexual abuse or sexual harassment, and 4) whether the resident received information about the facility's rules against sexual abuse and harassment. Four youth informed this auditor that they did not receive this information (nor could they inform this auditor what was communicated). One youth reported that they had us sign a form and initial it but the staff person didn't review what was on it. And one youth reported that this information is found in the Youth Handbook but that resident hadn't read it yet. It should be noted that a review of the Youth Handbook obtained at the intake area of the Facility did not contain the requisite PREA-related information. Many of the residents that answered in the affirmative informed this auditor that they read the information from the PREA posters displayed in the waiting area of intake. A review of these posters reveal that they do not contain the requisite information; a review of the posted (also found on the Agency's website) reveals that it fails to inform the youth that they: 1) have a "right to not be sexually abused or harassed" (instead it reads, "you have the right to be safe at all times" and "no one

has the right to ask you for sex or sexual favors"; and 2) have a "right not to be punished for reporting sexual abuse or sexual harassment" (instead it reads, "you will be protected, and be free from retaliation, if you make a report of sexual abuse or sexual harassment"). Furthermore, as reviewed in Standards 115.351 (Resident Reporting) and 115.353 (Access to Outside Confidential Support Service), the poster incorrectly informs the reader how to report an allegation and also fails to provide information on outside emotional support services.

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is not fully compliant with this provision. Please see the below "Final Audit Report Reassessment" for review.

115.333(c)-(e):

During the pre-onsite portion of the facility indicated compliance in its PAQ responses and provided this auditor with applicable facility policies and protocols.

During the onsite portion of this audit this auditor interviewed staff and/or residents (as outlined above) having first-hand knowledge as to operations and practices within the facility as it pertains to this provision. All interviewees corroborated those practices within the facility adhere to the procedures previously provided to the auditor.

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is compliant with this provision.

115.333(f):

The facility indicated compliance with this provision. As reviewed in subsection (a)-(b) of this Standard, key information is omitted and incorrect on the Facility's PREA posters and no related information is made available to the youth through the Youth Handbook.

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is fully compliant with this provision. Please see the below "Final Audit Report Reassessment" for review.

Interim Report Corrective Action:

Develop and provide resident information explaining the agency's zero-tolerance policy regarding sexual abuse and sexual harassment and explaining how to report incidents or suspicions of sexual abuse or sexual harassment in an age-appropriate fashion.
Develop and 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, their rights to be free from retaliation for reporting such incidents, and Agency policies and procedures for responding to such incidents.
Ensure that key information is continuously and readily available or visible to residents through posters, resident handbooks, or other written formats.

Final Audit Report Reassessment:

During the post-onsite audit portion of this audit, the auditor identified that the agency was not fully compliant with provisions (a), (b), and (f) of this standard. The Agency provided the auditor with "SYSC PREA Audit Corrective Action Specific Findings" on February 18, 2022. The Agency developed the following corrective action plan with respect to this provision:

115.333 Corrective Action #1: The agency has several means of explaining to youth at SYSC their rights under PREA. Form 2095, A Guide to Preventing and Reporting Sexual Abuse, and Sexual Harassment (formally Form 2181 & provided to the auditor in agency's December 2021 response), clearly outlines SYSC's zero tolerance policy (at page #2) and how to report sexual abuse (at pages 7-8 & pgs. 10-11). This information, while not part of the SYSC Handbook, is given to youth during

	their SYSC orientation. To ensure that all youth are provided with a copy of Form 2095, the agency has created a Youth Orientation Packet Checklist to record that this information has been provided. Going forward, the information contained in Form 2095, and any other relevant PREA education information, will be incorporated into the SYSC Handbook (Form 2040). It is anticipated that the Youth Handbook will be updated in June/July of 2022. The PREA Compliance Manager will also monitor that all youth are given the appropriate PREA information at orientation by randomly auditing youth files to confirm that the Youth Orientation Packet Checklist has been completed for all residents. 115.333 Corrective Action #2: To supplement the written the information provided to youth regarding their rights under PREA, SYSC has enhanced its resident education piece by adopting a video explaining to youth about zero tolerance and sexual harassment. The video will be provided to residents within a week of their arrival at SYSC and as part of their orientation. The video is a product of a collaborative effort between the Office of Justice and the Idaho State Police and is catered to a juvenile justice youth audience. The video addresses zero tolerance, definitions of sexual abuse and harassment, avenues to report abuse, steps to take if abused, what the investigation process looks like, retaliation, and other critical information as it relates to PREA. All SYSC residents who watch this video with have an opportunity to speak with a member of the SYSC staff should they have any follow up questions. SYSC staff will confirm that youth have had the opportunity to watch this video by checking the information off on the newly updated Juvenile PREA Intake Checklist (Form 2035). A link to the video is as follows: (https://youtu.be/TRqJd_tZh1A). 115.333 Corrective Action #3: SYSC has adopted the PREA approved posters, which will be hung throughout the facility to ensure that youth have constant access to the required information. During the post-corrective action period, this auditor reviewed the newly revised/created policies to verify the Agency's stated efforts. A review of the updated PREA Posters reveals that it has all requisite information contained within the poster, including at least one way to report abuse to a public or private entity or office that is not part of the agency (PREA Standard 115.351(b)). The facility now has two ways to report to an outside agency: 1) YWCA and NH Office of the Child Advocate. The facility has established compliance with provision (f). However, the Facility did not evidence implementation of the expanded resident education by providing this auditor with executed Youth Orientation Checklists completed during the requisite time period. As noted in prior corrective action responses and follow-up by this auditor, due to the timing of when the corrective action and evidence was obtained, this auditor could not re-interview residents to supplement the information provided to ensure these processes are being executed in a compliant fashion (as it relates to the PREA Standards). Based upon the review and analysis of all the available evidence, the auditor has determined that the agency has not evidenced compliance with this standard.

115.334	Specialized training: Investigations
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	115.334: Specialized training: Investigations. The following evidence was analyzed in making the compliance determination: 1. Documents: (Policies, directives, forms, files, records, etc.) a. Sununu Youth Services Center Pre-Audit Questionnaire (PAQ) responses b. Sexual Assault and Sexual Harassment Policy 2055 (effective August 2017) c. PREA Investigator Training Rosters d. Training Curriculum 2. Interviews a. Investigative Staff 3. Site Review Observations: a. Observations during on-site review of physical plant Findings (By Provision): 115.334(a)-(c): During the pre-onsite portion of the facility indicated compliance in its PAQ responses and provided this auditor with applicable facility policies and protocols. During the onsite portion of this audit this auditor interviewed staff and/or residents (as outlined above) having first-hand knowledge as to operations and practices within the facility as it pertains to this provision. All interviewees corroborated those practices within the facility adhere to the procedures previously provided to the auditor. Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is compliant with this provision. 115.334(d): the Auditor is not required to audit this provision.

115.335	Specialized training: Medical and mental health care
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	115.335: Specialized training: Medical and mental health care. The following evidence was analyzed in making the compliance determination: 1. Documents: (Policies, directives, forms, files, records, etc.) a. Sununu Youth Services Center Pre-Audit Questionnaire (PAQ) responses b. Sexual Assault and Sexual Harassment Policy 2055 (effective August 2017) c. NCIC Training Curriculum d. Training Curriculum Staff List 2. Interviews a. Medical and Mental Health Staff 3. Site Review Observations: a. Observations during on-site review of physical plant Findings (By Provision): 115.335(a): During the pre-onsite portion of the facility indicated compliance in its PAQ responses and provided this auditor with applicable facility policies and protocols. During the onsite portion of this audit this auditor interviewed staff and/or residents (as outlined above) having first-hand knowledge as to operations and practices within the facility as it pertains to this provision. All interviewees corroborated those practices within the facility adhere to the procedures previously provided to the auditor. Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is compliant with this provision. 115.335(b): A NOT APPLICABLE determination has been made for this provision. Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is compliant with this provision. 115.335(c)-(d): During the pre-onsite portion of the facility indicated compliance in its PAQ responses and provided this auditor with applicable facility policies and protocols. During the onsite portion of this audit this auditor interviewed staff and/or residents (as outlined above) having first-hand

	knowledge as to operations and practices within the facility as it pertains to this provision. All interviewees corroborated those practices within the facility adhere to the procedures previously provided to the auditor. Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is compliant with this provision.

115.341	Obtaining information from residents
	Auditor Overall Determination: Does Not Meet Standard
	Auditor Discussion

115.341: Screening for risk of victimization and abusiveness.

The following evidence was analyzed in making the compliance determination:

Documents: (Policies, directives, forms, files, records, etc.)

a. Sununu Youth Services Center Pre-Audit Questionnaire (PAQ) responses

b. Sexual Assault and Sexual Harassment Policy 2055 (effective August 2017)

c. Proactive Safety Screening ad Planning Policy 2131 (effective February 2022)

d. Form 2197: PREA Vulnerability Assessment Instrument

e. Form 2197 (New Form – PD 22-13)

f. Resident case files

g. CrtStream Resident Files

Interviews
Random Residents
Staff responsible for risk screening
Random Staff
PREA Coordinator/Director of Operations
Site Review Observations:
Observations during on-site review of physical plant

Findings (By Provision):

115.341(a):

During the pre-onsite portion of this audit, the Facility indicated compliance with this provision and provided Policy 2055: Sexual Assault and Sexual Harassment. Section II(A) establishes,

A. "Within 72 hours of a youth's arrival at the SYSC, and every six months throughout a youth's commitment, the SYSC shall obtain and use information about each youth's personal history and behavior to reduce the risk of sexual abuse by or upon the youth (115.341 (a)).

1. For the initial screening, Clinical and Medical staff shall abide by Policy 2132 "Clinical Services for Committed Residents" or Policy 2160 "Residential Services for Detained Residents."

2. For the periodic six-month screenings, pursuant to this standard, Clinical staff shall abide by Policy 2130 "Treatment Plans and Reviews."

3. The SYSC shall use an objective screening instrument (115.341 (b)) that at a minimum ascertains information regarding:

(a) The youth's prior sexual victimization or abusiveness (115.341 (c1));

(b) Any gender non-conforming appearance or manner or identification as lesbian, gay, bisexual, transgendered, or intersex and whether the youth may therefore be vulnerable to sexual abuse (115.341 (c2));

(c) Current charges and offense history (115.341 (c3));

(d) Age (115.341 (c4));

(e) Level of cognitive and emotional development (115.341 (c5));

(f) Physical size and structure (115.341 (c6));

(g) Mental illness or mental disabilities (115.341 (c7));

(h) Intellectual or developmental disabilities (115.341 (c8));

(i) Physical disabilities (115.341 (c9));

(j) The youth's own perception of vulnerability (115.341 (c10)); and

(k) Any other specific information about individual youth that may indicate heightened needs for supervision, additional safety precautions, or separation from certain other youth (115.341 c11).

The facility indicated that over the past 12 months 54 residents were admitted and given this information at intake. 100% of which were reported to have been screened within 72 hours of their entry into the facility.

During the onsite portion of this audit, this auditor reviewed six random resident confidential case files. All six files indicated that the resident completed Form 2197: PREA Vulnerability Assessment Instrument within 72 hours of intake. This auditor interviewed 10 residents. All residents reported that staff conducted this questionnaire within days of their arrival to the facility.

This auditor also interviewed staff responsible for risk screening. The clinical team is responsible for conducting this assessment. This staff person reported that upon every intake an assessment is completed using Form 2197. The staff person indicated that they do not reassess the resident's risk periodically throughout their confinement. This was evidenced by a youth's confidential case file. This youth arrived at this program (for his/her most recent stay) on March 16, 2019. This youth's last vulnerability assessment was completed on March 17, 2019.

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is not fully compliant with this provision. Please see the below "Final Audit Report Reassessment" for review.

115.341(b):

During the pre-onsite portion of this audit, the Facility indicated compliance with this provision and provided Form 2197: PREA Vulnerability Assessment and Instrument. A review of this assessment tool establishes that the screener scores responses and aggregates the score at the conclusion of the assessment to establish whether the youth is "vulnerable to victimization," "sexually aggressive," or "no designated roommate" in a way that would allow the determination to be replicated by a subsequent or different evaluator.

Based upon the review and analysis of all the available evidence, the auditor has determined that the facility is compliant with this provision.

115.341(c):

During the pre-onsite portion of this audit, the Facility indicated compliance with this provision and provided Form 2197: PREA Vulnerability Assessment and Instrument. A review of this assessment tool establishes that the agency does not ascertain information about: Prior sexual victimization or abusiveness in a clear or concise way. Instead, the evaluator asks the youth "Have you ever been attacked, bullied, or abused by people your own age (peers)?" and "Have you ever had a sexual experience that you did not want to have?" (See #4, p. 2). Nowhere in the instrument does it specifically ascertain information about prior sexual victimization. Abusiveness is covered under question #10, page 3 of the instrument. Additionally, the instrument does not ascertain information about the youth's gender nonconforming appearance. Lastly, the instrument ascertains information as to the youth's gender identification as lesbian, gay, bisexual, transgender, or intersex but does not do so in a way that establishes whether the resident may therefore be vulnerable to sexual abuse. The

aforementioned information is not computed as part of the vulnerability assessment, instead it appears to be demographic information.

As required by this provision, Form 2197 does ascertain information about: (3) Current charges and offense history; (4) Age; (5) Level of emotional and cognitive development; (6) Physical size and stature; (7) Mental illness or mental disabilities; (8) Intellectual or developmental disabilities; (9) Physical disabilities; (10) The resident's own perception of vulnerability; and (11) Any other specific information about individual residents that may indicate heightened needs for supervision, additional safety precautions, or separation from certain other residents.

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is not fully compliant with this provision. Please see the below "Final Audit Report Reassessment" for review.

115.341(d):

During the pre-onsite portion of the facility indicated compliance in its PAQ responses and provided this auditor with applicable facility policies and protocols.

During the onsite portion of this audit this auditor interviewed staff and/or residents (as outlined above) having first-hand knowledge as to operations and practices within the facility as it pertains to this provision. All interviewees corroborated those practices within the facility adhere to the procedures previously provided to the auditor.

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is compliant with this provision.

115.341(e):

During the onsite portion of this audit, this auditor was provided access to CrtStream, an online case management database for the storage of information for the youth in the Facility. A review of this database reveals that the Form 2197: PREA Vulnerability Assessment Instrument is made available on the youth's page. Through informal and formal (those interviews utilizing the PREA protocols) interviews with staff, it was revealed that all staff have access to this information on CrtStream.

At the start of the corrective action period, the auditor determined that the agency is not compliant with this provision as the agency has not 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 in accordance with this provision.

Based upon the review and analysis of all the available evidence, and following a period of corrective action, the auditor has determined that the agency is fully compliant with this provision. Please see the below "Final Audit Report Reassessment" for review.

Interim Report Corrective Action:

Develop policy and procedures that requires that the resident's risk level be reassessed periodically throughout their confinement.
Develop Vulnerability Assessment that at a minimum, shall attempt to ascertain information about: (1) Prior sexual victimization or abusiveness; and (2) Any gender nonconforming appearance or manner or identification as lesbian, gay, bisexual, transgender, or intersex, and whether the resident may therefore be vulnerable to sexual abuse.
Implement appropriate controls on the dissemination within the facility of the vulnerability assessment instrument in order to ensure that sensitive information is not exploited to the resident's detriment by staff or other residents.

Recommendations:

1. Include the date of intake on the Vulnerability Assessment Instrument in order to easily ascertain its timely completion.

Final Audit Report Reassessment:

During the post-onsite audit portion of this audit, the auditor identified that the agency was not fully compliant with provisions (a), (c), and (e) of this standard. The Agency provided the auditor with "SYSC PREA Audit Corrective Action Specific Findings" on February 18, 2022. Follow-up information and evidence was provided to the auditor on March 25, 2022. The Agency developed the following corrective action plan with respect to this provision:

115.341 Corrective Action #1: The prior version of Policy 2055: Sexual Assault and Sexual Harassment. Section II(A) read, "Within 72 hours of a youth's arrival at the SYSC, and every six months throughout a youth's commitment, the SYSC shall obtain and use information about each youth's personal history and behavior to reduce the risk of sexual abuse by or upon the youth (115.341 (a))." A majority of youth at SYSC are in the facility for less than a six-month. Because the majority of stays were for less than six months, based youth would only receive the PREA Vulnerability Assessment at intake. One youth is currently approaching a six-month stay and a plan is in place to ensure a vulnerability assessment takes place prior to the six-month threshold.

Additionally, Policy 2055 has been rewritten and broken out into several smaller policies, including a new Policy 2131 which includes the following at Section II (B) "Form 2197 will be repeated periodically throughout the youth's stay, not to exceed 6-months, using updated information from all sources including but not limited to, treatment plan meetings, third-party reports, and any other documentation obtained." This will ensure the vulnerability assessment is reviewed periodically in addition to upon intake.

Policy 2131 will follow standard policy implementation protocol. All Policy Directive (PD) releases are emailed to supervisors to review and discuss with staff. Staff are required to read the policy and sign the PD Receipt form confirming that they have read, understood, and will adhere to the policy within 30 days. Additionally, at each annual performance evaluation, supervisors and staff discuss the Professionalism and Ethics Policy, which makes clear the staff requirement to understand and abide by all State laws, DHHS Policy, and DCYF Division policies.

Going forward, the PREA Compliance Manager will review audit logs for PREA-specific policies and will ensure monitoring of new policy implementation.

115.341 Corrective Action #2: Based on the information contained within the auditor's findings, the agency has updated Form 2197: PREA Vulnerability Assessment Instrument to capture (2) Any gender nonconforming appearance or manner or identification as lesbian, gay, bisexual, transgender, or intersex, located under the "LACK OF FIT" WITH THE JUVENILE JUSTICE CULTURE section on pg. 4. This section is incorporated into the resident's overall score to help determine whether they may be vulnerable to sexual abuse.

The Department will carefully review the questions utilized to address Prior Sexual Victimization in conjunction with a file review of the youth's history in order to collect the information in a clear, concise manner. Because the Vulnerability Assessment and associated scoring is based in evidence-based protocol, the Policy Team will have to work closely with our Clinical staff to develop appropriate language.

115.341 Corrective Action #3: Previously Form 2197: PREA Vulnerability Assessment Instrument was completed by hand and scanned into CrtStream as an attachment. All staff had access to the "attachments" within Crtstream. In response to this audit a permission's only form was created in Crtstream (now Youth Center) so now access to this information is limited to appropriate staff. Currently only 2 members of the SYSC medical team have access to this form.

Recommendation #1: Form 2197 was also updated to include the intake date of the youth's admission into SYSC per the auditor's recommendations, under "Date of Youth's admission to Sununu Youth Center," located at the top of the form.

During the post-corrective action period, this auditor reviewed the newly revised/created policies to verify the Agency's stated efforts. The auditor reviewed the updated vulnerability assessment and was able to confirm that this assessment adequately addressed the missing information outline above (specifically, the updated assessment assesses risks by objectively scoring the particular youth's gender non-confirming appearance, history of victimization, and gender identity). Furthermore, the facility evidenced that reassessments have begun by providing me with the initial and reassessment of a youth (initial being conducted on 8/24/21 and the reassessment being conducted on 3/24/22). The facility further evidenced the implementation of the new vulnerability assessment by providing this auditor with a completed initial assessment, dated 3/24/2022. These assessments, however, were conducted outside of the timeframe this auditor is allowed to review. As a result, the facility has failed to demonstrate compliance within the 180-day corrective action period.

	Based upon the review and analysis of all the available evidence, the auditor has determined that the agency has not evidenced compliance with this standard.

115.342	Placement of residents
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	115.342: Use of screening information The following evidence was analyzed in making the compliance determination: Documents: (Policies, directives, forms, files, records, etc.) Sununu Youth Services Center Pre-Audit Questionnaire (PAQ) responses Sexual Assault and Sexual Harassment Policy 2055 (effective August 2017) Classification of Committed Youth Policy 2140 (effective December 2018) Interviews Random Residents PREA Compliance Manager PREA Coordinator Staff responsible for risk screening Residents that identify as lesbian, gay, bisexual, transgender, or intersex Staff who supervise residents in isolation Residents in isolation Site Review Observations: Observations during on-site review of physical plant Findings (By Provision): 115.342(a)-(i): During the pre-onsite portion of the facility indicated compliance in its PAQ responses and provided this auditor with applicable facility policies and protocols. During the onsite portion of this audit this auditor interviewed staff and/or residents (as outlined above) having first-hand knowledge as to operations and practices within the facility as it pertains to this provision. All interviewees corroborated those practices within the facility adhere to the procedures previously provided to the auditor. Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is compliant with this provision.

115.351	Resident reporting
	Auditor Overall Determination: Does Not Meet Standard
	Auditor Discussion
	115.351: Resident reporting. The following evidence was analyzed in making the compliance determination: 1. Documents: (Policies, directives, forms, files, records, etc.) a. Sununu Youth Services Center Pre-Audit Questionnaire (PAQ) responses b. Sexual Assault and Sexual Harassment Policy 2055 (effective August 2017) c. Ombudsman Program Policy 2105 (effective June 2014) d. PREA Informational Notices e. Agreement on Processes Between DHHS Office of the Ombudsman and DHHS Division for Children, Youth, and Families/Sununu Youth Services Center f. Form 2594 – Updated PREA Informational Notices g. Ombudsman Program Policy 2105 (effective February 2105) 2. Interviews a. Random Residents b. Random Staff c. YWCA of NH Representative d. Grievance Staff 3. Site Review Observations: a. Observations during on-site review of physical plant; review of information displayed throughout the facility Findings (By Provision): 115.351(a): During the pre-onsite portion of the facility indicated compliance in its PAQ responses and provided this auditor with applicable facility policies and protocols. During the onsite portion of this audit this auditor interviewed staff and/or residents (as outlined above) having first-hand knowledge as to operations and practices within the facility as it pertains to this provision. All interviewees corroborated those practices within the facility adhere to the procedures previously provided to the auditor. Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is compliant with this provision. 115.351(b): During the pre-onsite portion of this audit, the Facility provided policies 2055: Sexual Assault and Sexual Harassment and 2105: Ombudsman Program in support of their compliance in this standard in its Pre-Audit Questionnaire (PAQ) responses. Section IV(C) of Policy 2055 establishes, “[t]he SYSC has designated the “Ombudsman Program” to receive and immediately forward youth reports of sexual abuse and sexual harassment to SYSC Administration as a way for committed or detained youth to report abuse or harassment to an entity that is not part of the SYSC while allowing the youth to remain

anonymous upon request. . . barring immediate safety concerns" (p. 11). Section I(C)(1) of Policy 2105 establishes, "[t] he SYSC Ombudsman is one way for youth to report abuse or harassment to a public office that is not part of the SYSC and is able to receive and immediately forward youth reports of sexual abuse and sexual harassment to the SYSC Director or designee, allowing youth to remain anonymous upon request. . .barring immediate safety concerns" (p. 2).

During the pre-onsite portion of this audit, this auditor interviewed an executive-level representative of the YWCA of New Hampshire. This representative reported that the MOU between the Facility and YWCA had been in existence for greater than five years but prior to signing the renewed MOU in April of 2021, had not heard from the Facility for a couple years (when the prior MOU needed to be signed). This representative also reported that although they were capable of receiving reports of sexual abuse or sexual harassment from youth from the facility, that was not part of their Memorandum of Understanding with the Facility and would treat any report as confidential and would follow internal protocols but would not report that information back to the facility. Lastly, this representative reported that YWCA had not been contacted by a youth at the Facility over the past 12 months.

During the onsite portion of this audit, this auditor observed PREA informational notices displayed throughout the facility. The Notices establish, "Anyone wanting to report an alleged incident of sexual abuse or sexual harassment may: 1) Report directly to any SYSC employee; 2) File a grievance anonymously or directly with the Ombudsman; 3) Request a reporting form from any staff; 4) Call DCYF Central Intake at 1(800) 894-5533 (in-state) or (603)271-6556 (out-of-state); 5) Call the YWCA at (603)668–2299; or 6) Access TDD or TTY services for the hearing impaired at: 1 (800) 735-2964 or 7-1-1."

Also, during the onsite portion of this audit, this auditor interviewed Grievance staff, a representative of the Office of the Ombudsman. This representative reported to this auditor that the Grievance procedure is a separate procedure from reporting of sexual abuse and sexual harassment and that residents should be using the separate procedure. This representative reported that there was little the Office could do with an anonymous report and that PREA reports are "not supposed to be confidential." The representative further reported that if a sexual abuse or sexual harassment claim was left in the grievance box, they would place it in an envelope and leave it in the Facility's administrator's internal mailbox. When this auditor inquired as to whether this person would follow-up on that report, the representative stated they would not. Additionally, the Office of the Ombudsman is within the New Hampshire Department of Health and Human Services just as the Division of Children, Youth, and Families. This Office would not represent a public or private entity that is not part of the agency.

This auditor also interviewed 10 randomly selected residents. Out of 10 residents, eight indicated that there was no one who does not work at this facility that you could report to about sexual abuse or sexual harassment. Further, nine residents reported that they were unsure or that a youth was not allowed to make a report without having to give their names. The one youth that indicated that you could make an "anonymous" report stated, that the youth doesn't have to give their name, but they need to ask staff for the form (so they know anyway)."

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is not fully compliant with this provision. Please see the below "Final Audit Report Reassessment" for review.

115.351(c):

During the pre-onsite portion of this audit, the Facility provided policies 2055: Sexual Assault and Sexual Harassment in support of their compliance in this standard in its Pre-Audit Questionnaire (PAQ) responses. Section IV(A) establishes,

As stated in subsection (b) of this standard, out of 10 residents interviewed, eight indicated that there was no one who does not work at this facility that you could report to about sexual abuse or sexual harassment. Further, nine residents reported that they were unsure or that a youth was not allowed to make a report without having to give their names. The one youth that indicated that you could make an "anonymous" report stated, that the youth doesn't have to give their name, but they need to ask staff for the form (so they know anyway)." All residents reported that the facility accepts reports of sexual abuse and sexual harassment that are made verbally, in writing, and from third parties.

Also, during the onsite portion of this audit, this auditor interviewed 12 randomly selected staff. All staff were able to inform this auditor that a youth can report sexual abuse or sexual harassment verbally, in writing, and through third partied (the later taking some prompts by this auditor for the staff to understand what is meant by this). However, the majority of staff were unable to inform this auditor that the Facility would not investigate anonymous reports of sexual abuse or sexual harassment.

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is not fully compliant with this provision. Please see the below "Final Audit Report Reassessment" for review.

115.351(d):

During the pre-onsite portion of the facility indicated compliance in its PAQ responses and provided this auditor with applicable facility policies and protocols.

During the onsite portion of this audit this auditor interviewed staff and/or residents (as outlined above) having first-hand knowledge as to operations and practices within the facility as it pertains to this provision. All interviewees corroborated those practices within the facility adhere to the procedures previously provided to the auditor.

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is compliant with this provision.

115.351(e):

During the pre-onsite portion of the facility indicated compliance in its PAQ responses and provided this auditor with applicable facility policies and protocols.

During the onsite portion of this audit this auditor interviewed staff and/or residents (as outlined above) having first-hand knowledge as to operations and practices within the facility as it pertains to this provision. All interviewees corroborated those practices within the facility adhere to the procedures previously provided to the auditor.

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is compliant with this provision.

Interim Report Corrective Action:

Develop at least one way for residents to report sexual abuse or sexual harassment to a public or private entity that is not part of the agency where that entity will immediately forward the resident report to agency officials and that allows for the resident to remain anonymous upon request.
Develop a way for residents to report sexual abuse or sexual harassment anonymously.

Recommendation(s):

1. Ensure residents have access to tools necessary to make a written report without the need to ask staff for said tools (e.g., forms available near the grievance box, centrally located on the unit, copies made available to the youth upon intake, etc.).

Final Audit Report Reassessment:

During the post-onsite audit portion of this audit, the auditor identified that the agency was not fully compliant with provisions

(b) and (c) of this standard. The Agency provided the auditor with "SYSC PREA Audit Corrective Action Specific Findings" on February 18, 2022. Follow-up information and evidence was provided to the auditor on March 25, 2022. The Agency developed the following corrective action plan with respect to this provision:

AGENCY CORRECTIVE ACTION:

115.351 Corrective Action #1 - It is the opinion of the Office of the Attorney General for the State of New Hampshire that the DHHS Office of the Ombudsman functions as an independent entity, appointed to investigate complaints against any part of the Department of Health and Human Services—New Hampshire's largest agency. It is not embedded in the Division of Children, Youth, and Families (DCYF), remaining intentionally separate from the operations and leadership of the agency and SYSC. Its engagement with and independence from DCYF are outlined in a joint agreement on processes between the DHHS Office of the Ombudsman and DCYF. In response to this finding, this joint agreement has been updated with the following statement:

Should the Associate Ombudsman receive a complaint that alleges conduct that falls within the Prison Rape Elimination Act (PREA), the Associate Ombudsman shall immediately forward the complaint via email to the Director of SYSC and to the PREA Investigator. Should the Associate Ombudsman receive a complaint that alleges conduct that falls within the Prison Rape Elimination Act (PREA), and the complainant wishes to remain anonymous, the Associate Ombudsman shall immediately forward the anonymous complaint to the Director of SYSC and to the PREA Investigator.

115.351 Corrective Action #2 - A meeting was held between SYSC leaders and the YWCA about the breadth of services that the YWCA may be able to provide relative to counseling, reporting, and other functions. This continues to be an area of ongoing exploration, as the YWCA does not feel equipped to be the entity to engage in the confidential reporting process. However, as noted above, the DHHS-wide Office of the Ombudsman is prepared to provide this role as an independent entity handling both confidential and non-confidential reports.

115.351 Corrective Action #3 - A checklist was developed to ensure the Youth Handbook contains all ancillary documents required by PREA. We updated Form 2105 (Complaint Form), which allows youth to report issues anonymously or non-anonymously to the Ombudsman. Once such reports are made, they are handled through the above cited process. It also contains Form 2055 (Reporting Form For Sexual Abuse, Sexual Harassment, and Retaliation), which enables youth to report issues anonymously or non-anonymously directly to the PREA Compliance Manager.

115.351(b), Corrective Action #4 - We are obsoleting our all DCYF-made versions of PREA Notices and adopting template posters published by the National PREA Resource Center that have all required content areas. These templates have been updated with our specific agency names and numbers, and approved by DCYF leadership.

115.351 Corrective Action Recommendation #1 - SYSC leaders are meeting on February 23, 2022 to develop a plan for staff training, with the intention of ensuring all staff are aware of the process for anonymous reporting.

During follow-up this auditor requested a signed copy of the above-mentioned agreement between the facility and the Office of the Ombudsman. The auditor received a partially signed agreement, lacking the signature of the Office of the Ombudsman. Since the onsite portion of the audit, the Facility has made efforts to increase the engagement with YWCA as a possible out of agency mechanism for youth to report allegations of sexual abuse and sexual harassment. As noted by the facility, this is an area of ongoing exploration. Furthermore, although this auditor understands the purpose of the Office of the Ombudsman as delineated in Corrective Action #1, that Office remains part of the Agency itself. The Standard is clear that there needs to be at least one mechanism for a resident to make a report out of agency. Although it appears the Facility is taking steps to achieve this requirement (as previously discussed), this process is not in place at the close of the corrective action period. Additionally, in order for this auditor to make a compliance determination, this auditor would also need to interview random residents and staff to determine their understanding of these procedures. As noted, this auditor was unable to conduct such interviews within the requisite timeframe. In later standards, it appears that the NH Office of the Child Advocate is a reporting mechanism outside of the Agency for the residents at this facility. It remains that this auditor was unable to verify actual implementation and resident and staff knowledge these important changes.

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency has not evidenced compliance with this standard.

115.352	Exhaustion of administrative remedies
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	1 115.352: Exhaustion of administrative remedies. The following evidence was analyzed in making the compliance determination: 1. Documents: (Policies, directives, forms, files, records, etc.) a. Sununu Youth Services Center Pre-Audit Questionnaire (PAQ) responses b. Ombudsman Program Policy 2105 (effective June 2014) c. Youth Handbook d. Form 2181: A Guide to Preventing and Reporting Sexual Abuse, and Sexual Harassment e. Ombudsman Program Policy 2105 (effective February 2022) f. PREA: What You Need to Know (Form 2095) 2. Interviews a. Random Residents b. Residents that Reported Prior Sexual Abuse 3. Site Review Observations: a. Observations during on-site review of physical plant Findings (By Provision): 115.352(a), (d), (e), & (g): During the pre-onsite portion of the facility indicated compliance in its PAQ responses and provided this auditor with applicable facility policies and protocols. During the onsite portion of this audit this auditor interviewed staff and/or residents (as outlined above) having first-hand knowledge as to operations and practices within the facility as it pertains to this provision. All interviewees corroborated those practices within the facility adhere to the procedures previously provided to the auditor. Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is compliant with this provision. 115.352(b), (c), (f): During the pre-onsite portion of this audit, the Facility provided Policy 2105: Ombudsman Program in support of their compliance in this standard in its Pre-Audit Questionnaire (PAQ) responses. As outlined in Standard 115.351, this auditor interviewed Grievance staff, a representative of the Office of the Ombudsman. This representative reported to this auditor that the Grievance procedure is a separate procedure from reporting of sexual abuse and sexual harassment and that residents should be using the separate procedure. This representative reported that there was little the Office could do with an anonymous report and that PREA reports are “not supposed to be confidential.” The representative further reported that if a sexual abuse or sexual harassment claim was left in the grievance box, they

would place it in an envelope and leave it in the Facility's administrator's internal mailbox. When this auditor inquired as to whether this person would follow-up on that report, the representative stated they would not. Additionally, the Office of the Ombudsman is within the New Hampshire Department of Health and Human Services just as the Division of Children, Youth, and Families. This Office would not represent a public or private entity that is not part of the agency.

A review of the Youth Handbook reveals that there does not contain any information with regards to Grievances and/or the Office of the Ombudsman. Youth are given a photocopy of a portion of Form 2181: A Guide to Preventing and Reporting Sexual Abuse, and Sexual Harassment. One section of this form states, "Or you can make a report by: Filing a grievance with the Ombudsman by putting it in the locked grievance on your box." It should be noted that this Form is not complete and partially illegible in the manner that is it provided to the youth.

Based upon the review and analysis of all the available evidence, and after being provided additionally information and clarification, the auditor has determined that this Standard is NOT Applicable. Please see Final Audit Report Reassessment below.

Final Audit Report Reassessment:

During the post-onsite audit portion of this audit, the auditor identified that the agency was not fully compliant with provisions (b), (c), and (f) of this standard. The Agency provided the auditor with "SYSC PREA Audit Corrective Action Specific Findings" on February 18, 2022. Follow-up information and evidence was provided to the auditor on March 25, 2022. The Agency developed the following corrective action plan with respect to this provision:

AGENCY CORRECTIVE ACTION:

115.351(b), (c), (f): Clarification

The facility has determined that there was a misunderstanding regarding the application of Standard 115.352 to SYSC. This standard only applies if the agency has in a place an administrative appeals process. At SYSC, youth do not have any administrative rights to appeal an SYSC finding. This is not the role of the Ombudsman, who instead serves as a third-party independent entity to receive and share with the PREA coordinator both anonymous and non-anonymous PREA-related reports (see Corrective Action Section 115.351), not to facilitate administrative appeals processes. Standard 115.352 (a) "Exhaustion of Administrative Remedies" states:

An agency shall be exempt from this standard if it does not have administrative procedures to address resident grievances regarding sexual abuse.

The question asked as part of the Auditor's guidance in the Auditing Tool. Given these practices, SYSC is exempt from standards 115.352 (a) – 115.352 (g).

Upon follow-up, the Facility clarified the role of the Office of the Ombudsman; "While our Ombudsman's office serves as a means to report PREA complaints, those complaints are directly forwarded on to the SYSC administration for investigation. That concludes the Ombudsman's involvement in the matter. There are no administrative remedies available to address the potential issue if some disagrees with the outcome of a PREA investigation. As these administrative remedies do not exist, we are of the belief that we are exempt from Standards 115.352 (a) – 115.352 (g)." Revised Policy 2105: Ombudsman Program states: "The Office of the Ombudsman forwards youth reports received of sexual abuse, sexual harassment and sexual misconduct to the SYSC Administrator, or designee, allowing youth to remain anonymous upon request and barring any immediate safety concerns" (Section I(C)). The policy limits the role of the Office of the Ombudsman.

Based upon the review and analysis of all the available evidence and updated information, the auditor has determined that this standard is NOT APPLICABLE.

115.353	Resident access to outside confidential support services and legal representation
	Auditor Overall Determination: Does Not Meet Standard
	Auditor Discussion

115.353: Resident access to outside confidential support services

The following evidence was analyzed in making the compliance determination:

1. Documents: (Policies, directives, forms, files, records, etc.)

a. Sununu Youth Services Center Pre-Audit Questionnaire (PAQ) responses

b. Resident Orientation Policy 2027 (effective February 2019)

c. PREA Informational Notices

d. Photographs of Resident Informational Boards

e. Updated PREA Informational Notices (Form 2594)

2. Interviews

a. Random Residents

b. Residents that Reported Prior Sexual Abuse

c. Community-Based Victim Services Provider

3. Site Review Observations:

a. Observations during on-site review of physical plant; review of information displayed near resident phones

Findings (By Provision):

115.353(a)-(b):

During the pre-onsite portion of this audit, the Facility provided Policy 2027: Residential Orientation in support of their compliance in this standard in its Pre-Audit Questionnaire (PAQ) responses. Section V(D)(1) establishes: "the SYSC shall ensure that key information is continuously and readily available or visible to youth through posters, youth handbooks, or other written formats. . .This information shall consist of: 1. How youth may access outside victim advocates for emotional support services related to sexual abuse, including the providing, posting, or otherwise making known and accessible mailing addresses and telephone numbers, including toll-free hotline numbers where available, of the Manchester YWCA" (p. 3). The police further establishes that "[t]he SYSC shall ensure youth are trained on, and have reasonable communication with, the above described organizations and agencies, in as confidential a manner as possible" (p. 4).

During the pre-onsite portion of this audit, this auditor interviewed an executive-level representative of the YWCA of New Hampshire. This representative reported that a MOU between the Facility and YWCA had been in existence for greater than five years but prior to signing the renewed MOU in April of 2021, had not heard from the Facility for a couple years (when the prior MOU needed to be signed). This representative also reported that they had never been – nor had ever been invited to tour – to the Facility. Lastly, this representative reported that YWCA had not been contacted by a youth at the Facility over the past 12 months.

During the onsite portion of this audit, this auditor observed PREA informational notices displayed throughout the facility. The Notices establish, "Anyone wanting to report an alleged incident of sexual abuse or sexual harassment may: 1) Report directly to any SYSC employee; 2) File a grievance anonymously or directly with the Ombudsman; 3) Request a reporting form from any staff; 4) Call DCYF Central Intake at 1(800) 894-5533 (in-state) or (603)271-6556 (out-of-state); 5) Call the YWCA at (603)668–2299; or 6) Access TDD or TTY services for the hearing impaired at: 1 (800) 735-2964 or 7-1-1." The notices fail, however, to provide information to the youth (or any reader) that YWCA is available for emotional support services.

Also, during the onsite portion of this audit, this auditor interviewed 10 youth. Out of the 10 youth randomly selected for interviews, nine youth did not know if there are services available out of the Facility for dealing with sexual abuse, if the youth ever needed it; nor could any resident inform this auditor what kinds of services are available, whether the facility fave the youth mailing addresses and telephone numbers, when the youth is able to speak with people from these services, and whether conversations with people from these services remain private.

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is not fully compliant with this provision. Please see the below "Final Audit Report Reassessment" for review.

115.353(c)-(d):

During the pre-onsite portion of the facility indicated compliance in its PAQ responses and provided this auditor with applicable facility policies and protocols.

During the onsite portion of this audit this auditor interviewed staff and/or residents (as outlined above) having first-hand knowledge as to operations and practices within the facility as it pertains to this provision. All interviewees corroborated those practices within the facility adhere to the procedures previously provided to the auditor.

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is compliant with this provision.

Interim Report Corrective Action:

Ensure staff/the facility are providing residents with information about access to outside victim advocates for emotional support services related to sexual abuse in a manner that allows for residents to retain this information or be able to know where to look in the event they wanted to access this information.
Develop clear information and educate residents (and staff) to what extent communications to outside support services are kept confidential.

Final Audit Report Reassessment:

During the post-onsite audit portion of this audit, the auditor identified that the agency was not fully compliant with provisions (a) and (b) of this standard. The Agency provided the auditor with "SYSC PREA Audit Corrective Action Specific Findings" on February 18, 2022. Follow-up information and evidence was provided to the auditor on March 25, 2022. The Agency developed the following corrective action plan with respect to this provision:

Corrective Action:

115.353 Corrective Action #1 - SYSC has adopted the PREA approved posters which will be hung throughout the facility. Under the "How to Report" section of these posters includes the contact information for the DCYF Central Intake Office, the YWCA of New Hampshire, and the Office of the Child Advocate as outside avenues for youth to report sexual abuse or sexual harassment. The poster also includes an updated "Victim Support Services" section which clarifies that the YWCA of New Hampshire is available to provide emotional support services for youth at the facility.

On January 25, 2022, members of the SYSC audit team met with a representative of YWCA of New Hampshire to engage in the initial steps to solidifying the relationship between the YWCA and SYSC. It was through this meeting that it was learned that the YWCA is able and willing to offer a variety of training topics to the staff and residents at SYSC. A tour of SYSC for members of YWCA has been scheduled for February 18, 2022. Additionally on February 23, 2022, members of the YWCA will be meeting with the SYSC Training Coordinator to formulate future training opportunities/partnerships between the two organizations.

115.353 Corrective Action #2 – As the auditor already noted , Policy 2027, Residential Orientation, at Section D3(a) states: "The SYSC shall ensure youth are trained on, and have reasonable communication with, the above described organizations and agencies, in as confidential a manner as possible (115.353 (a))," and "(t)he SYSC shall inform youth, 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 (115.353 (b)).” This information is consistent with the requirements of PREA standard 115.353 (a)&(b). The deficiency revealed by the auditor was the facility’s ability to communicate the requirements of Policy 2027 to the residents at SYSC and to ensure that the residents are able to retain this information. The information required by 115.353 (a)&(b) is currently not included in Form 2040, the SYSC Youth Handbook; Form 2095, A Guide to Preventing & Reporting Sexual Abuse, and Sexual Harassment; nor any other written information what is provided to SYSC residents. The agency plans to update the SYSC Youth Handbook (Form 2040) by June/July of 2022. Going forward, the information contained in Policy 2027, as well as any other relevant PREA education information, will be incorporated into the revised SYSC Handbook. Attachment: · DCYF FORM 2594 (Poster) During the post corrective action portion of this audit, this auditor was able to review the revised PREA posters as well as photographs of the posters being displayed. As previously reported, these posters have substantively been updated both stylistically and content-wise. YWCA is currently listed on these notices. However, as indicated by the facility, its corrective action is still ongoing and the target date for completing these necessary steps to educate their residents (and come into compliance) is dated past the requisite timeframe. Furthermore, it should be noted, that due to the overwhelming responses received by the random residents interviewed, new interviews would have been needed for a compliance determination on this standard. As noted previously, these interviews were not possible within the required timeframe. Based upon the review and analysis of all the available evidence, the auditor has determined that the agency has not evidenced compliance with this standard.

115.354	Third-party reporting
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	115.354: Third-party reporting. The following evidence was analyzed in making the compliance determination: 1. Documents: (Policies, directives, forms, files, records, etc.) a. Sununu Youth Services Center Pre-Audit Questionnaire (PAQ) responses b. Sexual Assault and Sexual Harassment Policy 2055 (effective August 2017) c. PREA Informational Notices d. Form 2037: Parent Orientation Notice of Understanding e. Form 2497: A Guide to the Prevention and Reporting of Sexual Abuse for Interns, Contractors, Vendors, and Volunteers f. Form 2477: Staff Orientation Notice of Understanding g. Form 2036: Juvenile Orientation Notice of Understanding h. Form 2498: Intern/Volunteer Orientation Notice of Understanding i. Form 2476: PREA: What Staff Need to Know j. Agency Website 2. Site Review Observations: a. Observations during on-site review of physical plant; review of information displayed throughout the facility Findings (By Provision): 115.354(a): During the pre-onsite portion of the facility indicated compliance in its PAQ responses and provided this auditor with applicable facility policies and protocols. During the onsite portion of this audit this auditor interviewed staff and/or residents (as outlined above) having first-hand knowledge as to operations and practices within the facility as it pertains to this provision. All interviewees corroborated those practices within the facility adhere to the procedures previously provided to the auditor. Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is compliant with this provision.

115.361	Staff and agency reporting duties
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	115.361: Staff and agency reporting duties. The following evidence was analyzed in making the compliance determination: 1. Documents: (Policies, directives, forms, files, records, etc.) a. Sununu Youth Services Center Pre-Audit Questionnaire (PAQ) responses b. Sexual Assault and Sexual Harassment Policy 2055 (effective August 2017) c. Ombudsman Program Policy 2105 (effective June 2014) d. Abuse or Neglect of Committed or Detained Youth – Staff Misconduct Defined, Reporting Requirements, and Sanctions Policy 2475 (effective June 2014) e. Investigative Files f. SYSC PREA First Responder Workflow g. Learning Objectives to the SYSC Online PREA Annual Training h. Updated Daily Roll Call Form i. Policy 2055 PREA - Immediate Response to Abuse and First Responder Duties (February 2022) 2. Interviews a. Facility Director b. Random Staff 3. Site Review Observations: a. Observations during on-site review of physical plant Findings (By Provision): 115.361(a): During the pre-onsite portion of the facility indicated compliance in its PAQ responses and provided this auditor with applicable facility policies and protocols. During the onsite portion of this audit this auditor interviewed staff and/or residents (as outlined above) having first-hand knowledge as to operations and practices within the facility as it pertains to this provision. All interviewees corroborated those practices within the facility adhere to the procedures previously provided to the auditor. Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is compliant with this provision. 115.361(b): During the pre-onsite portion of this audit, the Facility indicated compliance in its Pre-Audit Questionnaire and provided Policy 2475: Abuse or Neglect of Committed or Detained Youth – Staff Misconduct Defined, Reporting Requirements, and Sanctions. Section III(A)(1) establishes, "[i]f staff has reason to believe a committed or detained youth has been abused or neglected as these terms are defined in RSA 169-C:3, the staff is required to report the suspected abuse or neglect to the Division for Children, Youth and Families – Central Intake at 1-800-894-5533 or 603-271-6556, in accordance with the

requirements set forth by RSA 169-C:29 and this policy" (p. 5). Section 1(F) of Policy 2055: Sexual Assault and Sexual Harassment also establishes, "[i]n addition to any other reporting responsibilities included in this policy, staff who have reason to suspect that any child/youth has been abused or neglected must report as required under RSA 169-C:29 by calling DCYF Central Intake Unit at (800) 894-5533 or 271- 6563" (p. 5).

During the onsite portion of this audit, the auditor interviewed 12 randomly selected staff chosen randomly by the auditor. Out of all staff only one staff was able to identify what NH's mandatory reporting law was. Nine staff unequivocally informed this writer that they were not trained on this topic or could not tell this auditor whether they were mandatory reporters in the State or what their responsibilities were under the law.

Based upon the review and analysis of all the available evidence, and following a period of corrective action, the auditor has determined that the agency is fully compliant with this provision. Please see the below "Final Audit Report Reassessment" for review.

115.361(c):

During the pre-onsite portion of the facility indicated compliance in its PAQ responses and provided this auditor with applicable facility policies and protocols.

During the onsite portion of this audit this auditor interviewed staff and/or residents (as outlined above) having first-hand knowledge as to operations and practices within the facility as it pertains to this provision. All interviewees corroborated those practices within the facility adhere to the procedures previously provided to the auditor.

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is compliant with this provision.

115.361(d):

During the pre-onsite portion of the facility indicated compliance in its PAQ responses and provided this auditor with applicable facility policies and protocols.

During the onsite portion of this audit this auditor interviewed staff and/or residents (as outlined above) having first-hand knowledge as to operations and practices within the facility as it pertains to this provision. All interviewees corroborated those practices within the facility adhere to the procedures previously provided to the auditor.

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is compliant with this provision.

115.361(e):

During the onsite portion of this audit, this auditor interviewed the Facility Director. The Facility Director indicated that upon receiving any allegation, the staff would follow the internal chain of commands (notify the Supervisor-on-Duty, the administrator on-call, and the Facility Director. From there, notifications would be made to the medical and mental health departments, DCYF Central Intake, the State Police, and then to the assigned probation officer and parents. In the event that the youth was engaged with Child Protective Services, the Facility Director noted facility staff would notify his/her guardian as well. The Facility Director did report, however, that the youth's attorney or other legal representative is not a person the facility has protocols to call or notify.

Based upon the review and analysis of all the available evidence, and following a period of corrective action, the auditor has

determined that the agency is fully compliant with this provision. Please see the below "Final Audit Report Reassessment" for review.

115.361(f):

During the onsite portion of this audit, this auditor interviewed the Facility Director. The Facility Director indicated the facility report all allegations of sexual abuse and sexual harassment, including third-party and anonymous reports, to the facility's designated investigators. Also, while onsite, this auditor reviewed sixteen investigative files that included third-party allegations.

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is compliant with this provision.

Interim Report Corrective Action:

1. Develop and implement procedures that staff understand and follow applicable state mandatory reporting laws.

2. Develop and implement procedures that ensure the facility head or designee reports an allegation of sexual abuse to the juvenile's attorney or other legal representative of record within 14 days of receiving the allegation.

Final Audit Report Reassessment:

During the post-onsite audit portion of this audit, the auditor identified that the agency was not fully compliant with provisions (b), and (e) of this standard. The Agency provided the auditor with "SYSC PREA Audit Corrective Action Specific Findings" on February 18, 2022. Follow-up information and evidence was provided to the auditor on March 25, 2022. The Agency developed the following corrective action plan with respect to this provision:

AGENCY CORRECTIVE ACTION:

115.361 Corrective Action #1 - Section 3 of the SYSC's PREA training describes New Hampshire's Mandatory Reporting law, codified as RSA 169-C:29. All staff who have not had PREA Training in 2022 will receive a refresher by February 15, 2022. This refresher will include the Resident's right to be free of sexual abuse and sexual harassment, how to comply with relevant laws related to mandating reporting of sexual abuse to outside authorities, and relevant laws regarding the applicable age of consent. Going forward, all staff at SYSC will be required to attend an annual PREA training to ensure retention of this information. This training requirement will be monitored by the SYSC Training Coordinator.

Also, the agency added to Section 3 of SYSC's PREA training is the following True/False question:

· NH Law requires any person who suspects that a child under age 18 has been abused or neglected must report that suspicion immediately to DCYF.

TRUE OR FALSE Answer = TRUE

SYSC has also updated their Daily Roll Call form to include an area called SYSC Training Corner to assist staff retain the information that have been previously trained on. Here abbreviated training information to staff will be given every 7 days. Staff will acknowledge having received this training information by signing off on the Roll Call form. This form will then be scanned in and saved in a Roll Call folder

115: 361 (e), Corrective Action #2: Former Policy 2055 already required that the youth's attorney be notified upon receiving a PREA allegation. This requirement continues to be carried over in Revised Policy 2055 Section VI(A). The agency's First Responder Workflow on page #2 also indicates that a youth's attorney is to be notified.

It is understood that during the audit the Facility Director reported that a youth's attorney or legal representation would not be notified or contacted upon receiving a PREA allegation from the juvenile. New Hampshire RSA 169-B:12, entitled Appointment of Counsel; Waiver of Counsel was amended in 2021 to include Section VI, which provides, "(w)henever a juvenile is detained, committed, or otherwise placed outside his or her home, the court shall appoint counsel if such

	appointment has not previously been made in the proceedings. Such appointment shall be made at a time sufficiently in advance of the decision to place the juvenile outside the home to allow counsel to provide effective representation on the issue of placement, and such appointment shall continue until the court no longer has jurisdiction over the juvenile pursuant to this chapter. The court shall not accept a waiver of counsel when appointment is required by this paragraph." NH Stat. 169-B:12 (New Hampshire Statutes (2021 Edition). Prior to this statutory amendment, legal representation for committed juveniles would cease post-disposition. Thus, committed youth would not have legal representation to contact prior to the 2021 statutory amendment. It is assumed, though not confirmed, that when answering this question that the Facility Director was not familiar with the updated law. This has been clarified among staff and now the youth's attorney/legal representation is contacted within 14 days upon receiving a PREA allegation as required by 115.361(e). Upon follow-up and clarification, it was reviewed that the updated policy and procedures were implemented on February 16, 2022, to include the daily booster trainings listed as part of the revised supervisory daily roll call. The auditor is further satisfied with the Facility's response to Corrective Action #2. Based upon the review and analysis of all the available evidence, the auditor has determined that the agency has evidenced compliance with this standard after a period of corrective action.

115.362	Agency protection duties
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	115.362: Agency protection duties. The following evidence was analyzed in making the compliance determination: 1. Documents: (Policies, directives, forms, files, records, etc.) a. Sununu Youth Services Center Pre-Audit Questionnaire (PAQ) responses b. Sexual Assault and Sexual Harassment Policy 2055 (effective August 2017) c. Emergency Response Policy 2053 (effective April 2015) 2. Interviews a. Agency Head b. Facility Director c. Random Staff 3. Site Review Observations: a. Observations during on-site review of physical plant Findings (By Provision): 115.362(a): During the pre-onsite portion of the facility indicated compliance in its PAQ responses and provided this auditor with applicable facility policies and protocols. During the onsite portion of this audit this auditor interviewed staff and/or residents (as outlined above) having first-hand knowledge as to operations and practices within the facility as it pertains to this provision. All interviewees corroborated those practices within the facility adhere to the procedures previously provided to the auditor. Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is compliant with this provision.

115.363	Reporting to other confinement facilities
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	115.363: Reporting to other confinement facilities. The following evidence was analyzed in making the compliance determination: 1. Documents: (Policies, directives, forms, files, records, etc.) a. Sununu Youth Services Center Pre-Audit Questionnaire (PAQ) responses b. Sexual Assault and Sexual Harassment Policy 2055 (effective August 2017) 2. Interviews a. Agency Head b. Facility Director 3. Site Review Observations: a. Observations during on-site review of physical plant Findings (By Provision): 115.363(a) – (d): During the pre-onsite portion of the facility indicated compliance in its PAQ responses and provided this auditor with applicable facility policies and protocols. During the onsite portion of this audit this auditor interviewed staff and/or residents (as outlined above) having first-hand knowledge as to operations and practices within the facility as it pertains to this provision. All interviewees corroborated those practices within the facility adhere to the procedures previously provided to the auditor. Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is compliant with this provision.

115.364	Staff first responder duties
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	115.364: Staff first responder duties. The following evidence was analyzed in making the compliance determination: 1. Documents: (Policies, directives, forms, files, records, etc.) a. Sununu Youth Services Center Pre-Audit Questionnaire (PAQ) responses b. Sexual Assault and Sexual Harassment Policy 2055 (effective August 2017) c. Emergency Response Policy 2053 (effective April 2015) 2. Interviews a. Security Staff and Non-security Staff First Responders b. Residents who Reported a Sexual Abuse 3. Site Review Observations: a. Observations during on-site review of physical plant Findings (By Provision): 115.364(a)-(b): During the pre-onsite portion of the facility indicated compliance in its PAQ responses and provided this auditor with applicable facility policies and protocols. During the onsite portion of this audit this auditor interviewed staff and/or residents (as outlined above) having first-hand knowledge as to operations and practices within the facility as it pertains to this provision. All interviewees corroborated those practices within the facility adhere to the procedures previously provided to the auditor. Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is compliant with this provision.

115.365	Coordinated response
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	115.365: Coordinated response. The following evidence was analyzed in making the compliance determination: 1. Documents: (Policies, directives, forms, files, records, etc.) a. Sununu Youth Services Center Pre-Audit Questionnaire (PAQ) responses b. Sexual Assault and Sexual Harassment Policy 2055 (effective August 2017) c. Form 2097: Juvenile PREA (Sexual Abuse) First Responder Checklist d. Policy 2055 – PREA – Immediate Response to Sexual Abuse and First Responder Duties (February 2022) e. Policy 2088 PREA Investigations f. Policy 218- Medical/Clinical Response to PREA g. Form 2097: PREA Juvenile Sexual Abuse Responder Checklist 2. Interviews a. Facility Director 3. Site Review Observations: a. Observations during on-site review of physical plant Findings (By Provision): 115.365(a): During the pre-onsite portion of this audit, the Facility indicated compliance and provided Policy 2055: Sexual Assault and Sexual Harassment. The Purpose statement establishes, "[t]his policy is the SYSC plan to coordinate all actions taken in response to an incident of sexual abuse among staff first responders, medical and mental health practitioners, investigators, and SYSC Administration" (p. 2). The Facility also provided this auditor with Form 2097: Juvenile PREA (Sexual Abuse) First Responder Checklist. The Form (completed) was also evidence in investigative files. During the onsite portion of this audit, this auditor interviewed the Facility Director. The Facility Director indicated that the facility has developed a written institutional plan to coordinate actions taken in response to an incident of sexual abuse among staff first responders, medical and mental health practitioners, investigators, and facility leadership and referenced the aforementioned Form. A review of the First Responder Protocol only addresses security staff responsibilities and fails to establish a coordinate response with the other required program areas (first responders, medical and mental health practitioners, investigators, and facility leadership). Based upon the review and analysis of all the available evidence, and following a period of corrective action, the auditor has determined that the agency is fully compliant with this provision. Please see the below "Final Audit Report Reassessment" for review. Interim Report Corrective Action: 1. Developed a written institutional plan that coordinates actions to be taken in response to an incident of sexual abuse

among staff first responders, medical and mental health practitioners, investigators, and facility leadership.

Final Audit Report Reassessment:

During the post-onsite audit portion of this audit, the auditor identified that the agency was not fully compliant with provisions (a), (c), and (e) of this standard. The Agency provided the auditor with "SYSC PREA Audit Corrective Action Specific Findings" on February 18, 2022. Follow-up information and evidence was provided to the auditor on March 25, 2022. The Agency developed the following corrective action plan with respect to this provision:

AGENCY CORRECTIVE ACTION:

115.365 Corrective Action #1 - Prior to engagement in this audit, the DCYF Policy Unit had identified a need to deconstruct Policy 2055 into a number of more targeted policies. The unit put this work on hold during the period of the audit in order to ensure the final product would be responsive to the audit findings. In response to this finding, Policy 2055 Sexual Abuse and Sexual Harassment was revised to extract information to break out specific policy content. The new revised policy 2055 PREA – Immediate Response to Sexual Abuse and First Responder Duties specifies actions taken by first responders and the plan for coordinated actions among facility staff immediately following incident of sexual abuse. In the revised policy, the response of program areas within the facility has been defined as follows: first responders in section I of the policy; medical staff in section II of the policy; and facility leadership in sections III and VI of the policy. The role of the investigator has been extracted to new policy 2088 PREA Investigations to detail the investigative process. Further actions to the immediate response for clinical and medical staff are covered in the current policy 2180 Medical/Clinical Response to PREA.

To support the current and revised policies the Form 2097 PREA Juvenile Sexual Abuse First Responder Checklist was updated for content and built into the facility's automated electronic information system YouthCenter for completion and tracking.

Policies 2055 and 2088 will follow standard implementation protocol. All Policy Directive (PD) releases are emailed to supervisors to review and discuss with staff. Staff are required to read the policy and sign the PD Receipt form confirming that they have read, understood, and will adhere to the policy within 30 days. Additionally, at each annual performance evaluation, supervisors and staff discuss the Professionalism and Ethics Policy, which makes clear the staff requirement to understand and abide by all State laws, DHHS Policy, and DCYF Division policies.

Going forward, the PREA Compliance Manager will review audit logs for PREA-specific policies and will ensure monitoring of new policy implementation.

A review of this updated policy corroborates the identified sections that detail the facility's coordinated response among the required programmatic areas. During the follow-up period after receipt of the corrective action plan, it was reviewed that implementation was complete on February 16, 2022 for all corrective action policies, including for this standard.

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency has evidenced compliance with this standard after a period of corrective action.

115.366	Preservation of ability to protect residents from contact with abusers
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	115.366: Preservation of ability to protect residents from contact with abusers. The following evidence was analyzed in making the compliance determination: 1. Documents: (Policies, directives, forms, files, records, etc.) a. Sununu Youth Services Center Pre-Audit Questionnaire (PAQ) responses b. Agency website: https://apps.das.nh.gov/laborrelations/cba.aspx?y=latest&a=seiu-1984 c. Collective Bargaining Agreement (effective June 29, 2021) 2. Interviews a. Agency Head 3. Site Review Observations: a. Observations during on-site review of physical plant Findings (By Provision): 115.366(a): During the pre-onsite portion of this audit, the agency indicated that it had entered into or renewed any collective bargaining agreement or other agreement since August 20, 2012, or since the last PREA audit and provided this auditor a link to the Agency's website (listed above) that publishes the Collective Bargaining Agreement (effective June 29, 2021). A review of this Agreement establishes that it does not limit 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. During the onsite portion of this audit, this auditor interviewed the Director of the Division for Children, Youth, and Families of the Department of Health and Human Services. This executive reported that every few years the Agency enters into a collective bargaining agreement. This executive further reported that the Agreement does not limit removal or discipline as required by this provision and that any administrative investigation would result in the employee being placed on paid leave pending the outcome and any criminal investigations would result in the employee being placed on unpaid leave pending the outcome. Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is compliant with this provision. 115.366(b): The auditor is not required to audit this provision.

115.367	Agency protection against retaliation
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	115.367: Agency protection against retaliation. The following evidence was analyzed in making the compliance determination: 1. Documents: (Policies, directives, forms, files, records, etc.) a. Sununu Youth Services Center Pre-Audit Questionnaire (PAQ) responses b. Sexual Assault and Sexual Harassment Policy 2055 (effective August 2017) c. Abuse or Neglect of Committed or Detained Youth – Staff Misconduct Defined, reporting Requirements, and Sanctions Policy 2475 (effective June 2014). d. Policy 2095 PREA Youth Reporting and Protection Against Retaliation (February 2022) e. Retaliation Monitoring Tool 2. Interviews a. Agency Head b. Facility Director c. Designated Staff Member Charged with Monitoring Retaliation d. Residents who Reported a Sexual Abuse 3. Site Review Observations: a. Observations during on-site review of physical plant Findings (By Provision): 115.367(a): During the pre-onsite portion of this audit, the Facility indicated compliance and provided Policy 2055: Sexual Assault and Sexual Harassment. Section XII(A)(1) establishes, "[r]etaliation for any report or cooperation in any investigation is prohibited. All youth and staff who report sexual abuse or sexual harassment, or cooperate with sexual abuse or sexual harassment investigations shall be protected from retaliation by other youth or staff" (p. 23). The Facility further reported that "[a]ll staff are charge[d] with monitoring" retaliation. A review of this policy reveals that the Agency has 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. During the onsite portion of this audit, the auditor interviewed the Agency Head or Designee, Facility Director, Designated Staff Member Charged with Monitoring Retaliation, as well as Residents who Reported Sexual Abuse. The designated Agency Head reported that retaliation is taken seriously at the Facility. The Facility Director indicated that the Facility has zero tolerance towards retaliation. The Designated Staff Member Charged with Monitoring Retaliation selected to interview reported that they would consistently check-in with the person and be aware of possible retaliation. This staff reported that there is no documentation that these check-ins occur or any protective measures taken. Based upon the review and analysis of all the available evidence, and following a period of corrective action, the auditor has determined that the agency is fully compliant with this provision. Please see the below "Final Audit Report Reassessment" for review.

115.367(b):

During the pre-onsite portion of the facility indicated compliance in its PAQ responses and provided this auditor with applicable facility policies and protocols.

During the onsite portion of this audit this auditor interviewed staff and/or residents (as outlined above) having first-hand knowledge as to operations and practices within the facility as it pertains to this provision. All interviewees corroborated those practices within the facility adhere to the procedures previously provided to the auditor.

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is compliant with this provision.

115.367(c)-(d):

During the pre-onsite portion of this audit, the Facility indicated compliance and provided Policy 2055: Sexual Assault and Sexual Harassment. Section XII(A)(1) establishes, "[t]he SYSC shall monitor: youth conduct, youth disciplinary reports, housing (i.e., referral to CSU) or program changes. Supervisory staff shall monitor staff for negative performance reviews, reassignments, or other indicators that might indicate possible retaliation. The SYSC shall continue such monitoring beyond 90 days if monitoring indicates a continuing need" (p. 23). Further, Section I(D)(2) of Policy 2475: Abuse or Neglect of Committed or Detained Youth – Staff Misconduct Defined, reporting Requirements, and Sanctions establishes, "[a]ll staff must immediately report to the SYSC Director or designee and the SYSC PREA Coordinator. . . (b) Retaliation against youth or staff who reported such an incident; and/or (c) Any staff neglect or violation of responsibilities that may have contributed to a sexual abuse or harassment incident or retaliation" (p. 2). The Facility Reported that there were no times during the past 12 months where retaliation occurred.

As outlined in subsection (a) of this standard, the Facility does not have an established procedure in place to monitor retaliation. Despite having three allegations of sexual abuse prior to the onsite portion of this audit that were determined not to be "unfounded," the Facility provided no documentation that they routinely checked in with the alleged victim and/or reporting parties, or that retaliation was specifically monitored.

Based upon the review and analysis of all the available evidence, and following a period of corrective action, the auditor has determined that the agency is fully compliant with this provision. Please see the below "Final Audit Report Reassessment" for review.

115.367(e):

During the pre-onsite portion of the facility indicated compliance in its PAQ responses and provided this auditor with applicable facility policies and protocols.

During the onsite portion of this audit this auditor interviewed staff and/or residents (as outlined above) having first-hand knowledge as to operations and practices within the facility as it pertains to this provision. All interviewees corroborated those practices within the facility adhere to the procedures previously provided to the auditor.

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is compliant with this provision.

115.367(f): The auditor is not required to audit this provision.

Interim Report Corrective Action:

1. Establish protocols to ensure the agency's 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 is carried out.

2. Establish policies and procedures that monitors the conduct or treatment of residents or staff who reported sexual abuse and of residents who were reported to have suffered sexual abuse to see if there are any changes that may suggest possible retaliation by residents or staff.

3. Establish policies and procedures that ensures monitoring for retaliation includes periodic status checks.

Final Audit Report Reassessment:

During the post-onsite audit portion of this audit, the auditor identified that the agency was not fully compliant with provisions (a), (c), and (e) of this standard. The Agency provided the auditor with "SYSC PREA Audit Corrective Action Specific Findings" on February 18, 2022. Follow-up information and evidence was provided to the auditor on March 25, 2022. The Agency developed the following corrective action plan with respect to this provision:

AGENCY CORRECTIVE ACTION

115.367 Corrective Action #1 – The agency has replaced the previous Sexual Assault and Sexual Harassment Policy 2055 with four new, more targeted policies, including 2095 PREA youth reporting and protection against retaliation. This new policy establishes that all staff are responsible for documenting and reporting incidents of retaliation, and clarifies that the PREA Compliance Manager is the designated staff responsible to coordinate and document all efforts to monitor for and address retaliation for the 90-day period.

All Policy Directive (PD) releases, including Policy 2095, are first emailed to supervisors to review and discuss with staff. Staff are required to read the policy and sign the PD Receipt form confirming that they have read, understood, and will adhere to the policy within 30 days. Additionally, at each annual performance evaluation, supervisors and staff discuss the Professionalism and Ethics Policy, which makes clear the staff requirement to understand and abide by all State laws, DHHS Policy, and DCYF Division policies.

Going forward, the PREA Compliance Manager will review audit logs for PREA-specific policies and will ensure monitoring of new policy implementation.

115.367 Corrective Action #2 – New Policy 2095 PREA Youth Reporting and Protection Against Retaliation clarifies who is responsible for monitoring for retaliation, what changes they should be observing, and specific measures to protect youth against retaliation.

115.367 Corrective Action #3 – The agency has developed a tool to document initial and ongoing periodic efforts to monitor for retaliation. Per Policy 2095, the PREA Compliance Manager is the designated staff responsible to for documenting the elements on the tool.

A review of the newly created Policy 2095 reveals that Sections V and VI specifically address retaliation and specific events and characteristics to look for. Additionally, a senior level administrator within the facility has been tasked with overseeing these monitoring practices. Upon following-up with the facility, this auditor was informed that the policy was fully implemented on February 16, 2022.

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency has evidenced compliance with this standard after a period of corrective action.

115.368	Post-allegation protective custody
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	115.368: Post-allegation protective custody. The following evidence was analyzed in making the compliance determination: 1. Documents: (Policies, directives, forms, files, records, etc.) a. Sununu Youth Services Center Pre-Audit Questionnaire (PAQ) responses b. Isolation Log 2. Interviews a. Facility Director b. Staff who Supervise Residents in Isolation. 3. Site Review Observations: a. Observations during on-site review of physical plant Findings (By Provision): 115.368(a): During the pre-onsite portion of this audit, the Facility indicated that this provision was "Not Applicable" and reported that this standard is "Not Applicable – the victim would not be segregated at SYSC." The Facility also reported that there have been no times a resident who alleged to have suffered sexual abuse was placed in isolation over the past 12 months. This standard is applicable to all juvenile facilities. During the onsite portion of this audit, the Auditor interviewed the Facility Director, Staff who Supervise Residents in Isolation, Random Staff, as well as the Crisis Stabilization Unit Log (i.e., isolation unit log). This auditor compared the isolation log with reports of sexual abuse and sexual harassment and was able to determine that no victim was placed in isolation. Additionally, both the Facility Director and all staff reported that under no circumstances would the victim be placed in isolation. Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is compliant with this provision. Recommendation: 1. Solidify this practice in Agency/Facility Policy.

115.371	Criminal and administrative agency investigations
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	115.371: Criminal and administrative agency investigations The following evidence was analyzed in making the compliance determination: 1. Documents: (Policies, directives, forms, files, records, etc.) a. Sununu Youth Services Center Pre-Audit Questionnaire (PAQ) responses b. Sexual Assault and Sexual Harassment Policy 2055 (effective August 2017) c. Investigative records/reports for allegations of sexual abuse or sexual harassment d. Administrative and/or Criminal investigation reports 2. Interviews a. Investigative Staff b. Residents who Reported a Sexual Abuse c. PREA Coordinator d. Facility 3. Site Review Observations: a. Observations during on-site review of physical plant Findings (By Provision): 115.371(a)-(j): During the pre-onsite portion of the facility indicated compliance in its PAQ responses and provided this auditor with applicable facility policies and protocols. During the onsite portion of this audit this auditor interviewed staff and/or residents (as outlined above) having first-hand knowledge as to operations and practices within the facility as it pertains to this provision. All interviewees corroborated those practices within the facility adhere to the procedures previously provided to the auditor. Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is compliant with this provision. 115.371(k): Auditor is not required to audit this provision. 115.371(l): During the pre-onsite portion of the facility indicated compliance in its PAQ responses and provided this auditor with applicable facility policies and protocols. During the onsite portion of this audit this auditor interviewed staff and/or residents (as outlined above) having first-hand knowledge as to operations and practices within the facility as it pertains to this provision. All interviewees corroborated

	those practices within the facility adhere to the procedures previously provided to the auditor. Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is compliant with this provision.

115.372	Evidentiary standard for administrative investigations
	Auditor Overall Determination: Does Not Meet Standard
	Auditor Discussion

115.372: Evidentiary standard for administrative investigations.

The following evidence was analyzed in making the compliance determination:

1. Documents: (Policies, directives, forms, files, records, etc.)

Sununu Youth Services Center Pre-Audit Questionnaire (PAQ) responses
Sexual Assault and Sexual Harassment Policy 2055 (effective August 2017)
Investigative records/reports for allegations of sexual abuse or sexual harassment
Policy 2088 PREA Investigations (February 2022)
2. Interviews

Investigative Staff

Findings (By Provision):

115.372(a):

During the pre-onsite portion of this audit, the Facility indicated compliance with this provision and provided this auditor with Policy 2055: Sexual Assault and Sexual Harassment Policy. Section VI(D) of this policy establishes, "[t]he SYSC standard for determining whether allegations of sexual abuse or sexual harassment are substantiated shall be no higher than a preponderance of the evidence when conducting administrative investigations" (p. 18).

During the onsite portion of this audit, this auditor interviewed a Facility investigator. The investigator informed this auditor that the standard of evidence required to substantiate allegations of sexual abuse or sexual harassment was to determine "truth to those findings." This auditor also interviewed additional investigators both utilizing the protocols and informally, one investigator was able to inform this auditor that the required standard was by a "preponderance of the evidence."

This auditor review documentation of completed a total of six administrative investigation reviews for sexual abuse allegations while onsite (all incidents that were identified pursuant to the PREA Auditor Handbook). An additional 10 reviews were conducted on sexual harassment investigative files. Of these reviews, four investigations completed established an inconsistency in applying this evidentiary standard. In one investigation, the investigator established the event did in fact occur, but "unsubstantiated" the allegation. In another, the investigator "substantiated for unwanted contact" but unsubstantiated the PREA allegation (despite the alleged victim claiming that the contact was sexualized and felt uncomfortable). In a separate allegation, the investigator unsubstantiated the allegation despite the alleged perpetrator admitting to slapping the buttocks of the alleged victim. Lastly, in a 3rd party complaint allegation where at least one witness provides an account of the sexually harassing behavior, the investigator determined the allegation to be "unfounded" due to the alleged victim not participating in the investigation. This investigator also states in his/her investigation that the account of the witness was "hearsay."

It is evident from the above-described investigations that there is a lack of consistency in applying the requisite burden of proof in addition to the definitions of "substantiated," "unsubstantiated," and "unfounded." It also appears that the investigator conflates a determination whether or not an allegation occurred with what they think a disciplinary sanction should be (and whether it should rise to a PREA-related consequence).

Pursuant to PREA Standard Section 115.5 – General Definitions:

§ "Substantiated allegation means an allegation that was investigated and determined to have occurred."

§ "Unfounded allegation means an allegation that was investigated and determined not to have occurred."

§ "Unsubstantiated allegation means an allegation that was investigated and the investigation produced insufficient evidence

to make a final determination as to whether or not the event occurred."

Although "hearsay" (in the most basic sense, an out of court statement offered in court to establish proof of the matter asserted) is not admissible in Court against an accused in a criminal proceeding, an accused is not guaranteed the full panoply of rights in an administrative hearing than one does for example during a jury trial. Additionally, there are numerous exceptions and exemptions to the hearsay rule. Suffice it to say that a witness account of what an alleged perpetrator said – that statement being the basis of the allegation – should have been considered by the investigator. Additionally, an alleged victim of a PREA allegation need not participate in an investigation. The facility, however, must still thoroughly investigate that claim.

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is not fully compliant with this provision. Please see the below "Final Audit Report Reassessment" for review.

Interim Report Corrective Action:

1. Develop policies and procedures that ensures the agency imposes a standard of a preponderance of the evidence or a lower standard of proof for determining whether allegations of sexual abuse or sexual harassment are substantiated.

2. Establish or improve existing practices to ensure all allegations are thoroughly investigated.

Final Audit Report Reassessment:

During the post-onsite audit portion of this audit, the auditor identified that the agency was not fully compliant with provisions (a), (c), and (e) of this standard. The Agency provided the auditor with "SYSC PREA Audit Corrective Action Specific Findings" on February 18, 2022. Follow-up information and evidence was provided to the auditor on March 25, 2022. The Agency developed the following corrective action plan with respect to this provision:

AGENCY CORRECTIVE ACTION:

115.372 Corrective Action #1 – New Policy 2088, Sec V, C1 includes the appropriate standard of proof, preponderance of the evidence, to be used in determining whether a PREA allegation has been substantiated.

115.372 Corrective Action #2 - All SYSC PREA Investigators, including all SYCS Residential Supervisors and the SYSC PREA Compliance Manager, will complete two online PREA investigator trainings through the National Institute of Corrections. The first training, entitled "Investigating Sexual Abuse in a Confinement Setting" is a two hour training designed to assist agencies in meeting the requirements of Prison Rape Elimination Act (PREA) Section 115.34 Specialized Training for Investigators. The second online training all SYSC Investigators are required to take is the 3 hour "Investigating Sexual Abuse in a Confinement Setting: Advanced Investigations.

In addition, all SYSC Investigators will also be require to take "Minimal Facts Interview Training" provided by Victim Service Quality Assurance Department for the Granite State Children's Alliance. The training will be scheduled prior to Feb 22, 2022. The training points for this presentation will include the following topics:

- Why repetitive interviews are damaging to a child abuse investigation;
- Distinguish the difference between a Forensic Interview and a Minimal Facts Interview;
- Factors to consider before conducting a Minimal Facts Interview; and
- Simple tools for conducting a Minimal Facts Interview

In following-up with the facility, the auditor learned that Policy 2088 was implemented on February 16, 2022. The above-referenced training was scheduled for March 30, 2022 (outside the permissible timeframe for this audit). It should be noted that this is not a training standard, however due to the timing of the corrective action (as noted previously), this auditor could not reconduct investigator interviews to determine whether this standard's corrective action had been adequately addressed. As a result, the facility has failed to evidence compliance with this provision.

	Based upon the review and analysis of all the available evidence, the auditor has determined that the agency has not evidenced compliance with this standard.

115.373	Reporting to residents
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	115.373: Reporting to residents. The following evidence was analyzed in making the compliance determination: 1. Documents: (Policies, directives, forms, files, records, etc.) a. Sununu Youth Services Center Pre-Audit Questionnaire (PAQ) responses b. Sexual Assault and Sexual Harassment Policy 2055 (effective August 2017) Basic Rights for Committed and Detained Youth Policy 2090 (effective August 2014) Investigative records/reports for allegations of sexual abuse or sexual harassment Criminal investigation reports Resident Notification 2. Interviews Investigative Staff Facility Director Residents who Reported a Sexual Abuse Findings (By Provision): 115.373(a)-(e): During the pre-onsite portion of the facility indicated compliance in its PAQ responses and provided this auditor with applicable facility policies and protocols. During the onsite portion of this audit this auditor interviewed staff and/or residents (as outlined above) having first-hand knowledge as to operations and practices within the facility as it pertains to this provision. All interviewees corroborated those practices within the facility adhere to the procedures previously provided to the auditor. Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is compliant with this provision.

115.376	Disciplinary sanctions for staff
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	115.376: Disciplinary sanctions for staff. The following evidence was analyzed in making the compliance determination: 1. Documents: (Policies, directives, forms, files, records, etc.) a. Sununu Youth Services Center Pre-Audit Questionnaire (PAQ) responses b. Sexual Assault and Sexual Harassment Policy 2055 (effective August 2017) c. Hiring, Promoting, Corrective and Disciplinary Actions for SYSC Personnel, Contractors, and Volunteers Policy 2476 (effective June 2014) d. Administrative and/or Criminal Investigations 2. Interviews a. Facility Director b. PREA Compliance Manager 3. Site Review Observations: a. Observations during on-site review of physical plant Findings (By Provision): 115.376(a)-(d): During the pre-onsite portion of the facility indicated compliance in its PAQ responses and provided this auditor with applicable facility policies and protocols. During the onsite portion of this audit this auditor interviewed staff and/or residents (as outlined above) having first-hand knowledge as to operations and practices within the facility as it pertains to this provision. All interviewees corroborated those practices within the facility adhere to the procedures previously provided to the auditor. Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is compliant with this provision.

115.377	Corrective action for contractors and volunteers
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	115.377: Corrective action for contractors and volunteers. The following evidence was analyzed in making the compliance determination: 1. Documents: (Policies, directives, forms, files, records, etc.) a. Sununu Youth Services Center Pre-Audit Questionnaire (PAQ) responses b. Sexual Assault and Sexual Harassment Policy 2055 (effective August 2017) c. Hiring, Promoting, Corrective and Disciplinary Actions for SYSC Personnel, Contractors, and Volunteers Policy 2476 (effective June 2014) d. 2100 Addressing Rule Violations (effective December 2020) e. 2132 SYSC Programming (effective March 2021) f. SYSC Guide to Behavioral Learning, Expectations & Related Practices 2. Interviews a. Facility Director 3. Site Review Observations: a. Observations during on-site review of physical plant Findings (By Provision): 115.377(a)-(b): During the pre-onsite portion of the facility indicated compliance in its PAQ responses and provided this auditor with applicable facility policies and protocols. During the onsite portion of this audit this auditor interviewed staff and/or residents (as outlined above) having first-hand knowledge as to operations and practices within the facility as it pertains to this provision. All interviewees corroborated those practices within the facility adhere to the procedures previously provided to the auditor. Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is compliant with this provision.

115.378	Interventions and disciplinary sanctions for residents
	Auditor Overall Determination: Does Not Meet Standard
	Auditor Discussion

115.378: Disciplinary sanctions for residents.

The following evidence was analyzed in making the compliance determination:

1. Documents: (Policies, directives, forms, files, records, etc.)

a. Sununu Youth Services Center Pre-Audit Questionnaire (PAQ) responses

b. Sexual Assault and Sexual Harassment Policy 2055 (effective August 2017)

c. Addressing Rules Violations Policy 2100 (effective December 2020)

d. Youth Handbook

2. Interviews

a. Facility Director

b. Medical and Mental Health Staff

3. Site Review Observations:

a. Observations during on-site review of physical plant

Findings (By Provision):

115.378(a)-(c):

During the pre-onsite portion of the facility indicated compliance in its PAQ responses and provided this auditor with applicable facility policies and protocols.

During the onsite portion of this audit this auditor interviewed staff and/or residents (as outlined above) having first-hand knowledge as to operations and practices within the facility as it pertains to this provision. All interviewees corroborated those practices within the facility adhere to the procedures previously provided to the auditor.

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is compliant with this provision.

115.378(d):

During the pre-onsite portion of this audit, the Facility indicated compliance with this provision and provided this auditor with Policy 2100: Addressing Rules Violations. The Facility cited Section VI(A) as the pertinent section to this provision's requirements. However, this policy in full does not address this provision.

During the onsite portion of this audit, this auditor interviewed mental health staff. This staff person reported that Facility provides trauma-focused cognitive behavioral theory for children traumatized. The staff person reported that the Facility does not – or would not voluntarily – offer therapy, counseling, or other interventions designed to address and correct the underlying reasons or motivations for sexual abuse. This staff person further reported that any specialized services the Facility would offer through the youth's attorney or probation officer as due to confidentiality the Facility could not reach out to community-based organizations directly. This person did report, however, that access to general programming or education is never conditioned on participation in any mental health services.

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is not fully compliant with this provision. Please see the below "Final Audit Report Reassessment" for review.

115.378(e):

During the pre-onsite portion of the facility indicated compliance in its PAQ responses and provided this auditor with applicable facility policies and protocols.

During the onsite portion of this audit this auditor interviewed staff and/or residents (as outlined above) having first-hand knowledge as to operations and practices within the facility as it pertains to this provision. All interviewees corroborated those practices within the facility adhere to the procedures previously provided to the auditor.

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is compliant with this provision.

115.378(f):

During the pre-onsite portion of this audit, the Facility indicated compliance with this provision and provided this auditor with Policy 2100: Addressing Rules Violations. The Facility cited Section IV as the pertinent section to this provision's requirements. However, this policy in full does not address this provision. Further, a review of the SYSC Youth Handbook reveals that outside listing "[a]ll inappropriate sexual behavior (including founded PREA)," the Handbook does not provide youth any information related to PREA.

Based upon the review and analysis of all the available evidence, and following a period of corrective action, the auditor has determined that the agency is fully compliant with this provision. Please see the below "Final Audit Report Reassessment" for review.

115.378(g):

During the pre-onsite portion of this audit, the Facility indicated compliance with this provision and provided this auditor with Policy 2055: Sexual Assault and Sexual Harassment. Section I(A) establishes, "[t]he Sununu Youth Services Center (SYSC) establishes zero tolerance towards all forms of sexual abuse, sexual harassment, and/or other forms of sexual misconduct. Sexual or sexualized behavior or sexual harassment from staff-to-staff, staff-to-youth, or youth-to- youth is expressly prohibited" (p. 4). The Facility further cited Section IV of Policy 2100: Addressing Rules Violations. This policy is silent as to whether the agency deems such activity to constitute sexual abuse only if it determines that the activity is coerced as required by this provision.

Based upon the review and analysis of all the available evidence, and following a period of corrective action, the auditor has determined that the agency is fully compliant with this provision. Please see the below "Final Audit Report Reassessment" for review.

Interim Report Corrective Action:

Develop and implement a practice to offer offending youth therapy, counseling, or other interventions designed to address and correct the underlying reasons or motivations for the abuse.
Develop and implement disciplinary protocol that prohibits disciplinary action for a report of sexual abuse made in good faith based upon a reasonable belief that the alleged conduct occurred.
Develop and implement disciplinary protocol that deems sexual activity between residents to constitute sexual abuse only if it determines that the activity is coerced as required by this provision.

Final Audit Report Reassessment:

	During the post-onsite audit portion of this audit, the auditor identified that the agency was not fully compliant with provisions (d), (f), and (g) of this standard. The Agency provided the auditor with "SYSC PREA Audit Corrective Action Specific Findings" on February 18, 2022. Follow-up information and evidence was provided to the auditor on March 25, 2022. The Agency developed the following corrective action plan with respect to this provision: AGENCY CORRECTIVE ACTION: 115.378(d), Corrective Action #1: Policy 2132, Section V. establishes that youth who need intervention specific to sexual misconduct may participate in SYSC's clinical and therapeutic interventions aimed at addressing underlying causes. Additionally, subparagraph A. states the treatment team will determine if participation in such interventions are required to access any rewards-based behavior incentives, and clarifies that participation will not be a condition to accessing general programming or education. As a part of the therapeutic program, the clinician works with the Juvenile Probation and Parole Officer through treatment planning to identify groups or services in the community specific to the youth's needs and the clinician meets with the identified youth at least weekly for individual therapy (Standard Operating Procedure 2132.2 Clinical Services for Committed Youth). 115.378(f), Corrective Action #2: SYSC Guide to Behavioral Learning, Expectations and Related Practices establishes a behavioral incentive program for youth expectations and youth rule violations. The guide clarifies that "Regardless of findings, SYSC prohibits any disciplinary action for youth alleging sexual abuse if the report was made in good faith and based on the youth's reasonable belief that the alleged conduct occurred" (top of page 7). This guide is incorporated by reference into DCYF Policy 2100 Addressing Rules Violations. 115.378(g), Corrective Action #3: SYSC Guide to Behavioral Learning, Expectations and Related Practices establishes a behavioral incentive program for youth expectations and youth rule violations. The guide clarifies that "SYSC will not deem sexual activity between youth to constitute sexual abuse if the investigation determines that the sexual activity was not coerced" (bottom of page 6). This guide is incorporated by reference into DCYF Policy 2100 Addressing Rules Violations. The auditor's review of the policy and additional information that appears to have bee available but was not provided to the auditor during the pre-onsite and onsite portions of this audit. Based on the above, this auditor finds that the facility has evidenced compliance with provisions (f) and (g). However, the facility's corrective action for provision (d) is non-responsive to the listed deficiency. Regardless of protocols that are in place, the mental health staff at the time of the onsite portion of the audit had another interpretation of the services the facility provides and the availability of this specific programming. The facility has not evidenced that this was adequately addressed during the corrective action portion of this audit. Based upon the review and analysis of all the available evidence, the auditor has determined that the agency has not evidenced compliance with this standard.

115.381	Medical and mental health screenings; history of sexual abuse
	Auditor Overall Determination: Meets Standard
	Auditor Discussion

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

The following evidence was analyzed in making the compliance determination:

1. Documents: (Policies, directives, forms, files, records, etc.)

a. Sununu Youth Services Center Pre-Audit Questionnaire (PAQ) responses

b. Sexual Assault and Sexual Harassment Policy 2055 (effective August 2017)

c. 2132.2 Clinical Services for Committed Youth (effective March 2021)

d. 2131 Proactive Safety Screening and Planning (effective February 2022)

2. Interviews

a. Medical and Mental Health Staff

b. Residents who Disclosed Sexual Victimization at Risk Screening

c. Staff Responsible for Risk Screening

3. Site Review Observations:

a. Observations during on-site review of physical plant

Findings (By Provision):

115.381(a):

During the pre-onsite portion of this audit, the Facility indicated compliance with this provision and provided this auditor with Policy 2055: Sexual Assault and Sexual Harassment. Section II(D) establishes, "[i]f a screening indicates that a youth has experienced prior sexual victimization, whether it occurred in an institutional setting or in the community, staff receiving this information must ensure the youth is referred for a follow-up meeting with Medical or Clinical staff that must occur within 14 days of the screening" (p. 8). The Facility reported that within the past 12 months 10 residents reported prior victimization, all of which received a follow-up meeting with a medical or mental health practitioner.

During the onsite portion of this audit, this auditor interviewed the residents who disclose sexual victimization at risk screening that were still in the facility. These youth reported that they were not offered a follow-up with a doctor or offered mental health services that addressed the prior victimization.

Based upon the review and analysis of all the available evidence, and following a period of corrective action, the auditor has determined that the agency is fully compliant with this provision. Please see the below "Final Audit Report Reassessment" for review.

115.381(b):

During the pre-onsite portion of this audit, the Facility indicated compliance with this provision and provided this auditor with Policy 2055: Sexual Assault and Sexual Harassment. Section II(E) establishes, "[i]f a screening indicates that a youth has previously perpetrated sexual abuse, whether it occurred in an institutional setting or in the community, staff receiving this information shall ensure the youth is referred for a follow-up meeting with a Clinician that will occur within 14 days of the screening" (p. 8). The Facility reported that within the past 12 months no residents qualified for these services.

During the onsite portion of this audit, this auditor interviewed the Staff responsible for risk screening. This staff reported that mental health services are delivered following a trauma-focused cognitive behavioral therapy model for children traumatized and that clinical services for any youth who previously perpetrated sexual abuse are not currently available in the Facility.

Based upon the review and analysis of all the available evidence, and following a period of corrective action, the auditor has determined that the agency is fully compliant with this provision. Please see the below "Final Audit Report Reassessment" for review.

115.381(c):

During the pre-onsite portion of this audit, the Facility indicated compliance with this provision and provided this auditor with Policy 2055: Sexual Assault and Sexual Harassment. Section II(F) establishes, "[a]ny information related to sexual victimization or abusiveness that occurred in an institutional setting shall be strictly limited to Medical, Clinical, and other staff as necessary to inform treatment plans, and security and management decisions, including: housing, bed, work, education, and program assignments, or as otherwise required by Federal, State, or local law" (p. 8).

During the onsite portion of this audit, this auditor was provided access to CrtStream, an online case management database for the storage of information for the youth in the Facility. A review of this database reveals that the victimization screening in full is made available on the youth's page. Through informal and formal (those interviews utilizing the PREA protocols) interviews with staff, it was revealed that all staff have access to this information on CrtStream.

Based upon the review and analysis of all the available evidence, and following a period of corrective action, the auditor has determined that the agency is fully compliant with this provision. Please see the below "Final Audit Report Reassessment" for review.

115.381(d):

During the pre-onsite portion of the facility indicated compliance in its PAQ responses and provided this auditor with applicable facility policies and protocols.

During the onsite portion of this audit this auditor interviewed staff and/or residents (as outlined above) having first-hand knowledge as to operations and practices within the facility as it pertains to this provision. All interviewees corroborated those practices within the facility adhere to the procedures previously provided to the auditor.

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is compliant with this provision.

Interim Report Corrective Action:

Develop and implement a practice to offer all residents at this facility who have disclosed any prior sexual victimization during a screening pursuant a follow-up meeting with a medical or mental health practitioner.
Develop and implement a practice to offer all residents who have ever previously perpetrated sexual abuse are offered a follow-up meeting with a mental health practitioner within 14 days of the intake screening.
Develop and implement appropriate safeguards to the dissemination of information related to sexual victimization or abusiveness.

Final Audit Report Reassessment:

During the post-onsite audit portion of this audit, the auditor identified that the agency was not fully compliant with provisions (a)–(c) of this standard. The Agency provided the auditor with "SYSC PREA Audit Corrective Action Specific Findings" on February 18, 2022. Follow-up information and evidence was provided to the auditor on March 25, 2022. The Agency

developed the following corrective action plan with respect to this provision:

AGENCY CORRECTIVE ACTION:

115.381 Corrective Action #1 &2 - Prior to engagement in this audit, the DCYF Policy Unit had identified a need to deconstruct Policy 2055 into a number of more targeted policies. The unit put this work on hold during the period of the audit in order to ensure the final product would be responsive to the audit findings. In response to this finding, policy 2131 Proactive Safety Screening and Planning was revised to streamline and clarify the SYSC practices for completing a Form 2197 PREA Vulnerability Assessment Instrument with all youth admitted to the facility and in section II-C defines the role of clinical staff in following-up within 14 days for any youth who have disclosed previous victimization.

In addition, a personal safety plan is created for these youth within 3 days of their admission with information pertinent to all staff working with the youth to support them given the information found in the PREA Vulnerability assessment and a Becks Suicide Screening. The personal safety plan is noted in the revised policy 2131 under section IV as being used inform treatment planning for the youth and is reviewed by the clinical every 30 days for updates. As a part of the therapeutic program, the clinician works with the Juvenile Probation and Parole Officer through treatment planning to identify groups or services in the community specific to the youth's needs and the clinician meets with the identified youth at least weekly for individual therapy (Standard Operating Procedure 2132.2 Clinical Services for Committed Youth).

115.381 Corrective Action #3 - In response to this finding, the Form 2197 PREA Vulnerability Assessment Instrument was built into the Facility's automated electronic information system YouthCenter with restrictions on who can access the form so that the form content is safeguarded to be accessible to the clinical staff who need the information for treatment planning purposes.

Further, prior to engagement in this audit, the DCYF Policy Unit had identified a need to deconstruct Policy 2055 into a number of more targeted policies. The unit put this work on hold during the period of the audit in order to ensure the final product would be responsive to the audit findings. The policy 2040 PREA General Provisions was created with information extracted from policy 2055 and revised to include as section VIII a statement on the protection of information related to sexual victimization or abusiveness to be limited to use by staff as necessary for treatment, security, and management decisions.

Upon auditor follow-up it was revealed that newly created policy 2131 – Proactive Safety Screening and Planning was fully implemented on February 16, 2022 (within the requisite time frame). Section II(C) is responsive to the corrective action for provisions (a) and (b) of this standard insomuch as it requires a follow-up clinical appointment within 14-calendar days if a youth indicates the "youth has experienced prior sexual victimization or previously perpetrated sexual abuse." The audited facility indicated that there were no examples to provide since the implementation of this policy. Furthermore, the facility adequately addressed Corrective Action #3 for provision (c) of this standard as safeguards/limitations have been placed on who can access this information on YouthCenter.

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency has evidenced compliance with this standard after a period of corrective action.

115.382	Access to emergency medical and mental health services
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	115.382: Access to emergency medical and mental health services. The following evidence was analyzed in making the compliance determination: 1. Documents: (Policies, directives, forms, files, records, etc.) a. Sununu Youth Services Center Pre-Audit Questionnaire (PAQ) responses b. Sexual Assault and Sexual Harassment Policy 2055 (effective August 2017) c. Medical/Clinical Response to PREA Policy 2180 (effective May 2020) 2. Interviews a. Medical and Mental Health Staff b. Residents who Reported a Sexual Abuse c. Security Staff and Non-Security Staff First Responders 3. Site Review Observations: a. Observations during on-site review of physical plant Findings (By Provision): 115.382(a)-(d): During the pre-onsite portion of the facility indicated compliance in its PAQ responses and provided this auditor with applicable facility policies and protocols. During the onsite portion of this audit this auditor interviewed staff and/or residents (as outlined above) having first-hand knowledge as to operations and practices within the facility as it pertains to this provision. All interviewees corroborated those practices within the facility adhere to the procedures previously provided to the auditor. Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is compliant with this provision.

115.383	Ongoing medical and mental health care for sexual abuse victims and abusers
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	115.383: Ongoing medical and mental health care for sexual abuse victims and abusers. The following evidence was analyzed in making the compliance determination: 1. Documents: (Policies, directives, forms, files, records, etc.) a. Sununu Youth Services Center Pre-Audit Questionnaire (PAQ) responses b. Medical/Clinical Response to PREA Policy 2180 (effective May 2020) 2. Interviews a. Medical and Mental Health Staff b. Residents who Reported a Sexual Abuse 3. Site Review Observations: a. Observations during on-site review of physical plant Findings (By Provision): 115.383(a)-(h): During the pre-onsite portion of the facility indicated compliance in its PAQ responses and provided this auditor with applicable facility policies and protocols. During the onsite portion of this audit this auditor interviewed staff and/or residents (as outlined above) having first-hand knowledge as to operations and practices within the facility as it pertains to this/these provision(s). All interviewees corroborated those practices within the facility adhere to the procedures previously provided to the auditor. Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is compliant with this provision.

115.386	Sexual abuse incident reviews
	Auditor Overall Determination: Meets Standard
	Auditor Discussion

115.386: Sexual abuse incident reviews.

The following evidence was analyzed in making the compliance determination:

1. Documents: (Policies, directives, forms, files, records, etc.)

a. SYSC Pre-Audit Questionnaire (PAQ) responses

b. Data Collection and Review for PREA Policy 2375 (effective June 2014)

c. Form 2196 PREA Case Review Protocol

d. Form 2096 Investigation for Sexual Abuse, Assault and Harassment

e. Documentation of criminal and administrative investigations for sexual abuse and sexual harassment

f. PREA Case Review Documentation

g. PREA Case Review Protocol (February 2022 Edition)

h. NH DCYF Defined Terms R-S (February 2022)

i. PREA Allegations Tracking Sheet

2. Interviews

a. Facility Director of Designee

b. Incident Review Team Member

c. PREA Compliance Manager

3. Site Review Observations:

a. Observations during on-site review of physical plant

Findings (By Provision):

115.386(a)-(b):

During the pre-onsite portion of this audit, the Facility indicated compliance with this provision and provided this auditor with Policy P-2375: Data Collection and Review for PREA. Section I(D) establishes, “DCYF shall maintain, review, and collect data as needed from all available incident-based documents, including reports, investigation files, and sexual abuse incident reviews” (p. 2). The Facility also provided master copies of Investigative forms and PREA Review forms in addition to the SYSC’s PREA Case Review Protocol, which “outlines procedures to ensure victim confidentiality, to conduct a case review meeting, and to choose an appropriate review format” (p. 1). The Facility indicated in its PAQ that over the past 12 months, there were no criminal and/or administrative investigations of alleged sexual abuse completed at the facility, excluding only "unfounded" incidents. While onsite there was on incident occurring just outside the previously requested 12-month period (occurring 10/31/2019) and five incidents occurring after the 12-month period but prior to the onsite portion of this audit (three of which were either unfounded or screened out). There were no criminal investigations for allegations occurring within the past 12-month period that was brought to this auditor’s attention during this audit process.

During the onsite portion of this audit, this auditor review documentation of completed a total of six administrative investigation reviews for sexual abuse allegations while onsite (all incidents that were identified pursuant to the PREA Auditor Handbook). An additional 10 reviews were conducted on sexual harassment investigative files. Excluding unfounded incidents, no sexual abuse incident reviews were evidenced to have been completed. Furthermore, in review of the sexual harassment incident reviews, five reviews were either not completed or not completed within 30 days following completion of the investigation (ranging from five weeks to three months following the investigation).

Based upon the review and analysis of all the available evidence, and following a period of corrective action, the auditor has determined that the agency is fully compliant with this provision. Please see the below "Final Audit Report Reassessment" for review.

115.386(c)-(e):

During the pre-onsite portion of the facility indicated compliance in its PAQ responses and provided this auditor with applicable facility policies and protocols.

During the onsite portion of this audit this auditor interviewed staff and/or residents (as outlined above) having first-hand knowledge as to operations and practices within the facility as it pertains to this provision. All interviewees corroborated those practices within the facility adhere to the procedures previously provided to the auditor.

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is compliant with this provision.

Corrective Action Needed:

Develop protocol that allows the facility to demonstrate that it conducts a sexual abuse incident review within 30 days of the conclusion of the criminal or administrative sexual abuse investigation.

Recommendations:

1. Amend Form 2196F to expand review of "sexual orientation" to include 115.386(d) required language ("gender identity; lesbian, gay, bisexual, transgender, or intersex identification, status")

Final Audit Report Reassessment:

During the post-onsite audit portion of this audit, the auditor identified that the agency was not fully compliant with provisions (a) and (b) of this standard. The Agency provided the auditor with "SYSC PREA Audit Corrective Action Specific Findings" on February 18, 2022. Follow-up information and evidence was provided to the auditor on March 25, 2022. The Agency developed the following corrective action plan with respect to this provision:

AGENCY'S CORRECTIVE ACTION:

115.386 Corrective Action #1: Form 2196 PREA Case Review Protocol (at pgs. 1 & 3) includes the requirement that all sexual abuse incident reviews must be initiated within 30 days of the completion of the criminal or administrative investigation. To this extent, the PREA Compliance Manager will track these investigations through the attached PREA Allegations Tracking Sheet. This tracking sheet allows the agency the ability to record when a criminal or administrative investigation has been completed by the New Hampshire State Police or the agency's Special Investigations Unit and allows SYSC to ensure its incident reviews and the accompanying reports are conducted within the 30-day required time frame.

The SYSC Quality Assurance Incident Review (SQAIR) panel is a meeting of internally involved facility staff and external oversight & facilitation provided by the Bureau of Evaluation, Analytics and Reporting to review and critique all incidents involving the use of RSA 126-U reportable restraint and seclusion, to ensure best practice is consistently upheld, and provide feedback that will influence improvements in future practice.

Moving forward, all incidents of alleged sexual abuse, and a random selection of alleged sexual harassment and alleged sexual misconduct incidents will be incorporated into the SQAIR meeting process, and afforded the same protections as all current DCYF quality assurance review practices.

As part of the audit, it was noted that six instances of "sexual abuse" were misidentified as "sexual harassment," thus not triggering a sexual abuse incident review.

	In an effort to alleviate any confusion regarding the definitions of “sexual abuse” and “sexual harassment,” the agency had updated its glossary at section R-S (pages 7-9) to align with PREA definitions of sexual abuse and sexual harassment. All SYSC PREA Investigators will complete two online PREA investigator trainings offered through the National Institute of Corrections. The first training, entitled “Investigating Sexual Abuse in a Confinement Setting” is a two-hour training designed to assist agencies in meeting the requirements of Prison Rape Elimination Act (PREA) Specialized Training for Investigators. The second online training all SYSC Investigators are required to take is the 3 hour “Investigating Sexual Abuse in a Confinement Setting: Advanced Investigations.” These six investigations identified by the auditor as having been misidentified will be pulled and re-analyzed by the PREA Incident Review Team within 60 days after all SYSC PREA Investigators have completed the National Institute of Corrections PREA Investigator Training. This review will be facilitated by the SYSC PREA Compliance Manger and the PREA Incident Review Team. 115.386 (d), Recommendation 1: Form 2196 (page 4) has been updated to include the required language regarding “gender identity; lesbian, gay, bisexual, transgender, or intersex identification, status.” A review of NH DCYF Defined Terms reveals that the aforementioned terms of sexual abuse, sexual harassment, and sexual misconduct has been incorporated into this policy directive. Further, the facility has substantively revised the PREA Case Review Protocol as outline above. Lastly, the facility provided this auditor with a master tracking sheet to be used for future incident reviews to ensure ongoing compliance. This auditor finds the above-referenced corrective action and supporting documentation adequately addresses the concerns previously raised. Based upon the review and analysis of all the available evidence, the auditor has determined that the agency has evidenced compliance with this standard after a period of corrective action.

115.387	Data collection
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	115.387: Data collection. The following evidence was analyzed in making the compliance determination: 1. Documents: (Policies, directives, forms, files, records, etc.) a. SYSC Pre-Audit Questionnaire (PAQ) responses b. Data Collection and Review for PREA Policy 2375 (effective June 2014) 2. Interviews a. PREA Coordinator b. Facility Director 3. Site Review Observations: a. Observations during on-site review of physical plant Findings (By Provision): 115.387(a)-(f): During the pre-onsite portion of the facility indicated compliance in its PAQ responses and provided this auditor with applicable facility policies and protocols. During the onsite portion of this audit this auditor interviewed staff and/or residents (as outlined above) having first-hand knowledge as to operations and practices within the facility as it pertains to this provision. All interviewees corroborated those practices within the facility adhere to the procedures previously provided to the auditor. Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is compliant with this provision.

115.388	Data review for corrective action
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	115.388: Data review for corrective action. The following evidence was analyzed in making the compliance determination: 1. Documents: (Policies, directives, forms, files, records, etc.) a. SYSC Pre-Audit Questionnaire (PAQ) responses b. Data Collection and Review for PREA Policy 2375 (effective June 2014) c. PREA 2020 Annual Report d. PREA 2019 Annual Report e. Agency website (https://www.dhhs.nh.gov/djjs/institutional/prea.htm) 2. Interviews a. PREA Coordinator b. Agency Head 3. Site Review Observations: a. Observations during on-site review of physical plant Findings (By Provision): 115.388(a)-(d): During the pre-onsite portion of the facility indicated compliance in its PAQ responses and provided this auditor with applicable facility policies and protocols. During the onsite portion of this audit this auditor interviewed staff and/or residents (as outlined above) having first-hand knowledge as to operations and practices within the facility as it pertains to this provision. All interviewees corroborated those practices within the facility adhere to the procedures previously provided to the auditor. Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is compliant with this provision.

115.389	Data storage, publication, and destruction
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	115.389: Data storage, publication, and destruction. The following evidence was analyzed in making the compliance determination: 1. Documents: (Policies, directives, forms, files, records, etc.) a. SYSC Pre-Audit Questionnaire (PAQ) responses b. Data Collection and Review for PREA Policy 2375 (effective June 2014) c. PREA 2020 Annual Report d. PREA 2019 Annual Report e. Agency website (https://www.dhhs.nh.gov/djjs/institutional/prea.htm) f. Historical data since August 20, 2012 2. Interviews a. PREA Coordinator 3. Site Review Observations: a. Observations during on-site review of physical plant Findings (By Provision): 115.389(a): During the pre-onsite portion of the facility indicated compliance in its PAQ responses and provided this auditor with applicable facility policies and protocols. During the onsite portion of this audit this auditor interviewed staff and/or residents (as outlined above) having first-hand knowledge as to operations and practices within the facility as it pertains to this provision. All interviewees corroborated those practices within the facility adhere to the procedures previously provided to the auditor. Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is compliant with this provision. 115.389(b): During the pre-onsite portion of this audit, the Facility indicated compliance with this provision and reported that agency policy requires that aggregated sexual abuse data from facilities under its direct control . . . be made readily available to the public at least annually through its website. The facility reported its website to be https://www.dhhs.nh.gov/djjs/institutional/prea.htm. A review of this website reveals that it contains a link to SYSC's Annual PREA Reports, as well as PREA audit reports that contain aggregated sexual abuse data and pertinent policies and procedures, and informational notices. Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is compliant with this provision.

115.389(c):

During the pre-onsite portion of this audit, the Facility indicated compliance with this provision and indicated that before making aggregated sexual abuse data publicly available, the agency removes all personal identifiers. A review of the agency's website (https://www.dhhs.nh.gov/djjs/institutional/prea.htm) and the annual reports publicly available, this auditor was able to confirm that personal identifiers have been removed.

During the onsite portion of the audit, this auditor interviewed the PREA Coordinator. The PREA Coordinator reported that only personal identifying information (PII) is not included and/or redacted from the annual report.

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is compliant with this provision.

115.389(d):

During the pre-onsite portion of the facility indicated compliance in its PAQ responses and provided this auditor with applicable facility policies and protocols.

During the onsite portion of this audit this auditor interviewed staff and/or residents (as outlined above) having first-hand knowledge as to operations and practices within the facility as it pertains to this provision. All interviewees corroborated those practices within the facility adhere to the procedures previously provided to the auditor.

Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is compliant with this provision.

115.401	Frequency and scope of audits
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	115.401: Frequency and scope of audits. The following evidence was analyzed in making the compliance determination: 1. Documents: (Policies, directives, forms, files, records, etc.) a. Agency Website: https://www.dhhs.nh.gov/djjs/institutional/prea.htm b. Prior PREA Audit Reports 2. Pre/Onsite/Post-Audit Observations a. General observations during the audit process Findings (By Provision): 115.401(a)-(b): A review of the agency's website and prior Final Audit Reports revealed that the agency has only one confinement facility. This Facility was last audited on April 25, 2018 (date of Final Audit Report). Due to the global COVID-29 Pandemic and related state protocols to prevent the spread of COVID-19, the onsite portion of this audit was unable to be scheduled until June 15, 2021, a date schedule after this auditor obtained his full vaccination. Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is fully compliant with this provision. SYSC is the only confinement facility this Agency has. The Agency made every effort to conduct the Audit within the requisite 3-year timeframe however the COVID-19 pandemic prevented its timely completion. 115.401(h): During the onsite portion of this audit, this auditor had access to, and the ability to observe, all areas of the audited facility. The facility provided this auditor with unfettered access to the facility and its staff and residents. Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is fully compliant with this provision. 115.401(i): During the pre-audit, onsite, and post-onsite portion of this audit this auditor was permitted to request and received copies of any relevant documents that this auditor requested, including but not limited to: facility logs, resident files, personnel files, policy and procedure manuals, postings, resident handbooks, intake and classification documents, etc. Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is fully compliant with this provision. 115.401(m): During the onsite portion of this audit this auditor was permitted to conduct private interviews with residents and staff at

	various locations throughout the facility. The rooms chosen were confirmed to not have video or voice recording capabilities. Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is fully compliant with this provision. 115.401(n): During the pre-audit potion of this audit residents were permitted to send confidential information or correspondence to the auditor in the same manner as if they were communicating with legal counsel. While onsite this auditor asked all residents interviewed whether they were made aware of and saw this auditor's notices that were displayed throughout the facility. All residents interviewed informed this auditor that the postings have been displayed for quite some time. Additionally, the residents informed me that staff at the facility provide envelopes and stamps free of charge and that outgoing mail is not screened. This auditor also interviewed a direct care staff that was responsible for resident mail. This staff person reported that the residents can have access to envelopes and stamps free of charge and that any outgoing mail is left in an outgoing mail box for a United States Postal Services carrier to collect the next business day. This staff person informed this auditor that outgoing mail is not screen and any letters to this auditor would have been treated the same way. Based upon the review and analysis of all the available evidence, the auditor has determined that the agency is fully compliant with this provision.

115.403	Audit contents and findings
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	115.403: Audit contents and findings. The following evidence was analyzed in making the compliance determination: 1. Documents: (Policies, directives, forms, files, records, etc.) a. Agency Website: https://www.dhhs.nh.gov/djjs/institutional/prea.htm b. Prior PREA Audit Reports 2. Interviews a. PREA Coordinator Findings (By Provision): 115.403(f): A review of the Agency's website reveals that all three Final Audit Reports were posted to its website. SYSC has an agency website (https://www.dhhs.nh.gov/djjs/institutional/prea.htm), which has a page dedicated to the posting or PREA-related information. This Facility was last audited on April 25, 2018 (date of Final Audit Report). Due to the global COVID-29 Pandemic and related state protocols to prevent the spread of COVID-19, the onsite portion of this audit was unable to be scheduled until June 15, 2021, a date schedule after this auditor obtained his full vaccination. Prior to the 2018 audit, the Facility was last audited on August 30, 2014. The onsite date of the audit preceding this current audit was October 25, 2017. Although not within three years of the Facility's first PREA audit, the previous auditor found the Facility in compliance with this standard. This auditor is tasked with determining compliance with respect to the current audit cycle. As outline above, forces outside the Agency's control prevented the completion of the audit within three years of the 2018 audit report. Based upon the review and analysis of all the available evidence (as stated above), the auditor has determined that the agency is fully compliant with this provision.

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.)	yes
	Does the PREA compliance manager have sufficient time and authority to coordinate the facility's efforts to comply with the PREA standards? (N/A if agency operates only one facility.)	yes
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 staffing levels and determining the need for video monitoring: Any findings of inadequacy from internal or external oversight bodies?	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: 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?	no
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 functions of the facility? (N/A for non-secure facilities)	yes
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?	no
	Does the facility require staff of the opposite gender to announce their presence when entering a resident housing unit?	no
	In facilities (such as group homes) that do not contain discrete housing units, does the facility require staff of the opposite gender to announce their presence when entering an area where residents are likely to be showering, performing bodily functions, or changing clothing? (N/A for facilities with discrete housing units)	na
115.315 (e)	**Limits to cross-gender viewing and searches**	
	Does the facility always refrain from searching or physically examining transgender or intersex residents for the sole purpose of determining the resident's genital status?	yes
	If a resident's genital status is unknown, does the facility determine genital status during conversations with the resident, by reviewing medical records, or, if necessary, by learning that information as part of a broader medical examination conducted in private by a medical practitioner?	yes
115.315 (f)	**Limits to cross-gender viewing and searches**	
	Does the facility/agency train security staff in how to conduct cross-gender pat down searches in a professional and respectful manner, and in the least intrusive manner possible, consistent with security needs?	yes
	Does the facility/agency train security staff in how to conduct searches of transgender and intersex residents in a professional and respectful manner, and in the least intrusive manner possible, consistent with security needs?	yes

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)?	no
	Does the agency prohibit the hiring or promotion of anyone who may have contact with residents who: Has been convicted of engaging or attempting to engage in sexual activity in the community facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse?	no
	Does the agency prohibit the hiring or promotion of anyone who may have contact with residents who: Has been civilly or administratively adjudicated to have engaged in the activity described in the bullet immediately above?	no
	Does the agency prohibit the enlistment of services of any contractor who may have contact with residents who: Has engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility, or other institution (as defined in 42 U.S.C. 1997)?	no
	Does the agency prohibit the enlistment of services of any contractor who may have contact with residents who: Has been convicted of engaging or attempting to engage in sexual activity in the community facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse?	no
	Does the agency prohibit the enlistment of services of any contractor who may have contact with residents who: Has been civilly or administratively adjudicated to have engaged in the activity described in the two bullets immediately above?	no
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?	no
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?	no
	Before hiring new employees who may have contact with residents, does the agency: Consult any child abuse registry maintained by the State or locality in which the employee would work?	no
	Before hiring new employees who may have contact with residents, does the agency: Consistent with Federal, State, and local law, make its best efforts to contact all prior institutional employers for information on substantiated allegations of sexual abuse or any resignation during a pending investigation of an allegation of sexual abuse?	no
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?	no
	Does the agency consult applicable child abuse registries before enlisting the services of any contractor who may have contact with residents?	no

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?	no
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?	no
	Does the agency ask all applicants and employees who may have contact with residents directly about previous misconduct described in paragraph (a) of this section in any interviews or written self-evaluations conducted as part of reviews of current employees?	no
	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.)	no
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.)	na
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.)	no

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 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.)	no
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?	no
	If a rape crisis center is not available to provide victim advocate services, does the agency make available to provide these services a qualified staff member from a community-based organization, or a qualified agency staff member?	no
	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 interviews?	no
	As requested by the victim, does this person provide emotional support, crisis intervention, information, and referrals?	no
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 not 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 (c)	**Policies to ensure referrals of allegations for investigations**	
	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
	Does the agency train all employees who may have contact with residents on: How to communicate effectively and professionally with residents, including lesbian, gay, bisexual, transgender, intersex, or gender nonconforming residents?	yes
	Does the agency train all employees who may have contact with residents on: How to comply with relevant laws related to mandatory reporting of sexual abuse to outside authorities?	yes
	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?	no
	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?	no
	Within 10 days of intake, does the agency provide age-appropriate comprehensive education to residents either in person or through video regarding: Their rights to be free from retaliation for reporting such incidents?	no
	Within 10 days of intake, does the agency provide age-appropriate comprehensive education to residents either in person or through video regarding: Agency policies and procedures for responding to such incidents?	no
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 (b)	**Specialized training: Investigations**	
	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 (a)	**Obtaining information from residents**	
	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?	no
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?	no
	During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Any gender nonconforming appearance or manner or identification as lesbian, gay, bisexual, transgender, or intersex, and whether the resident may therefore be vulnerable to sexual abuse?	no
	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 the agency attempt to ascertain information about: Physical disabilities?	yes
	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**	
	Does the agency always refrain from placing: Lesbian, gay, and bisexual residents in particular housing, bed, or other assignments solely on the basis of such identification or status?	yes
	Does the agency always refrain from placing: Transgender residents in particular housing, bed, or other assignments solely on the basis of such identification or status?	yes
	Does the agency always refrain from placing: Intersex residents in particular housing, bed, or other assignments solely on the basis of such identification or status?	yes
	Does the agency always refrain from considering lesbian, gay, bisexual, transgender, or intersex identification or status as an indicator or likelihood of being sexually abusive?	yes
115.342 (d)	**Placement of residents**	
	When deciding whether to assign a transgender or intersex resident to a facility for male or female residents, does the agency consider on a case-by-case basis whether a placement would ensure the resident's health and safety, and whether a placement would present management or security problems (NOTE: if an agency by policy or practice assigns residents to a male or female facility on the basis of anatomy alone, that agency is not in compliance with this standard)?	yes
	When making housing or other program assignments for transgender or intersex residents, does the agency consider on a case-by-case basis whether a placement would ensure the resident's health and safety, and whether a placement would present management or security problems?	yes
115.342 (e)	**Placement of residents**	
	Are placement and programming assignments for each transgender or intersex resident reassessed at least twice each year to review any threats to safety experienced by the resident?	yes
115.342 (f)	**Placement of residents**	
	Are each transgender or intersex resident's own views with respect to his or her own safety given serious consideration when making facility and housing placement decisions and programming assignments?	yes
115.342 (g)	**Placement of residents**	
	Are transgender and intersex residents given the opportunity to shower separately from other residents?	yes
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?	no
	Is that private entity or office able to receive and immediately forward resident reports of sexual abuse and sexual harassment to agency officials?	no
	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?	no
	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.	yes
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.)	na
	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.)	na

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.)	na
	Does the agency ensure that: Such grievance is not referred to a staff member who is the subject of the complaint? (N/A if agency is exempt from this standard.)	na
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.)	na
	If the agency determines that the 90 day timeframe is insufficient to make an appropriate decision and claims an extension of time (the maximum allowable extension of time to respond is 70 days per 115.352(d)(3)) , does the agency notify the resident in writing of any such extension and provide a date by which a decision will be made? (N/A if agency is exempt from this standard.)	na
	At any level of the administrative process, including the final level, if the resident does not receive a response within the time allotted for reply, including any properly noticed extension, may a resident consider the absence of a response to be a denial at that level? (N/A if agency is exempt from this standard.)	na
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.)	na
	Are those third parties also permitted to file such requests on behalf of residents? (If a third party, other than a parent or legal guardian, files such a request on behalf of a resident, the facility may require as a condition of processing the request that the alleged victim agree to have the request filed on his or her behalf, and may also require the alleged victim to personally pursue any subsequent steps in the administrative remedy process.) (N/A if agency is exempt from this standard.)	na
	If the resident declines to have the request processed on his or her behalf, does the agency document the resident's decision? (N/A if agency is exempt from this standard.)	na
	Is a parent or legal guardian of a juvenile allowed to file a grievance regarding allegations of sexual abuse, including appeals, on behalf of such juvenile? (N/A if agency is exempt from this standard.)	na
	If a parent or legal guardian of a juvenile files a grievance (or an appeal) on behalf of a juvenile regarding allegations of sexual abuse, is it the case that those grievances are not conditioned upon the juvenile agreeing to have the request filed on his or her behalf? (N/A if agency is exempt from this standard.)	na

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.)	na
	After receiving an emergency grievance alleging a resident is subject to a substantial risk of imminent sexual abuse, does the agency immediately forward the grievance (or any portion thereof that alleges the substantial risk of imminent sexual abuse) to a level of review at which immediate corrective action may be taken? (N/A if agency is exempt from this standard.)	na
	After receiving an emergency grievance described above, does the agency provide an initial response within 48 hours? (N/A if agency is exempt from this standard.)	na
	After receiving an emergency grievance described above, does the agency issue a final agency decision within 5 calendar days? (N/A if agency is exempt from this standard.)	na
	Does the initial response and final agency decision document the agency's determination whether the resident is in substantial risk of imminent sexual abuse? (N/A if agency is exempt from this standard.)	na
	Does the initial response document the agency's action(s) taken in response to the emergency grievance? (N/A if agency is exempt from this standard.)	na
	Does the agency's final decision document the agency's action(s) taken in response to the emergency grievance? (N/A if agency is exempt from this standard.)	na
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.)	na
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?	no
	Does the facility provide persons detained solely for civil immigration purposes mailing addresses and telephone numbers, including toll-free hotline numbers where available of local, State, or national immigrant services agencies?	no
	Does the facility enable reasonable communication between residents and these organizations and agencies, in as confidential a manner as possible?	no
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?	no
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 system, does the facility head or his or her designee promptly report the allegation to the alleged victim's caseworker instead of the parents or legal guardians? (N/A if the alleged victim is not under the guardianship of the child welfare system.)	yes
	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?	yes
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 is alleged to have suffered sexual abuse subject to the requirements of § 115.342?	yes
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 prosecution?	yes
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?	no
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 harassment policies?	yes
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 take appropriate remedial measures, and consider whether to prohibit further contact with residents?	yes
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 for the abuse, does the facility consider whether to offer the offending resident participation in such interventions?	no
	If the agency requires participation in such interventions as a condition of access to any rewards-based behavior management system or other behavior-based incentives, does it always refrain from requiring such participation as a condition to accessing general programming or education?	yes
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 (d)	**Access to emergency medical and mental health services**	
	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
	Does the review team: Consider whether the incident or allegation was motivated by race; ethnicity; gender identity; lesbian, gay, bisexual, transgender, or intersex identification, status, or perceived status; gang affiliation; or other group dynamics at the facility?	yes
	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 the confinement of its residents.)	na
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.)	na
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 publication would present a clear and specific threat to the safety and security of a facility?	yes
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