PREA Facility Audit Report: Final

Name of Facility: Minnesota Correctional Facility Red Wing (Juvenile)
Facility Type: Juvenile
Date Interim Report Submitted: 06/15/2024
Date Final Report Submitted: 10/17/2024

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: Sharon R. Shaver	**Date of Signature:** 10/17/2024

AUDITOR INFORMATION	
Auditor name:	Shaver, Sharon
Email:	sharonrshaver@gmail.com
Start Date of On-Site Audit:	04/23/2024
End Date of On-Site Audit:	04/26/2024

FACILITY INFORMATION	
Facility name:	Minnesota Correctional Facility Red Wing (Juvenile)
Facility physical address:	1079 Highway 292, Red Wing, Minnesota - 55066
Facility mailing address:	

Primary Contact

Name:	Stephanie Huppert
Email Address:	stephanie.huppert@state.mn.us
Telephone Number:	651-267-3617

Superintendent/Director/Administrator	
Name:	Shon Thieren
Email Address:	shon.thieren@state.mn.us
Telephone Number:	651-267-3686

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

Facility Health Service Administrator On-Site	
Name:	Kelly Classen
Email Address:	kelly.classen@state.mn.us
Telephone Number:	651-267-3684

Facility Characteristics	
Designed facility capacity:	80
Current population of facility:	72
Average daily population for the past 12 months:	72
Has the facility been over capacity at any point in the past 12 months?	No
Which population(s) does the facility hold?	Males

Age range of population:	13-20
Facility security levels/resident custody levels:	Juvenile Custody
Number of staff currently employed at the facility who may have contact with residents:	189
Number of individual contractors who have contact with residents, currently authorized to enter the facility:	0
Number of volunteers who have contact with residents, currently authorized to enter the facility:	32

AGENCY INFORMATION	
Name of agency:	Minnesota Department of Corrections
Governing authority or parent agency (if applicable):	State of MN
Physical Address:	1450 Energy Park Drive, Suite 200, Saint Paul, Minnesota - 55108
Mailing Address:	
Telephone number:	6123283582

Agency Chief Executive Officer Information:	
Name:	Paul Schnell
Email Address:	Paul.Schnell@state.mn.us
Telephone Number:	651-361-7226

Agency-Wide PREA Coordinator Information			
Name:	Diana Magaard	**Email Address:**	diana.magaard@state.mn.us

Facility AUDIT FINDINGS

Summary of Audit Findings

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

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

Number of standards exceeded:	
10	• 115.313 - Supervision and monitoring • 115.315 - Limits to cross-gender viewing and searches • 115.318 - Upgrades to facilities and technologies • 115.321 - Evidence protocol and forensic medical examinations • 115.333 - Resident education • 115.341 - Obtaining information from residents • 115.353 - Resident access to outside confidential support services and legal representation • 115.365 - Coordinated response • 115.373 - Reporting to residents • 115.381 - Medical and mental health screenings; history of sexual abuse
Number of standards met:	
33	
Number of standards not met:	
0	

POST-AUDIT REPORTING INFORMATION

GENERAL AUDIT INFORMATION

On-site Audit Dates

1. Start date of the onsite portion of the audit:	2024-04-23
2. End date of the onsite portion of the audit:	2024-04-26

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:	Mayo Clinic-St. Mary's (FME); Hope Coalition; Just Detention International; RAINN (through resident phone test).

AUDITED FACILITY INFORMATION

14. Designated facility capacity:	88
15. Average daily population for the past 12 months:	72
16. Number of inmate/resident/detainee housing units:	6
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:	72
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:	1
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:	43
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:	0
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:	5

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:	1
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:	2
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:	0
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):	The facility had no residents assigned during the audit who identified as transgender or intersex, who were LEP, or who had a vision or hearing disability.
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:	189
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:	11

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:	81
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:	Red Wing Juvenile Facility has shared staff services with Red Wing Adult Facility co-located on the same campus.

INTERVIEWS

Inmate/Resident/Detainee Interviews

Random Inmate/Resident/Detainee Interviews

53. Enter the total number of RANDOM INMATES/RESIDENTS/DETAINEES who were interviewed:	9
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?	The auditor selected all targeted interviewees first and then identified their housing units. Once the number of individuals already selected were categorized by their housing units, then the auditor selected the remaining random individuals from each of the housing units according to factors such as age, race, ethnicity, length of time in the facility, programming, and work assignments to ensure a balanced representative number of interviewees from each of the living units.
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):	On the first day of arrival there were (72) residents assigned to Red Wing Juvenile Facility based on a housing roster printed for the auditor. The auditor requested the facility provide lists of residents who met certain targeted categories based on the auditor's guide for interviewing inmates.
Targeted Inmate/Resident/Detainee Interviews	
58. Enter the total number of TARGETED INMATES/RESIDENTS/DETAINEES who were interviewed:	8

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".

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:	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).	Interviews with staff indicated there were no residents at the facility who met the criteria for this targeted category. The auditor observed residents while on the housing units, during meals, during recreation, and on work details and observed nothing that would indicate otherwise. The auditor further corroborated this during interviews with the HSA and Psychological Services Director.
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:	5
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).	Interviews with staff indicated there were no residents at the facility who met the criteria for this targeted category. The auditor observed residents while on the housing units, during meals, during recreation, and on work details and observed nothing that would indicate otherwise. The auditor further corroborated this during interviews with the HSA and Psychological Services Director.
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).	Interviews with staff indicated there were no residents at the facility who met the criteria for this targeted category. The auditor observed residents while on the housing units, during meals, during recreation, and on work details and observed nothing that would indicate otherwise. The auditor further corroborated this during interviews with the HSA and Psychological Services Director.

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:	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).	Interviews with staff indicated there were no residents at the facility who met the criteria for this targeted category. The auditor observed residents while on the housing units, during meals, during recreation, and on work details and observed nothing that would indicate otherwise. The auditor further corroborated this during interviews with the HSA and Psychological Services Director.
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:	2
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).	Interviews with staff indicated there were no residents at the facility who met the criteria for this targeted category. The auditor observed residents while on the housing units, during meals, during recreation, and on work details and observed nothing that would indicate otherwise. The auditor further corroborated this during interviews with the HSA and Psychological Services Director.
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:	1
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:	3
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:	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).	Interviews with staff indicated there were no residents at the facility who met the criteria for this targeted category. The auditor's interviews with staff, review of investigative case files and review of screening documentation supported there were no residents placed in segregated housing for risk of sexual victimization.
70. Provide any additional comments regarding selecting or interviewing targeted inmates/residents/detainees (e.g., any populations you oversampled, barriers to completing interviews):	The facility had (72) residents assigned on the first day of the audit and the auditor was required to interview at least (8) residents from these targeted categories (1-physical/ visual/hearing/cognitive disability or LEP; 1-LGB; 1-transgender/intersex; 1-in isolation; 2-reported sexual abuse in facility; 2-disclosed prior sexual victimization during screening). As the facility had no residents who met the targeted categories of hearing/ visual disability, LEP, transgender/intersex, isolation, and only (1) who reported an allegation at the facility, the auditor oversampled from the population with residents who had disclosed prior sexual victimization during screening, those with cognitive disability, and LGB to meet the minimum required targeted interviews.
Staff, Volunteer, and Contractor Interviews	
Random Staff Interviews	
71. Enter the total number of RANDOM STAFF who were interviewed:	33

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 auditor met no barriers to ensuring representation of staff. The auditor selected staff randomly from the employee list and shift rosters as well as from personal encounters while on the site inspection. The auditor oversampled random interviews because Red Wing-Adult Facility and Red Wing-Juvenile Facility share the same campus, services, and staff. All staff selected willingly participated in the interviews with the auditor.
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):	24
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:	Training Director; Chaplain/Volunteer Coordinator; Principal; Teacher; MNDOC Advocate Services Coordinator.
81. Did you interview VOLUNTEERS who may have contact with inmates/ residents/detainees in this facility?	◉ Yes ○ No
a. Enter the total number of VOLUNTEERS who were interviewed:	1
b. Select which specialized VOLUNTEER role(s) were interviewed as part of this audit from the list below: (select all that apply)	☐ Education/programming ☐ Medical/dental ☐ Mental health/counseling ☑ Religious ☐ Other
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.	Some of the specialized staff interviewed hold responsibilities for multiple roles. While 24 individual staff members were interviewed, 28 specialized questionnaires were administered. The auditor oversampled specialized staff to cover audits at both Red Wing Adult Facility and Red Wing Juvenile Facility since they share services, campus and staff.

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 Prison Rape Elimination Act (PREA) site review of the Minnesota Correctional Facility Red Wing (MCF-RW) was conducted April 21-23, 2024, by Sharon Ray Shaver, a Department of Justice (DOJ) certified PREA Auditor. This facility was audited through a contractual agreement between the Minnesota Department of Corrections (MN DOC) and Correctional Management & Communications Group, LLC (CMCG). This is the fourth PREA audit for MCF-RW Juvenile Facility. MCF-RW is located at 1079 Highway 292, Red Wing in Goodhue County, Minnesota. MCF-RW Juvenile is a juvenile residential facility operated by the Department of Corrections (DOC). Constructed in 1889, the physical plant of the facility consists of 30 buildings set within a perimeter fence that includes five general population living units and a secured unit. The facility's licensed bed space capacity is 88. Each general population living unit can house 16-24 residents and the secured unit can house 30 residents. The secured unit serves as the facility's intake unit and discipline unit, as well as providing secure detention bed space for counties. Other buildings include a school, main kitchen, administration building, and a variety of maintenance and storage buildings. Resident ages range from 14-20. The facility also has a garden where 75% of the produce is donated to the area food shelf, and the rest is used at the facility. Medical and mental health services are provided onsite, and the sexual assault forensic medical exams are conducted at Mayo Clinic-St. Mary's in Rochester, MN. Residents are allowed to correspond with anyone by mail unless prohibited/directed by the court. Interviews with residents indicated that they were aware of the PREA audit and had seen the notices posted on their housing units where they could correspond with the auditor. The auditor was advised that the facility runs three shifts (2140-0610/1st Watch; 0600-1400/2nd Watch; 1350-2150/3rd Watch). There are six formal counts and one standing ID count per day, and the auditor

was provided with those times. Residents are assigned housing in one of five living units, Stanford, Grinnell, Harvard, Yale, and Princeton. Yale, and Princeton are cottage-style units, and Stanford, Harvard, and Grinnell are dormitory-style. Dayton is the Juvenile Security/Intake Unit and is a secure single-cell unit operated from a central control unit and equipped with its own mini-gymnasium. MCF-RW also has one adult living unit (Knox), but it is operated as a separate unit and is separated from sight and sound of the residents housed in the juvenile facility. Visitation occurs in Centennial Hall, and the School, Gym, and Health Services are housed in one building. Duke is a juvenile service area that houses a full complement of exercise and fitness equipment for resident use, activity, and physical education offices, and the chapel. The mission of MCF-RW Juvenile is to encourage the development of healthy living and social
skills and prepare youth to re-enter the community with appropriate community resources to maintain a healthy and pro-social lifestyle. The facility complies with Children's Residential Facility (CRF) licensing standards (Minnesota Rule 2960) and participates in Performance-based Standards (PbS) to ensure programs and services are rooted in nationally recognized evidence-based practices for youth. The following services are provided by facility staff and available to residents as identified by assessment results and treatment goals: Aggression Replacement Training®; The Phoenix Curriculum; Peer Relationships; Trauma and Grief Component Therapy for Adolescents (TGCTA); Individual recreation/leisure planning; Mental health counseling; Chemical health education and counseling; Juvenile Sex Offender Treatment Program; Academic/vocational courses; Work experience; Transition/community reentry; Health/dental; Recreation/leisure; Volunteers/ mentors; Religion/spirituality; Each resident interviewed indicated they had been informed of their rights and responsibilities with related

	to PREA and the auditor's review of the residents' files provided evidence that supported the Facility Handbook, PREA brochure, and PREA training were delivered during intake and that a risk screening was conducted. All intakes are scheduled, which allows security and health services staff to be available when new individuals arrive at the facility. The auditor observed zero-tolerance posters throughout the buildings. The auditor observed a simulation of an intake process during the site visit. The auditor placed a phone call using a telephone in a randomly selected cottage during the site inspection. The instructions on the displayed poster were easy to follow, and the auditor left a recorded message and within the hour, the PREA Coordinator advised the facility and the auditor that the call was received. During the facility site review, all areas within the facility were inspected for sexual safety concerns, including the use of video cameras and security mirrors and the identification of any blind spots. The Complex is campus-style with multiple buildings, and the site inspection began from the administrative building and covered the whole campus. The auditor observed the agency's zero-tolerance and PREA informational posters, as well as the advocate's contact information posted prominently throughout the facility. During the inspection of the medical department, privacy screens were present in the medical examination rooms. Opposite gender announcements were made using the agency-wide "doorbell" system in each housing unit and on each floor where residents may be changing clothes or using the restroom. Areas inspected were well-lit, clean and organized, and in good repair. Because the Red Wing Campus houses two distinct facility operations, a separate audit was conducted for Red Wing Adult and Red Wing Juvenile facilities. These two facilities are co-located on the Red Wing Campus, services, and staff; however, they are audited under different PREA standards. The populations are kept

	separate and have no interactions unless there is direct staff supervision with the juveniles. Because of the sharing of staff for these facilities the auditor conducted two separate audits back-to-back with an overlap in the middle of the week. Since the facilities share staff, the auditor conducted interviews covering both the adult and juvenile facilities during each interview where applicable. The auditor oversampled random staff and specialized and counted the interviews for both facilities. Staff interviews were conducted either in the employees' work area or in the small conference room in the Administration Building. Resident interviews were conducted in the school area. Each facility has a distinct mission separate from the other. Because of the shared services, the auditor interviewed staff for purposes of MCF-RW Juvenile simultaneously with MCF-RW Adult over the course of the week that the auditor was on Red Wing Campus. The auditor reviewed documents, observed operations, observed interactions among staff and residents, conducted interviews over the course of the site visit and worked with the facility to ensure limited interruption to their operations. On day three, the auditor conducted an out-briefing with facility Leadership. The auditor did not provide the compliance findings during this meeting but explained that an analysis would be conducted of all the information collected to make a final determination. The facility was advised that additional correspondence and documentation may be necessary to aid in a comprehensive compliance review and left instructions for the documentation reviewed during the site visit to be uploaded into OAS attached to the applicable standards. During all phases of the auditing process, the auditor experienced no barriers to completing a thorough evaluation of compliance. The auditor found agency and facility staff to be forthcoming with information. All documentation requested was provided promptly. The auditor was allowed unfettered

	access to all areas of the facility. All staff and inmates willingly participated in the interview process. The Warden and Management Team were extremely accommodating and communicated directly to the auditor their appreciation for the feedback given during the site visit. MCF-RW Juvenile appears to be a well-operated, safe and healthy environment for both residents and staff. The facility met 31 standards, exceeded 9 standards, and did not meet 3 standards (115.341, 115.367, 115.371) upon issuance of the Interim Report. The facility entered a 180-day corrective action period to resolve the non-compliance which ended on October 1, 2024, at which time the facility had successfully demonstrated full compliance.

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.).	The auditor reviewed relevant documents provided by the facility and on the agency website in addition to the Pre-Audit Questionnaire (PAQ) and supporting documents. Using the PREA Compliance Audit Instrument and the Checklist of Documents during the review of the PAQ, a list was prepared for review during the onsite portion of the audit. Other documents reviewed will be referenced in the narrative sections under each individual standard discussion and included personnel records, resident records from institutional and medical files, employee and resident training records, incident reports, investigation files, facility correspondence, and local directives. Throughout the audit, an extensive document review was conducted. Various policies, forms, contracts, and additional working documents were reviewed, evaluated, and triangulated against information obtained from interviews and personal observations during the site visit which were instrumental in determining agency and facility compliance with the PREA Standards. Included below is the list of governing Minnesota Department of Corrections Policies that will be referenced throughout the audit report and are annotated throughout the report using only the policy number. This list is not intended to be exhaustive but outlines the core policy documents used in the evaluation process. Information obtained from these policies combined with the information provided with the PAQ and the observations, facility documentation, and general information collected from the site visit was carefully evaluated and assessed against each of the elements of the standards. • 102.050 PREA Data Collection, Review, and Distribution • 103.006 Supervision and Monitoring • 103.007 Juvenile Staffing Plans • 103.014 Background Checks for Applicants and Current Employees • 103.0141 Employees Who Are the

Subject of Criminal Investigation(s), Arrest(s), and/or Convictions(s)
- 103.225 Fact-Finding Process and Discipline Administration
- 103.410 In-Service Training
- 103.420 Pre-Service Orientation Training
- 107.005 Office of Special Investigations
- 107.007 Criminal Investigations
- 202.040 Offender Intake Screening and Processing
- 202.041 Juvenile Facility Admissions
- 202.045 Management of Transgender/ Gender Non-Confirming/Intersex Offenders/Residents
- 202.055RW Red Wing Operating Guideline
- 202.057 Sexual Abuse/Harassment Prevention, Reporting, and Response
- 203.010 Case Management Process
- 203.011 Case Management Process - Juveniles
- 203.015 Offender/Resident Risk Assessments
- 203.250 Modifications for Offenders/ Residents with Disabilities
- 300.045 Contractor Relationship to Department
- 300.300 Incident Reports
- 301.010 Searches
- 301.010RW Red Wing Operating Guidelines Searches
- 301.035 Evidence Management
- 301.055 Security Rounds
- 301.085RW Red Wing Operating Guideline Administrative Hold
- 302.020 Mail
- 302.121 Reporting Maltreatment - Juvenile
- 303.010RW Red Wing Operating Guideline Discipline Plan and Rules of Conduct
- 303.095 Juvenile Grievance Procedure
- 303.100 Grievance Procedure
- 500.030 Orientation Training for

Health Services Staff
- 500.100 Offender Co-Payment for Health Services
- 500.1261 Health Care for Juvenile Residents and Youthful Offenders
- 500.303 Mental Health Assessment
- Minnesota Department of Corrections-Red Wing Juvenile Resident Rules of Conduct

The auditor's search for state mandatory reporting laws found that reports concerning suspected abuse or neglect of children occurring in a facility licensed by the Minnesota Department of Human Services should be made to the Department of Human Services, Licensing Division's Maltreatment Intake line at 651-431- 6600. Minnesota law (Minn. Stat. section 626.556) requires professionals and their delegates who work with children to make a child protection report if they know of or have reason to believe a child is being neglected or abused or has been neglected or abused within the preceding three years immediately (within 24 hours). Mandated reporters include professionals and their delegates in the following fields: healthcare, social services, mental health, childcare, education, law enforcement, Guardians ad litem, clergy, probation, and correctional services.

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	5	0	3	2
Staff-on-inmate sexual abuse	2	0	2	0
Total	7	0	5	2

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	30	0	30	0
Staff-on-inmate sexual harassment	2	0	0	0
Total	32	0	30	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

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

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

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	2	10	18
Staff-on-inmate sexual harassment	0	1	1	0
Total	0	3	11	18

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:	3

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:	2
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:	1
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:	12
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:	11
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:	1
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 auditor reviewed the tracking spreadsheet for documented cases between February 21, 2023, through April 14, 2024. There were 39 allegations reported. Of these, 5 were Resident/Resident (R/R) Abuse; 30 were R/R Harassment; (2) were Staff(S)/R Abuse; (2) were S/R Harassment. There were 2 cases investigated both criminally and administratively and both were unfounded and investigated by specially trained investigators; An administrative investigation was conducted on all (39) cases by specially trained investigators except for 1. When the auditor requested the missing OSI Investigator's training records it was determined he had not completed the required training in investigating sexual abuse in confinement settings (This case is coded on the spreadsheet as a S/R Harassment, but should have been S/R Abuse). Cases were closed with the following dispositions (19) substantiated; 14 unsubstantiated; 6 unfounded. It should be noted that the information entered into the PAQ during the Pre-Audit Period will not agree with the number presented due to incidents that were reported after the PAQ was finalized. The auditor was required to review 12 cases based on the requirements of the Auditor's Handbook. The auditor selected 15 cases for review 2 R/R Abuse; 11 R/R Harassment; 1 S/R Abuse; 1 S/R Harassment. Outcomes of these cases were 9 substantiated; 3 unsubstantiated; 3 unfounded. The 7 case files reviewed by the auditor during the post audit and CAP period are not reflected in the survey questions 92 through 113 because they did not occur within the audit period.

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
Identify the name of the third-party auditing entity	Correctional Management & Communications Group, LLC

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
	Evidence Reviewed: Policy 202.057; Organizational Charts for Minnesota Department of Corrections (MN DOC), OSI, PREA Coordinator's Office and Facility; Review of Agency's Website; PREA Coordinator Position Job Description; Personal Observations During Site Visit; Information Obtained from Interviews. 115.311(a): Policy 202.057 mandates zero-tolerance toward sexual abuse and harassment to promote a safe and humane environment, free from sexual violence and misconduct for residents. The policy directs a system-wide program for the prevention, detection, reporting, response, and retention of records to an incident of sexual abuse/harassment of any resident by a resident, contractor, volunteer, staff, or visitor within the MN DOC. This policy applies to prisons, county jails, detentions, lockups, and residential placement facilities within the purview of the MN DOC. Formal and informal interviews with random staff indicated they are aware of the zero-tolerance policy and the agency's approach to preventing, detecting, and responding to sexual abuse and sexual harassment.

	115.311(b): This position is an upper-level position within the agency and is a direct report to the Office of Special Investigations (OSI) Corrections Investigations Director. The PREA Coordinator's job description comprehensively outlines the incumbent's duties, responsibilities, and authority. Based on the auditor's interview with the PREA Coordinator, she dedicates her full-time efforts toward developing, implementing, and overseeing the agency's efforts to comply with the standards in all of its facilities. Based on the position status and the support received from the OSI Director and Executive Leadership, she has sufficient authority to carry out her duties; Although the OSI organization chart shows her position within the OSI unit, the agency organizational chart does not reflect a PREA Coordinator position. The PREA Coordinator's job description comprehensively outlines the incumbent's duties, responsibilities, and authority. The PREA Unit received and filled three positions, a Management Analyst 3 and two Operational Analyst. Additionally, the agency approved (10) designated positions assigned at the facility level to assist the local PCMs with overseeing efforts locally. These employees are currently undergoing training for their new roles in the PREA Unit. The interview with the PREA Coordinator confirmed that she has previously not had enough time to manage all of the agency’s PREA-related responsibilities. However, during this audit cycle, she has hired additional staff and is in the process of realigning duties that will assist her in better managing the agency's PREA program statewide. She has indirect supervision for 12 facility PREA compliance managers throughout the agency. Her interactions with the PCMs occur through dissemination of monthly information via email and during monthly meetings with the facility held virtually in an effort to streamline processes, educate specific standard implementation, assist with audits, offer support, and create consistency across the state. The PREA Coordinator will address any issues with PREA standard compliance by addressing the concern with the Executive Leadership and facility staff. Policy updates will be initiated when needed. Based on this interview, it is clear that she is in the process of transitioning from being the only employee assigned to the PREA Unit to now having additional staff to assist with PREA oversight on a statewide level. With the additional staff, the PREA Coordinator will have assistance with providing training, database entry, and case management. Interview with the Agency Head determined that the PREA Coordinator is granted the necessary authority to coordinate the agency's efforts fully and has direct access to him as needed. 115.311(c): Each MN DOC has a designated PREA Compliance Manager (PCM). The PREA Coordinator meets monthly with the PCMs either in person or virtually. She also communicates collectively and individually, as needed, via telephone and email correspondence. The PCM coordinates compliance at the facility level, with oversight and guidance from the agency's PREA Coordinator. The facility reports for nearly all of the reporting period they were without a permanent AWO so there were periods of time that the PCM duties were not covered. The facility recently hired Stephanie Huppert as the new AWO as of March 2024 who will also serve as the PCM. The facility's PCM reports directly to the Warden and is an executive-level team member based on the Red Wing Organizational Chart review. In addition to

	hiring a new AWO/PCM, the facility just (April 2024) allocated a PCM Assistant (A) position being filled by Lieutenant Kyle Prall. Based on the interview with the Warden and AWO/PCM, this additional position will provide regular focus on PREA compliance issues and establish more consistency to the administrative investigations. Lt. Prall has been working unofficially in this capacity for the past few months to assist the facility in preparation for the audit. The PCM explained that coming into the position just before the was a huge lift in finding time to complete her other AWO duties and to ensure that the PREA standards requirements were well established at the facility, but with the addition of the PCMA, she believes that she will have sufficient time to manage her PREA related duties. Both the AWO/PCM and PCMA have completed the 115.334 specialized training for investigation sexual harassment. A systematic review and analysis of the evidence concluded the facility and agency have demonstrated compliance with all provisions of this standard.

115.312	**Contracting with other entities for the confinement of residents**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Evidence Reviewed: 115.12 Contracts for Confinement; Information Obtained from Interviews; PREA Audit Final Reports. 115.312(a)(b): Minnesota Department of Corrections (MN DOC) contracts with 12 facilities for the confinement of persons. The auditor reviewed a sample of three contracts and found language requiring the private entity to comply with the Prison Rape Elimination Act (PREA) of 2003 (Federal Law 42 U.S.C. 15601 et. seq.) with all applicable Federal PREA standards, and with all State policies and standards related to PREA for preventing, detecting, monitoring, investigating, and eradicating any form of sexual abuse within facilities/programs/offices owned, operated, or contracted. In addition to self-monitoring requirements, the MN DOC will conduct compliance monitoring, and an outside independent PREA audit is required. Each facility is required to provide a Final Report for an audit conducted by an independent PREA auditor every three years and in accordance with 115.401. The auditor found current PREA Final Reports on the contracted entities’ websites for the contracts reviewed. The facility indicated they had no contracts for the confinement of persons which is correct; however, the auditor explained that this standard is reviewed at the agency level. An interview with the agency's Contract Administrator and PREA Coordinator confirmed that all facilities contracted with are monitored for PREA compliance and are required to follow the standards as a condition of the contractual agreement. To determine if the contractor complies with required PREA practices. All contract facilities have or will complete and submit PREA compliance results within the

	contracting agency’s three-year cycle. The private entities are further monitored for compliance by the Grants & Subsidies/ Inspection Enforcement Unit of the MN DOC. A systematic review and analysis of the evidence concluded the facility and agency have demonstrated compliance with all provisions of this standard.

115.313	Supervision and monitoring
	Auditor Overall Determination: Exceeds Standard
	Auditor Discussion
	Evidence Reviewed: Policies 103.006;103.007; 301.055; 301.147; Facility Staffing Plan with 2021, 2022, 2023, 2024 Reviews; MCF-Red Wing-Juvenile Staffing Plan; Security Rounds; Administrative Tour Log Samples; 5-Year Camera Plan; Observations During Site Visit. 115.313(a)(c)(d): As directed by 103.006 and 103.007, the agency requires each facility it operates to develop, document, and make its best efforts to comply on a regular basis with a staffing plan that provides for adequate levels of staffing, and where applicable, video monitoring to protect residents against abuse. In consultation with the agency’s PREA Coordinator, each appointing authority/ designee must assess, determine, and document whether adjustments are needed to the staffing plan/program schedule, at least annually, to ensure the requirements of this standard. The auditor reviewed the current staffing plan and found the plan provides adequate coverage for resident supervision posts. The facility runs three shifts: 1st Watch is 2140-0610; 2nd Watch is 0600-1400; 3rd Watch is 1350-2150. Documented consideration was given to all elements of provision (a) of this standard in the development of the facility’s staffing plan. The most recent staffing plan review was conducted on December 20, 2023, and approved by the PREA Coordinator on December 21, 2023, with comment about the extended vacancy of the AWO/PCM position. The review noted no judicial findings of inadequacy, no findings of inadequacy from Federal investigative agencies or internal or external oversight bodies. The five-year camera plan plays a vital role in the facility’s staffing plan. Based on a review of the facility’s Five-Year Camera Plan, assessments for camera replacements and additions in designated areas are tiered out over each fiscal year. This plan is reviewed quarterly and maintained by the facility Camera Committee. This committee assesses the progress of additional technological needs of the facility. A review of the Camera Projects Report shows a dedicated effort in maintaining cameras to enhance supervision and keep residents and staff safe. The Camera Projects list specifically identifies areas where recommendations have been made for camera installations to enhance the facility’s ability to prevent sexual abuse. Red Wing Adult facility is located on the same secure campus and shares services and staff with the Red Wing Juvenile facility. During the site review the auditor compared the written staffing plan against the

	following observations to determine whether the staffing plan adequately assesses the staffing and/or electronic monitoring needs of the facility with sexual safety in mind, and, whether the facility is staffed according to the plan, as it is written, to later determine whether deviations from the plan have been documented: The auditor observed the number of staff, contractors, and volunteers and staffing patterns during every shift, including in the housing units, isolated areas, programming and education areas, recreation areas, and other areas where sexual abuse is most likely to occur. The auditor observed staff's line of sight and assessed whether there are blind spots. The auditor observed areas where residents are not allowed entry to determine whether movement in and out of that space is monitored to ensure that residents never enter those areas. The auditor observed the level of supervision and frequency of room checks in housing areas. The auditor observed that the facility houses only 1 resident per room. The auditor observed indirect supervision practices, including camera placement. In addition to observation of camera placement, the auditor inquired about and observed the control room/officer stations where camera monitoring occurs. The auditor's review of the current staffing plan, shift rosters, logbooks, post orders, and interviews with 30 staff working all shifts and 17 residents confirmed that staff maintain high visibility and sufficient supervision is provided by staff during all shifts, and found it provides adequate post coverage; the written plan documented that consideration was given to all elements of provision (a). The facility's capacity is 88 juvenile male residents, and the average daily population for the last 12 months was 72. The facility is staffed to maintain a ratio of 1:8 during resident waking hours and 1:16 during resident sleeping hours. The auditor reviewed a random sample of shift rosters and daily supervisor reports for the audit period and found that the staffing ratios were consistently maintained. Activity and Programming Schedules were reviewed, which confirmed coordinated movement of residents and staffing considerations for these Posts. The MCF-RW camera system is comprised of 334 cameras with 280 located in areas where juveniles have access. The system has the capability to store video for 21 days. In 2024, facility wide cameras have been replaced from analog to internet protocol (IP) based in order to get a clearer view of all areas. In remote or secluded areas where there is an increased chance of an incident, additional cameras have been added as they are identified and vetted through the camera committee. The PCM/AWO chairs the Camera Committee and meets with committee members on a regular basis to assess any needs for monitoring technology and to ensure that the current system is working properly. The auditor observed adequate camera coverage throughout the facility, both inside buildings and outside, for yard coverage. Blind spots were adequately covered by either mirrors, cameras, or direct staff monitoring. An interview with the Warden confirms that all modifications, new acquisitions, and upgrades are assessed for the effectiveness to keep residents safe, and that video monitoring technology is an important tool for the agency in supplementing direct supervision and for covering areas with little foot traffic. Budgetary allocations are made annually for updates and enhancements to this type of technology. The facility indicates 183 full-time equivalent staff with 99 funded security staff in the ranks for Correctional Officer I, II, III, 10 Lieutenants, and 1 Captain. The facility has 2 Living Unit Lieutenant who

	each supervise 2 cognitive behavioral living units, and 1 Living Unit Lieutenant who supervises the sex offender treatment program population. Each cognitive behavioral Lieutenant is responsible for overseeing approximately 32 residents, and the sex offender LT supervises approximately 8 residents. One Lt supervises the secured living unit (Dayton) in addition to the school. Each living unit has 1 or 2 Case Managers assigned within the uni. The facility has 2 Administrative staff; 1 Registered Nurse Supervisor; 1 Psychological Services Director; 1 Education Director; 1 IT Supervisor; 1 Records Supervisor and 1 Physical Plant Director. The facility has a vacancy rate of14%; however, they are able to maintain the required staffing ratios. An interview with the Warden found that the facility is currently experiencing issues filling open positions due to a statewide staffing shortage. Based on the auditor's observations during the site visit, staffing to juvenile ratios were maintained in every area inspected. Interviews with the Warden and PREA Compliance Manager verified that the facility has a documented staffing plan and that adequate staffing levels to protect residents against sexual abuse are considered in this plan. When assessing adequate staffing levels and the need for video monitoring, the facility staffing plan considers generally accepted detention and correctional practices; any judicial findings of inadequacy; any findings of inadequacy from federal investigative agencies; any findings of inadequacy from internal or external oversight bodies; all components of the facility’s physical plant (including “blind spots” or areas where staff or residents may be isolated); the composition of the incarcerated person population; the number and placement of supervisory staff; institution programs occurring on a particular shift; any applicable state or local laws, regulations, or standards; the prevalence of substantiated and unsubstantiated incidents of sexual abuse; and any other relevant factors. The staffing plan is reviewed at least annually and when there are significant changes to any of the practices listed in this standard. 115.313(b): As directed by 103.006, the agency mandates that in circumstances where the staffing plan is not complied with, the appointing authority/designee must document in a memorandum to the AWO a justification of all deviations from the plan. The facility stated in the PAQ they had no deviations; however, during the site visit it was clarified that the facility interpreted that question as to their ability to cover all required posts. All posts were covered by using voluntary or forced overtime when a staffing shortage occurred and documented in the daily report. The auditor confirmed during interviews with the Watch Commander and AWO and by reviewing the Watch Commanders' shift reports that all deviations are documented in the daily shift reports. Interviews with the Warden, AWO, HR, and confirmed that staffing reviews are conducted on a constant basis and that the agency utilizes overtime when necessary to maintain shift coverage in accordance with the designated staffing plan. 115.313(e): Policy 301.055 establishes the requirement of frequent, unscheduled security rounds and well-being checks on all shifts of occupied and unoccupied areas to detect and address issues that may affect the security and control of a facility or the safety of staff and residents. The policy specifies identification and

	deterrence of sexual abuse and harassment as an element of making supervisory rounds. Supervisors are required to conduct and document unannounced rounds on all shifts to identify and deter staff sexual offenses, and that staff shall not alert other staff if a supervisory round occurs unless such announcement is related to the legitimate operational functions of the institution. The Daily Security and Safety Logs are documented when unannounced rounds are conducted. The facility provided Administrative Tour logs for each day for the last 12 months. The Administrative Tour log provides a consistent method for staff to document unannounced rounds. The form identifies who, whether admin, supervisor or other, conducts the rounds. The auditor randomly selected documented unannounced rounds by 2 upper-level staff and corroborated these rounds through video review. It is clear that rounds are conducted. However, specific information (what was observed/safety concerns) is not documented on this form and the facility indicates the Officer of the Day does not complete a report at the end of the tour. It is recommended for staff to complete a thorough description of observations after each tour is conducted. The auditor reviewed sample logs from 5 living units from all shifts during the audit period observing sufficient documentation of supervisor unannounced PREA rounds being made on day and night shifts. Interviews with the Warden, AWO, Captain who are identified as higher-level staff, confirmed that unannounced rounds are conducted and documented in each unit's administrative rounds book and unit logs. Staff are advised through policy and training that alerting other staff, while conducting unannounced rounds is prohibited. Informal conversations with staff and interviews with 17 residents regarding supervision practices found both routine and unannounced rounds are made on a regular basis during business hours, all shifts and during holidays and weekends. A systematic review and analysis of the evidence concluded the facility and agency have demonstrated compliance with all provisions of this standard. Based on the weekly staffing reviews and monthly electronic equipment monitoring by the Camera Committee the facility exceeds the requirements of provision (c).

115.315	**Limits to cross-gender viewing and searches**
	Auditor Overall Determination: Exceeds Standard
	Auditor Discussion
	Evidence Reviewed by Auditor: Policy 202.045; Policy 301.010; Policy 301.055; Control Tactics Training Curricula and Participation Report; Annual training verification of Cross Gender and control tactics; FTO Pat Searches Training Plan; Memo confirming no female population; Observations During Site Visit; Information Obtained from Interviews. 115.315(a)(b)(c): Policy 301.010 requires that except in exigent circumstances, a

	strip search shall be conducted by a staff member of the same gender as the inmate. If exigent circumstances exist and a staff person at any MN DOC facility performs an opposite-gender unclothed body search, an incident report must be written and maintained in an electronic file by the Watch Commander. The facility also follows 301.010RW Operating Guidelines on Searches to provide facility-specific instructions to complete body searches on youth in a manner that is mindful of adolescent development, vulnerability, and trauma. These guidelines include the requirement for staff to document in an incident report: a) Reasons a suspicion-based staff-observed body search was conducted, the name and title of the administrative authority that approved it, and the names of the staff that conducted the search either in the body of the incident report or in the “Supervisor/Watch Commander Comments” section; b) Circumstances of an emergency situation that necessitates a pat or unclothed body search of a resident be conducted by staff of the opposite gender; and c) Rationale for conducting a body search in situations not covered in this operating guideline and the name and title of the administrative authority that approved the search. The guidelines provide specific instructions for conducting clothed pat searches, resident-conducted unclothed body searches, and staff-observed unclothed body searches. Interviews with 18 security staff found that unclothed body searches are rarely conducted of youth and generally only when the resident leaves the facility and returns. When an unclothed search is necessary, the general procedure used is the resident-conducted unclothed body search. This type of search allows the resident to be in a private area behind a half door and the trained security staff member provides instructions from the other side of the door, watching for anything to fall from the floor as the resident goes through the process directed by the officer. After the search is completed and once the resident is dressed, the resident is scanned with a handheld metal detector before they exit the intake area. Instructions provided in the guidelines for staff-observed unclothed body searches provide the youth to wear their underwear for as long as possible to minimize potential trauma and a sense of vulnerability. The facility indicates that no cross-gender unclothed body searches or cross-gender pat searches were conducted within the audit period; therefore, none were documented. A cross-gender unclothed body search or pat search would only occur under exigent circumstances based on interviews with 18 security staff, the PCMA, and 3 Watch Commanders. Visual body cavity searches of youth are only allowed to be conducted by medical and interview with the HSA confirmed that there have been none in the audit period. All security staff interviewed were aware these searches are prohibited barring exigent circumstances and that if exigent circumstances warranted a cross-gender search, that they would be required to document the search in a report including the details outlined in 301.010RW Operating Guidelines and submit it to the Watch Commander. Interviews with 3 Watch Commanders also verified that opposite-gender strip, visual body cavity searches, or opposite-gender pat searches have not occurred within the audit period. Interviews with 17 residents further verified that the only time they experience an unclothed body search is when they get in trouble and get admitted to Dayton (for disciplinary) or if they are placed on medical or mental health hold/ contract that requires it. Otherwise, they are pat searched periodically and

randomly and always by a male officer.

115.315(d): 301.055 requires that residents must be allowed to shower, perform bodily functions, and change clothing without staff of the opposite gender viewing a resident's breasts, buttocks, or genitalia except in exigent circumstances or when such viewing is incidental due to routine cell checks. Staff members of the opposite gender from the resident in a housing unit must announce their presence before entering the unit as described by institution post orders and written guidelines. The facility also has a statewide doorbell system that is used to announce opposite gender staff presence. Residents are made aware of this statewide doorbell system during intake, and it is explained in the resident handbook. The doorbell is installed on the main entrance of each housing unit and the auditor observed staff pressing the opposite-gender announcement bell each time the inspection team entered a living unit.

Random staff interviews 30 verified that female staff use the tone-system which announces their presence when entering a housing unit that houses residents of the opposite gender; additionally, before entering a shower or toilet area, they knock and announce if it is necessary to enter the area when these areas are being occupied by someone of the opposite gender. Interviews with 17 residents confirmed they are able to dress, shower, and use the toilet without being viewed by staff of the opposite gender. They denied ever being naked in full view of female staff. During the site visit, the auditor observed the intake area where unclothed body searches occur and determined that the area afforded privacy so that no opposite-gender viewing could occur. There were no cameras in the area that allowed viewing into the area which was checked by the auditor during the camera view inspection.

115.315(e): The MN DOC PREA training module prohibits physically searching an individual for purposes of determining an individual's genital status. Policy 202.045 establishes that staff shall not search or physically examine any individual for the sole purpose of determining the resident's genital status. This prohibition equally applies to transgender, gender non-conforming, or intersex individuals. If the individual's genital status must be known for treatment purposes or the individual's safety, it may be determined through conversations with the individual by reviewing medical records or, if necessary. The facility indicates no incidents of searching or physically examining a transgender or intersex resident for the sole purpose of determining the resident's genital status have every occurred. Interviews with 18 random security staff confirmed that they are aware of the policy prohibiting staff from searching or physically examining a transgender or intersex resident for the purpose of determining that resident's genital status. There were no transgender or intersex residents admitted to the facility during the site visit to interview.

115.315(f): Policy 301.010 requires that only properly trained staff may conduct searches, regardless of the search type. The agency trains security staff in how to conduct opposite-gender pat-down searches and searches of transgender and intersex incarcerated persons professionally and respectfully, and in the least intrusive manner possible, consistent with security needs. Policy 103.410 and Policy

	103.420 outline the course curriculum for staff, both preservice and in-service. All security staff receive training on how to conduct proper searches when they attend their basic training at the academy and then conducting proper searches is covered by the FTO when a new officer returns from the academy. The auditor reviewed the FTO curricula for "Pat Searches: Inclusive of Transgender/Non-Conforming/Intersex Offenders/Residents" and found the material to be consistent with training requirements. The auditor reviewed the curricula Control Tactics and Transgender Policy and Pat Searches and found they meet the requirements of this standard. The facility reports that 100% of the security staff has been trained in conducting cross-gender pat-down searches and searches of transgender and intersex residents in a professional and respectful manner, consistent with security needs. The auditor reviewed the completion roster 92 for Control Tactics and determined staff had received a refresher within the last year. The facility provided the completion roster for Transgender Policy and Pat Searches as of April 2024 and determined staff have received the required training. Staff listed on the roster who have not completed the training are non-security staff and do not conduct searches. An interview with the training officer confirmed that all security staff are trained on searches during the academy, upon return to the facility by the FTO, and then again periodically as needed and formally during annual in-service training. Interviews with 18 security staff confirmed receipt of training on how to conduct cross-gender pat-down searches and searches of transgender and intersex residents in a professional and respectful manner, consistent with security needs. They further confirmed that they are aware of the policy prohibiting staff from searching or physically examining a transgender or intersex resident for the purpose of determining that resident’s genital status. There were no transgender or intersex individuals housed at the facility during the site visit to interview. The auditor reviewed the curriculum for pre-service and annual in-service and found each covered a module on search procedures. All staff receives the PREA – Prison Rape Elimination Act Module in pre-service training upon hire and, as of this current year, during annual in-service annually. The facility reports that 100% of the security staff have been trained in conducting cross-gender pat searches and searches of transgender and intersex residents in a professional and respectful manner, consistent with security needs. The facility provided the completion roster for Transgender Policy and Pat Searches as of April 2024 and it was determined security staff have completed the required training. Interviews with staff confirmed receipt of training on how to conduct cross-gender pat-down searches and searches of transgender and intersex residents in a professional and respectful manner, consistent with security needs. During interviews with 17 youth the auditor was told that officers are respectful when conducting pat searches and unclothed body searches. A systematic review and analysis of the evidence concluded that the facility and agency have demonstrated compliance with all provisions of this standard. The facility and agency exceed provision (f) based on frequency of training covering proper search procedures; and provision (a) for implementation of the resident-conducted unclothed body searches to mitigate retraumatization of youth who have experienced past sexual abuse and to make them feel more comfortable during the

	procedure.

115.316	Residents with disabilities and residents who are limited English proficient
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Evidence Reviewed: Policy 203.250; Policy 202.041; Policy 202.050; Policy 202.057; Resident Education Handbook; Language Line Instructions; Orientation Screenshot; Module 3 Staff Training; Contracts for: Sign; Spoken; Access to an Interpreter - Language Line Quick Reference; Orientation Video; Written and Interpreting Language Services Contract; Chinese, Hmong, and Spanish PREA Hotline and Zero-Tolerance Posters; PREA "What You Need to Know"; Federal iSpeak poster - all languages; Observations During Site Visit; Information Obtained from Staff and Resident Interviews 115.316(a)(b): Policy 203.050 establishes at intake medical staff ask newly admitted residents if they require a modification. For residents who respond affirmatively, or alternatively, where medial staff have reason to believe a disability exists, the designated staff person must follow policy 203.050 and 202.041, Juvenile Facility Admissions, in addressing the modification needs. The DOC provides appropriate auxiliary aids and services, including American Sign Language (ASL) interpreters, when necessary to ensure that residents with speech, hearing, or vision disabilities are able to understand what is said and written and can communicate effectively. Facility staff follow the Sign Language Protocol to provide sign language assistance using either the designated staff interpreter or contract services. If, at intake, staff determine there is a need for sign language interpreting services, staff must contact the DOC’s sign language interpreter specialist for assistance. Facility staff may solicit assistance from State Services for the Blind for individuals with vision impairments or blindness. Policy 202.041 establishes that within 24 hours of admission, residents are given written orientation materials in a manner that residents with disabilities can understand. Information must be read and explained to residents that are incapable of understanding written documents or who are unable to read. Interpreters must be provided for English as a Second Language (ESL) residents. The agency's PREA policy 202.057 further states that a qualified interpreter is provided for individuals who have a disability that affects the individual's ability to communicate. The policy further establishes that the agency provides appropriate auxiliary aids and services, including American Sign Language (ASL) interpreters, when necessary to ensure that individuals with speech, hearing, or vision disabilities are able to understand what is said and written and can communicate effectively. The agency has a staff interpreter and maintains a contract with multiple vendors to provide in-person interpreting (ASL), remote interpreting (VRI), communication access real time (CART), and remote CART. Facility staff is provided access to the Sign Language Protocol to provide language

	assistance during intake; if a need is identified, staff must contact the agency's language interpreter specialist for assistance. Staff may solicit assistance from State Services for the Blind for individuals with vision impairments or blindness. Policy 202.050 requires facility staff to provide orientation materials for all residents, including translations or alternative formats for residents identified at intake or during orientation whose primary language is not English, who have sight and hearing barriers, or who have literacy barriers. Staff must assist residents as needed in understanding orientation and Prison Rape Elimination Act (PREA) materials. The agency's PREA policy, 202.057, states that individuals who do not speak and understand English are provided language interpretive services. The agency maintains statewide contracts with multiple vendors for spoken language interpretation services and written language translation services. Additionally, the PREA posters and Hotline posters are translated into Spanish, Hmong, and Chinese (the most common encountered in the agency) and were observed throughout the facility during the auditor's site visit inspection. The facility provided the auditor with a copy of the Language Line access instructions which provided detailed instructions on how staff can access interpreter services if needed. The agency has established procedures to provide incarcerated persons with limited English proficiency (LEP)/ESL 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. The PREA posters and brochures are published in English and Spanish. The facility utilizes LanguageLine Solutions through the agency contract when needed for interpreter services. The facility identified 4 LEP youth during the last 12 months, however there were no LEP youth identified during the on-site visit. Interviews with the HSA, 2 educators, the PCMA, and the AWO/PCM/ADA Coordinator all confirmed that there were 4 residents admitted during the audit period who were flagged as possibly needing language services; however, it was later determined that they were all fluent in English and were bilingual. No residents needed accommodative services, including language interpretation, within the audit period for delivering PREA education or to address any PREA related issue. The auditor interviewed the Intake Lieutenant who explained that frequently he processes new residents that don't appear to understand the information or are unable to read well. He explained he takes his time with the new resident and covers all of the written materials to make sure that he understands and allows him to ask questions. He explains the rules and other information such as the PREA policy in a manner that is age appropriate. He advised the auditor that there had been no youth within the audit period that had needed any accommodation for a disability; however, he explained how to access the ASL services and the other language services. Additionally, he displayed the PREA educational video to indicate that it is available in English and Spanish and Closed-Caption. He also explained that if a youth displayed a cognitive issue or other barriers that appeared that he was not understanding the material being presented he would reach out to the AWO/PCM who is the ADA Coordinator or to medical or mental health staff for assistance. During an interview with the HSA, she explained the same efforts to ensure that effective communication occurred with the new resident and discussed the multiple resources available within the agency and with

	community partners that may be used. The facility identified 1 youth with a physical disability and 95 with a cognitive disability. There were no residents identified with visual or hearing disabilities during the site visit. The auditor interviewed 1 resident with a physical disability and 4 residents with a cognitive disability and all confirmed to have a thorough understanding of all aspects of the sexual abuse and harassment prevention and reporting processes. The auditor's interview with the Agency Head confirmed that the agency has established procedures to provide incarcerated persons with disabilities and 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. During interviews with the AWO/PCM, the auditor confirmed that the Orientation Handbook and any other relevant documentation that is not already published in a language needed can be translated by contract providers into the needed language. The AWO/PCM confirms that procedures are in place to ensure that new intake individuals who are LEP will be provided the PREA education with the use of an interpreter when necessary. Conversation with the PREA Coordinator found that the PREA educational material will be submitted for translations when any other common language is identified there is a need. The MN DOC trains its employees on effective communications with individuals who are deaf or hard of hearing, who are blind or have low vision, who have intellectual disabilities, who have psychiatric disabilities, and who have speech disabilities through Staff Training PREA Module 3. 115.316(c): Interviews with staff confirmed there were no instances where resident interpreters, readers, or other types of resident assistants have been used and it was not the case that an extended delay in obtaining another interpreter could compromise the resident's safety, the performance of first-response duties under §115.364, or the investigation of the resident's allegations that staff would utilize agency resources to ensure these needs were met. The facility has had no instances where a resident translator was used. A systematic review and analysis of the evidence concluded the facility and agency have demonstrated compliance with all provisions of this standard.

115.317	**Hiring and promotion decisions**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Evidence Reviewed by Auditor: Policy 103.014; Policy 103.300; Policy 300.040; Policy 300.045; Lists of Personnel; Lists of Contractors; Personnel Records; Contractor Records; 5-Year Background Check Spreadsheet; Information Obtained from Interviews. 115.317(a)(b)(c): Policy 103.014 establishes that the department screens finalists

	for employment on their criminal history, associations with criminal justice-involved persons or currently/formerly incarcerated persons, employment history, including incidents of sexual harassment, and other background information, when they are being considered for initial appointment or rehire with the agency. The agency also conducts criminal history and employment history checks, including checking for incidents of sexual harassment, on a finalist for promotion. When a finalist's employment history includes a substantiated complaint of sexual harassment, the appointing authority must give additional consideration when making an employment decision. The DOC does not confirm a finalist's contingent job offer or promote anyone who a) has engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility, or other public or private institution responsible for the care and custody of people; 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; or c) has been civilly or administratively adjudicated to have engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility, or any other public or private institution responsible for the care and custody of people. The policy further outlines the extensive procedures involved in reviewing applicants for hire and promotion. Policies 103.014 and 300.020 provides consideration of any incident of sexual harassment in determining whether to enlist the services of any contractor who may have contact with incarcerated persons. Policy 103.014 requires a background investigation to be conducted on all prospective employees. The HR staffing representative/designee reviews the employment record of a current or former state employee finalist in the state employee management system. If a finalist has been discharged from state employment or otherwise disciplined, the HR designee must provide a summary of findings to the HR manager, who analyzes the facts and determines if additional information will be requested from the regional HR or other state agency. For finalists for trainee-corrections officer positions, the HR staffing designee must review negative results from the employment history check, including any substantiated complaints by a former or current employer of sexual harassment. The facility reports that 35 new employees were hired who may have contact with residents and who have had criminal records checks. The auditor randomly selected and reviewed personnel records for 19 employees consisting of 13 new hires and 5 promotions and found evidence that criminal history checks were conducted prior to employment/promotion with the agency. The auditor conducted interviews with the local HR and an HR team from the MN DOC headquarters to gather the full scope of the extensive background review conducted on all new employee candidates and existing employees using a third-party vendor for processing hiring and promotion applicants. Interviews confirmed that all vacant positions are posted either internally or externally. Once interviews are conducted and candidate selections are made, the background packet is completed by the candidate, and the process begins. The misconduct questions stated in provision (a) are included on the Consent for Background form, where the prospective or existing employee must answer the questions and sign the attestation. Databases checked during the

	background check include Federal Criminal Search, National Criminal Search, Nationwide Sex Offender, County Criminal Search, Statewide Criminal Search, MN BCA, and SS Trace. Interview with the HRD confirmed that the online application system automatically sends an email to all prior institutional employers listed on the application which asks for information about substantiated allegations of sexual abuse or any resignation during a pending investigation of an allegation of sexual abuse. The auditor reviewed a sample of (4) completed Employment Background Information Requests, which verified the following questions are asked: (a) has employee ever been internally investigated; (b) was the employee found to have engaged in sexual abuse or resigned pending an investigation of sexual abuse; (c) was the employee found guilty of sexual harassment in the workplace. The interview with the HRD also confirmed the facility considers prior incidents of sexual harassment when determining whether to hire or promote anyone, or to enlist the services of any contractor, who may have contact with residents. The HRD confirmed during her interview that hiring managers reach out to prior institutional employers to obtain information on any substantiated allegations of sexual abuse and any resignations during an investigation. Interviews with Central HR staff also corroborated that the prior employer reference check process was previously accomplished manually; however, the agency has implemented now uses an automated system, Skill Survey, contacts any prior institutional employer(s) by email requesting this information. Internal transfers/promotions are also checked through the agency's internal system DIGITS which shows any investigations and any disciplinary action taken at prior facilities. The local HR can also reach out directly to the prior facility to verify there is nothing current that has not been entered into the MN DOC database. 115.317(d)(e): Policy 300.04 requires background investigations to be conducted on all contractors who may have contact with residents before enlisting services. The facility indicated (81) approved contractors have been cleared for services in the last 12 months. The facility contracts for medical services who have a daily presence the same as MN DOC employees. The facility also contracts with contractors throughout the year for various services required at the facility. The auditor requested and reviewed (12) contractor files and found they contained evidence of a current background clearance, PREA misconduct questionnaires; disclosure of offender association; and PREA policy acknowledgment forms. The facility submitted background checks for (4) medical contractors and (5) interns, confirming checks are conducted prior to employment or services rendered. An interview with the AWO/PCM confirms that the facility completes background checks on direct-contact contractors, volunteers, and persons coming into the facility for tours. Interviews with the HRD also learned that contractor background checks are conducted by the Program Unit at Central Office for medical and interns and that service contractors are completed at the local facility. During an interview with the administrative staff who manages the local service contractor files the auditor learned that service contractor's clearance expires after one year and must be conducted annually if they are a recurring service provider. Policy 103.014 requires all current employees and contractors who may have

	contact with residents to have a background investigation conducted at least every five years. A memo provided (04/09/24) with the PAQ indicates the facility could not locate records of 5-year background checks; however, during the site visit and subsequent interview with the HRD the auditor learned that these backgrounds are tracked, completed, and maintained at Central HR. Central HR Staffing Unit maintains a system of tracking background checks on employees using SmartSheet to ensure that background checks are conducted at least every five years for employees and contractors and prior to promotion for an existing employee. These background checks are conducted by American Databank. A subsequent memo (05/13/24) indicates that background checks are conducted on 1/5 of the staff annually. The auditor requested evidence that background checks for staff at MCF-Red Wing are current; the facility provided a spreadsheet of 134 employees who have been employed at the facility for five years or more. The document verified that all had current background checks on file. Additionally, the auditor selected 8 random staff from the list and requested verification of the background check which was provided for review. The auditor determined that the agency and facility have a well implemented process for ensuring that background checks are conducted on employees and contractors at least every five years. 115.317(f)(g): The agency advises all employees that failure to disclose or attempts to withhold criminal history information will be grounds to disqualify an employee for hiring consideration through policy, during orientation, and in writing on the background check consent form. The application process is completed online and as part of the application process the applicant must attest to providing complete and truthful information and understanding that material omissions or providing materially false information are grounds for termination. Prior to using Skillpath in the application process, each applicant signed a misconduct form so some files contained a signed paper copy where the applicant was asked directly the three misconduct questions addressed in provision (a); however, with implementation of the new system through the third party vendor, each applicant is asked these misconduct questions as part of the application process which must be answered before submitting the application. An interview with the HRD and Central HR further verified that this information that the misconduct questionnaire is built into the system now and all new applicants and current employees applying for promotions will complete it online. The auditor randomly selected 13 employees that were hired within the past 12 months and reviewed their personnel file documents. All contained the attestation about omission of information and the questionnaire about prior misconduct. The interview with the HRD explained that all employees have a continuing duty to report misconduct, and that this is covered with the employee upon hire and during training. Random staff 30 interviews confirmed that employees are aware of the continuing duty to report misconduct and that material omissions or false information can result in termination. Interviews with the HRD confirmed that any sexual misconduct disclosed or found during the application process would disqualify a candidate from being employed. 115.317(h): The HRD advised the auditor that responses are provided to any requests for substantiated allegations on prior employees when requested by an

	institutional employer; however, there had been no requests for this information outside MN DOC during the audit period. A systematic review and analysis of the evidence concluded the facility and agency have demonstrated compliance with all provisions of this standard.

115.318	**Upgrades to facilities and technologies**
	Auditor Overall Determination: Exceeds Standard
	Auditor Discussion
	Evidence Reviewed: Policy 301.147; Memo: Vocational Area Modification; Five-Year Camera Plan; Information Obtained from Interviews; Observations During Site Visit. 115.318(a): The agency/facility has not acquired a new facility or made a substantial expansion or modification to existing facilities since the last PREA audit. Interviews with the Agency Head confirmed there were no newly acquired facilities nor any substantial modifications to a facility in the prior 12 months but further explained that design and planning of construction projects must consider the ability to protect or potential to hinder the protection of residents. An interview with the Warden and the Physical Plant Director learned that design and planning of construction projects must consider the ability to assist or potential to hinder the protection of residents. A memorandum provided by the Physical Plant Director documented considerations for PREA were taken into account during the remodel of Vocational Room 174 which will be the substance use disorders (SUD) area used by mental health staff. The memo documented "area will consist of four meeting rooms with clear sight lines and camera without audio installed in each meeting room and common space". During the site visit the auditor corroborated this information during an interview with the Physical Plant Director and observed the area and placement for cameras verifying there were no blind spots. 115.318(b): Policy 301.147 requires that when changes, additions, and/or enhancements are made to any portion of a facility video recording system, the PREA guidelines must be considered in the system design and construction. Facilities must create and maintain a five-year camera plan that details system design, operational goals, budget needs, and areas of concern. The camera plan must be updated annually and submitted to the deputy commissioner of facility services for approval at the beginning of each fiscal year. The camera plan must be retained at the facility and at the DOC central office according to retention schedules. Based on a review of the facility’s Five-Year Camera Plan, assessments for camera replacements and additions in designated areas are tiered out over each fiscal year. This plan is reviewed quarterly and maintained by the facility Camera Committee. This committee assesses the progress of additional technological needs of the facility. A review of the Camera Projects Report shows a dedicated effort in maintaining cameras to enhance supervision and keep residents and staff safe. The

	Camera Projects list specifically identifies areas where recommendations have been made for camera installations to enhance the facility's ability to prevent sexual abuse. The MCF-RW FY24 camera plan indicated the system was upgraded on 12/09/2021. The facility currently has 306 cameras installed. In the last two years, (148) cameras have been installed in various areas throughout the facility as replacements of analog cameras and one additional camera. The Physical Plant Director informed the auditor that this past year the facility replaced all analog cameras in living units with IP cameras. The Camera Projects list specifically identifies areas where recommendations can be made for camera installations to enhance the facility's ability to prevent sexual abuse. In remote or secluded areas where there is an increased chance of an incident, additional cameras have been added as they are identified and vetted through the camera committee. The documented Five-Year Camera Plan and DOC Camera Technical Standards indicate priorities are reviewed regularly. New camera placement requires consideration of PREA standards 115.313, 115.318, and 115.386 based on review of the documentation and an interview with the Physical Plant Director. Interviews with the Physical Plant Director, Warden and AWO/PCM confirmed that when a camera goes down, an emergency work order is submitted for immediate repair; additionally, camera needs and placements are included in the administration team's discussions and the staffing plan reviews. The auditor's interview with the Agency Head confirmed that the agency supports funding of monitoring technology to enhance the protection of residents from sexual abuse, among other safety concerns; additionally, the video recording system aids in the prevention efforts and as an investigative tool. After analysis and evaluation of the stated evidence, the auditor finds the agency and facility exceed the provisions of this standard due to frequency of assessing the facility's technology needs, documented consideration of PREA standards for projects and camera installations, and monitoring of the progress of projects.

115.321	**Evidence protocol and forensic medical examinations**
	Auditor Overall Determination: Exceeds Standard
	Auditor Discussion
	Evidence Reviewed by Auditor: Policy 107.007; Policy 202.057; Policy 301.035; Policy 500.100; Health Services Sexual Abuse Response Checklist Template; First Responder Sexual Abuse Checklist; A National Protocol for Sexual Assault Medical Forensic Examinations; Qualified Staff Member (Advocacy) Resume; Community Victim Advocate Programs Information/Contact Sheet; Case Files; MOU HOPE Coalition; Observations During Site Visit; Information Obtained from Interviews. 115.321(a)(b)(f): Policy 202.057 states that the agency maintains a zero-tolerance policy and investigates all reported or alleged incidents of sexual harassment or

	staff sexual misconduct. The policy outlines specific duties regarding the administrative investigation. In cases where the harassment allegation is between residents, the harassment allegations are investigated by the supervisor in charge of the alleged perpetrator's living area. An individual's sexual allegation against a staff person, volunteer, or visitor is reviewed by the agency's Office of Special Investigations (OSI) for any criminal violations. The PREA Coordinator reviews and determines if an investigation is warranted. Policy 107.007 outlines the procedures for conducting investigations of criminal activity by residents and for assisting law enforcement agencies with conducting criminal investigations involving paid employees, volunteers, contractors, and visitors within the department. Based on the auditor's review of agency policies 107.007, 301.035, 202.057, First Responder Sexual Abuse Response Checklist, Watch Commander Sexual Abuse Response Checklist, Health Services Sexual Abuse Response Checklist, and Sexual Abuse Response Team Guide; interviews with the PREA Coordinator, facility Investigators, and OSI Investigators the auditor determined the agency/facility follows a uniform evidence protocol that maximizes the potential for obtaining usable physical evidence for administrative proceedings and criminal investigations.This protocol is based on A National Protocol for Sexual Assault medical Forensic Examinations and is developmentally appropriate for adolescents. Interview with the OSI Investigator confirmed that allegations with a criminal element are referred to Red Wing Police Department. There have been no incidents forwarded to outside agencies for investigation within the past 12 months. An MOU with Red Wing PD confirms that they will follow requirements of paragraph (a) through (e) of this standard if they investigate a criminal case. Interviews with (18) random security staff determined that staff knows and understands the agency's protocol for obtaining usable physical evidence if an incarcerated person alleges sexual abuse and knew who was responsible for conducting sexual abuse investigations at their facility. Interviews with (3) facility investigators confirmed that all allegations of sexual abuse and sexual harassment are investigated, that abuse allegations and harassment allegations involving staff will be conducted by OSI. There were (5) allegations of sexual abuse reported within the audit period. All were referred to the appropriate authority for an investigation; none warranted a criminal investigation. 115.321(c): Policy 202.057 requires that alleged victims undergo a sexual assault forensic examination at a designated emergency room, where a SANE/SAFE must be utilized. The victim is to be provided an option to access a sexual abuse community advocate during the process. Policy 500.100 states that forensic medical examinations (FME) are offered without financial cost to the victim. In the last 12 months, the facility had no SANE referrals based on the information provided by the facility which was corroborated during an interview with the HSA. Interviews with medical staff and the HSA confirmed that victims of sexual abuse would be taken to the nearest emergency room (Mayo Clinic Red Wing) for medical treatment and FMEs. The HSA explained that they would first attempt the emergency room at Mayo Clinic Health System - Red Wing Hospital, but if they did not have a SANE available within a reasonable timeframe, they would transport the victim to the Mayo Clinic-St. Mary's in Rochester. The auditor verified with a call to the Mayo Clinic System Red Wing who confirmed via telephone call that they have SANE

	services available on call but not full time. The Mayo Clinic-St. Mary's in Rochester confirmed that they would have SAFE/SANE staff available to conduct a forensic medical examination. There were (5) allegations of sexual abuse reported within the audit period. All alleged victims were seen by the medical department but none of the cases warranted a forensic medical examination. 115.321(d)(e): Policy 202.057 requires the alleged victim be offered the option to access a sexual abuse community advocate. The policy further outlines a step-by-step process for sexual abuse advocacy, whether the resident consents or does not consent to a SANE exam. The agency has secured MOUs and/or contracts with 20 organizations across the state for advocacy response services. A resident victim may be connected with services from any of these organizations, generally the one closest to the facility or closest to the person's home to ensure continuum of services are available upon release. These agreements include response to requests from the DOC to provide advocacy when resident survivors are transported to the first available SANE for a sexual assault forensic exam. Additional services provided include acting as an outside responding agency and having a 24-hour phone line accessible; responding to requests to provide advocacy when a resident survivor requests community-based sexual assault advocacy (investigatory, follow-up interviews, and follow-up advocacy); assisting in coordinating on-going contact with a survivor who is incarcerated in a MN DOC facility. The agency provides qualified, internal advocates through the agency's Victim Services Unit when a community-based advocate is unavailable. These services are available via 651-361-7666 (free call) or by mail at Victim Services,1450 Energy Park Drive, St. Paul, MN 55108. Based on the auditor's interview with the agency's designated victim advocate, once she receives a referral for services or a request from an individual, she will make contact, usually within 24 hours, to assess the need. If available, she will connect the resident with outside community services, and if these are not available for the area, she will provide the advocacy directly. Upon request of the victim, an advocate will be provided during the forensic medical examination and during the interviews. This interview also verified that the correspondence with the victim advocate is confidential to the extent of complying with the State's Mandatory Reporting Laws for Juveniles. The agency does not detain residents specifically for civil immigration purposes. The local advocate contact information is provided to residents: Hope Center 1003 7th Street NW, Red Wing, MN 55066. An interview with the Case Manager and the PCMA confirmed that calls between the advocate and resident will be treated confidentially and will be conducted using an office phone or the "legal" phone which are not monitored. An interview with a representative of the Hope Center found that they are available to provide the services outlined in the MOU; however, there has been no request for services within the audit period. The auditor reviewed a sample of the case files and found in cases where sexual abuse was alleged, the documentation indicated the investigator informed the alleged victim of their right to request a victim advocate before conducting the initial interview. 115.321(h): The agency's Victim Services Unit is staffed with qualified victim advocates who have been screened for appropriateness to serve in a victim

	advocacy role. The auditor was provided a resume for the identified advocate for review and found sufficient credentials and training to serve in this capacity. A systematic review and analysis of the evidence concluded the facility and agency have demonstrated compliance with all provisions of this standard. Additionally, based on the agency having agreements or contracts for statewide support services the facility and agency exceed provision (d) of this standard.

115.322	Policies to ensure referrals of allegations for investigations
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Evidence Reviewed: Policy 107.005; Policy 107.007; Policy 202.057; MOU Red Wing Red Wing Police Department (PD); MN DOC Public Website; Information Obtained from Interviews. 115.322(a)(b)(c): Policy 202.057 requires an investigation for all reports or allegations regarding incidents of sexual harassment or staff sexual misconduct. The policy states that allegations without criminal components will be investigated administratively, and allegations containing criminal behavior will be criminally investigated. An individual's sexual allegation against a staff person, volunteer, or visitor is reviewed by the agency's Office of Special Investigations (OSI) for any criminal violations. The PREA Coordinator reviews and determines if an investigation is warranted. Policy 107.007 outlines the procedure for conducting a criminal investigation. The facility indicates on the PAQ that no allegations were referred for criminal investigation. Based on the information provided with the PAQ, the facility reported (30) allegations were received and (28) resulted in an administrative investigation and (1) resulted in a criminal investigation. The auditor was provided an updated Allegations Tracking Spreadsheet reflecting (5) allegations of sexual abuse and (30) allegations of sexual harassment were reported and referred for investigation between February 1, 2023-March 28, 2024. The facility provided an MOU between MCF-RW and Red Wing PD for cooperation in investigating and prosecuting criminal allegations confirming that Red Wing PD acknowledges and understands PREA standards and will follow the requirements of this standard as requested by the facility. The agency's investigative policies describe the investigative responsibilities as required by this standard. The agency’s policy regarding the referral of allegations of sexual abuse or sexual harassment for criminal investigation policy is published on the agency's public website at https://policy.doc.mn.gov/DocPolicy/. During the auditor’s interview with the Agency Head, he confirmed that the agency ensures an administrative or criminal investigation is completed for all allegations of sexual abuse or sexual harassment and explained the scope of the facility staff responsibilities as well as that of the OSI, to ensure that appropriate investigation is

	completed and documented. The auditor discovered during interviews with the AWO/PCM, PCMA, Warden, and (3) Watch Commanders that allegations are reported directly to the facility Warden, OSI, and/or the AWO through a Confidential Incident report by the Watch Commander. Once received, it is assigned for investigation and the next steps are determined based on the initial inquiry as to whether or not the allegation may need to be reviewed for criminal content. The PCMA enters the allegation into the Agency’s PREA database for tracking purposes. The OSI Investigator provided the auditor with an explanation of the local procedures that would be followed during a criminal investigation. He explained that he was new in the role as the facility's assigned OSI Investigator. The OSI Investigator confirmed during the interview that all criminal investigation referrals would be documented. The auditor conducted interviews with the Warden, AWO/PCM, OSI Investigator, PREA Coordinator and Watch Commanders. All parties interviewed explained that all allegations are referred for investigation and that OSI either conducts or oversees the investigation. When criminal behavior is involved, the OSI Investigator is the point of contact for the external law enforcement entity. A systematic review and analysis of the evidence concluded the facility and agency have demonstrated compliance with all provisions of this standard.

115.331	**Employee training**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Evidence Reviewed: Policy 103.420; Policy 103.420; Policy 202.057; FY23 RW Training Matrix; Staff PREA Training Acknowledgements (33); 2023 and 2024 PREA Refresher Training Roster; Sexual Orientation and Gender Based Needs Training Roster; Academy Schedule; PREA Brochure; PREA Training Modules 1-3; Annual Training Plan; PREA Online Refresher Report; Observations During Site Visit; Information Obtained from Interviews. 115.331(a)(b)(c): Policy 202.057 requires staff, volunteers, contractors, or any other individuals who have direct contact with residents to receive information regarding sexual abuse, harassment, misconduct, and the potential consequences for engaging in prohibited conduct with a resident. All DOC staff are trained to recognize the signs of resident sexual victimization and understand their responsibilities in the detection, prevention, prohibition, reporting, and consequences of sexual abuse and sexual harassment. The policy further states that staff must not engage in any form of retaliation against a resident who makes an allegation of sexual abuse or sexual harassment. Policy 103.410 establishes that all staff must adhere to the MN DOC training requirements outlined in the annual training plan and the requirements cannot be lowered below the posted training standard. A facility may increase or add training requirements based on facility needs. Where curriculum has been developed and standardized, the facilities must

	follow the DOC-approved curriculum. Training plan requirements are developed for individuals with resident contact and those with no resident contact. The training plan identifies the various job classifications and which categories of individuals need to take a particular course. The training plan is located on the employee development iShare site and includes a requirement that Prison Rape Elimination Act (PREA) refresher training must be completed annually. Policy 103.420 establishes that all facility, field services, MINNCOR, and must attend the orientation program which includes Preventing harassment and discrimination and PREA information; these job classes include corrections officers, non-corrections staff with resident contact, and all supervisory or managerial staff. The auditor's review of the FY23 Training Matrix further corroborates that PREA: The Standards training curriculum and Preventing Sexual Harassment was required as a refresher course for facility staff, interns and contractors, and non-facility staff. The auditor reviewed the training curricula PREA Training Modules 1-3 and found the material to contain the dynamics of sexual abuse and sexual harassment in confinement, common reactions of sexual abuse and sexual harassment victims, how to detect and respond to signs of threatened and actual sexual abuse, how to avoid inappropriate relationships with residents, how to communicate effectively with LGBTI and gender-nonconforming residents and on how to comply with relevant laws related to mandatory reporting of sexual abuse to outside authorities. The online PREA modules contain individual sections regarding the dynamics of both male and female residents, as well as a section on juvenile dynamics. All staff is trained on both male and female gender-specific information regardless of the gender of the facility that they are assigned to. An interview with the Training Coordinator confirmed that employees who transfer in from another type of facility receive a facility-specific orientation which includes a refresher course specific to the gender of the facility. Policy 103.420 requires employee training to include gender-specific topics. The auditor reviewed the training curricula and determined that the agency and facility meet the standard by providing gender-specific training to all employees. All new employees and contract employees receive PREA training during Pre-Service and then PREA online refresher training every year. The auditor reviewed two training rosters provided by the facility. The 2023 refresher training roster indicated that all staff had completed the required PREA refresher training except for 11 staff who were confirmed to be on extended leave from the facility. The staff listed who are not enrolled, have no resident contact, and are not required to complete the training annually. The 2024 refresher training roster indicates that all staff who are required to complete the refresher course are either enrolled or have already taken the course. The training coordinator provided a copy of the staff sign-in roster with staff signatures for all except the (11) staff on leave. An interview with the training coordinator corroborated the training schedules and verified that she monitors training statistics throughout the year to ensure that all employees who are enrolled in classes complete the training. She explained that she runs an exception report monthly, and weekly as the fiscal year begins to close and anyone who has not completed the required training is notified by an email reminder and a copy to the employee's supervisor. Any staff who are on extended leave will be enrolled upon their return to work. The auditor interviewed (30) random staff using

	the Random Staff Interview Protocol. The auditor oversampled staff interviews because Red Wing facility shares the same campus, services, and staff as Red Wing-Juvenile facility. All staff were able to explain to the auditor the PREA training that they received during training at the academy as well as the annual refresher training. When asked if they were trained on the (11) topics delineated in provision (a) they all responded yes. They were all knowledgeable about what the zero-tolerance policy for sexual abuse and sexual harassment means and how they can comply with the policy. They all knew how to fulfill their responsibilities under agency sexual abuse and sexual harassment prevention, detection, reporting, and response policies and procedures. They understood the residents' rights to be free from sexual abuse and sexual harassment and that there is no such thing as consensual sexual contact with residents. They understood that retaliation for reporting sexual abuse and sexual harassment and participating in an investigation is prohibited. Most all of them were able to explain most of the dynamics of sexual abuse and sexual harassment in confinement and the common reactions of sexual abuse and sexual harassment victims. They were all well aware of how to detect and respond to signs of threatened and actual sexual abuse. All staff explained how to avoid inappropriate relationships with residents by setting professional boundaries and how to communicate effectively and professionally with all residents including lesbian, gay, bisexual, transgender, intersex, or gender nonconforming residents. Lastly, they were informed on how to comply with relevant laws related to mandatory reporting of sexual abuse to outside authorities and the age of consent being 18. 115.331(d): Training is recorded either through the computer-based training system or through sign-in rosters when conducted in person. Based on an interview with the Training Coordinator, training that is conducted in person is also entered into the employee's electronic training record. The auditor reviewed the PREA Refresher completion page that advises the staff of their completion of the training and includes a digital certification with an acknowledgment of completion and understanding of the information provided. The auditor randomly selected and reviewed (33) staff records to review their signed training acknowledgment forms indicating staff understand the training they received. A systematic review and analysis of the evidence concluded the facility and agency have demonstrated compliance with all provisions of this standard.

115.332	**Volunteer and contractor training**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Evidence Reviewed by Auditor: Policy 300.40; Policy 300.045; DOC Volunteer Training PowerPoint; Signed Acknowledgement Forms; PREA Brochure; PREA Training Modules 1-3; List of Contractors and Volunteers; Contractor Training

	Acknowledgements; Volunteer Orientation PowerPoint; (1) Volunteer Packet; Information Obtained from Interviews. 115.332(a)(b)(c): Policy 202.057 requires all volunteers and contractors who have contact with residents to be trained on their responsibilities under the agency's policies and procedures regarding sexual abuse and sexual harassment prevention, detection, and response. Policy 300.045 provides further guidance about the various types of contractors and the requirements for different classifications. The facility indicated 21 volunteers and contractors, who may have contact with residents, have been trained in agency's policies and procedures regarding sexual abuse and sexual harassment prevention, detection, and response. Staff, volunteers, contractors, or any other individuals who have direct contact with residents must receive information regarding sexual abuse, harassment, misconduct, and the potential consequences for engaging in prohibited conduct with a resident. The facility reported on the PAQ there were 32 volunteers and contractors who have contact with residents, who have been trained in the agency's policies and procedures regarding sexual abuse and sexual harassment prevention, detection, and response. The facility provided a list of these contractors and volunteers as well as a list of 69 approved service contractors who have been advised of the agency's zero tolerance policy. The auditor reviewed 30 acknowledgment statements for contractors and 1 volunteer packet provided with the PAQ indicating they have received and understood the training on the agency's zero tolerance policy. Based on the auditor's interview with the AWO/PCM, service contractors are advised of the law, the zero-tolerance policy, and how/to whom to make a report; provide them with the sexual misconduct pamphlet and have them sign the acknowledgment statement. The auditor interviewed the staff member responsible for covering the training with contractors and she demonstrated how she delivers the training. Additionally, the auditor interviewed the volunteer coordinator who explained all volunteers must take the volunteer training annually before being allowed entry and contact with residents. Most service contractors will have a staff escort while in the facility unless they are long-term contractors, and in those cases, they are certified annually. In addition to the PREA Modules 1/2/3 training, volunteers must take the Volunteer Orientation Course, which includes agency policy related to personal associations between staff and residents; Prison Rape Elimination Act zero-tolerance policy on the prevention, reporting, and response to sexual assault and sexual harassment; and a sexual misconduct pamphlet. The auditor reviewed the Volunteer Training PowerPoint and found that it includes training on PREA, the agency's zero tolerance policy, setting personal boundaries, and how and to whom to make a report of sexual abuse or sexual harassment. During the onsite audit, the auditor randomly selected and reviewed 9 contractor files for review and found evidence that all had completed the required training and signed corresponding acknowledgment forms. The auditor interviewed 1 contractor during the site visit who was aware of the zero-tolerance policy, his responsibilities, and to whom to make a report if he becomes aware of an incident. The auditor

	interviewed 1 volunteer by phone and confirmed that he had received the required training as well. A systematic review and analysis of the evidence concluded the facility and agency have demonstrated compliance with all provisions of this standard.

115.333	Resident education
	Auditor Overall Determination: Exceeds Standard
	Auditor Discussion
	Evidence Reviewed: Policies 202.057; 202.041; 203.250: Sexual Abuse Prevention and Intervention Handouts; Resident Intake (Initial) and Orientation Checklist/ Acknowledgements (Comprehensive); Video Screenshot; Federal iSpeak Poster; PREA Poster (Multiple Languages); Contracts for: Sign; Spoken; Access to an Interpreter - Language Line Quick Reference; Written and Interpreting Language Services Contract; Chinese, Hmong, and Spanish PREA Hotline and Zero-Tolerance Posters; PREA "What You Need to Know"; PREA Hotline Poster (Multiple Languages); TTY Instructions; Juvenile PREA Video Safeguarding Your Sexual Safety RW; Information Obtained from Residents and Staff interviews; Observations During Site Visit. 115.333(a)(b)(c)(d): Policy 202.057 requires that newly committed residents receive orientation regarding sexual abuse/harassment and reporting. Policies 202.020 and 202.041 require that residents receive a written copy of the Prison Rape Elimination Act, Basic Rights, and rules governing conduct, disciplinary consequences, due process, and appeal procedures, among other documents within 24 hours of admission. Written materials must be provided in a manner that residents with disabilities can understand. Information must be read and explained to residents that are incapable of understanding written documents or who are unable to read. Interpreters must be provided for English as a Second Language (ESL) residents. Policy 203.250 explains step-by-step modifications for residents with disabilities, including auxiliary aids and services, sign language protocols, and how to obtain assistance from State Services for the Blind for residents who have visual impairments or blindness. The facility indicated in their PAQ that all 82 residents admitted in the past 12 months were given initial and comprehensive PREA training and provided 5 samples for review. Resident training records were requested and reviewed for 21 randomly selected residents and this review confirmed that residents receive information at the time of intake about the zero-tolerance policy and how to report incidents or suspicions of sexual abuse or sexual harassment and the comprehensive training on the same day. A review of the PREA Youth Safety Guide indicates that the information is provided in an age-appropriate fashion. Any residents identified as being LEP, deaf, visually impaired, or otherwise disabled, or who have limited

	reading skills will be provided with necessary accommodations to ensure their understanding of the materials. The facility identified 4 LEP youth during the last 12 months, however there were no LEP youth identified during the on-site visit. Interviews with the HSA, 2 educators, the PCMA, and the AWO/PCM/ADA Coordinator all confirmed that there were 4 residents admitted during the audit period who were flagged as possibly needing language services; however, it was later determined that they were all fluent in English and were bilingual. No residents required accommodative services, including language interpretation, within the audit period for delivering PREA education or to address any PREA related issue. The facility identified 1 youth with a physical disability and 95 with a cognitive disability. There were no residents identified with visual or hearing disabilities during the site visit. The auditor interviewed the Intake Lieutenant who walked the auditor through a simulation of the intake process since there were no new arrivals during the site visit. He explained that frequently he processes new residents that don't appear to understand the information or are unable to read well. He explained he takes his time with the new resident and covers all of the written materials to make sure that he understands and allows the resident to ask questions. He explains the rules and other information such as the PREA policy in a manner that is age appropriate. He advised the auditor that there had been no youth within the audit period that had needed any accommodation for a disability; however, he explained how to access the ASL services and the other language services. Additionally, he displayed the PREA educational video to indicate that it is available in English and Spanish and Closed-Caption. He also explained that if a youth displayed a cognitive issue or other barriers that appeared that he was not understanding the material being presented he would reach out to the AWO/PCM who is the ADA Coordinator or to medical or mental health staff for assistance. During an interview with the HSA, she explained the same efforts to ensure that effective communication occurred with the new resident and discussed the multiple resources available within the agency and with community partners that may be used. Red Wing is the only juvenile facility operated by the MN DOC so there are no intra-system transfers. There were 72 residents admitted to the facility on day one of the site visit. The facility identified 1 youth with a physical disability and 95 with a cognitive disability; no resident who are LEP; no residents identified with visual or hearing disabilities; 5 bisexual; and no transgender or intersex. The auditor interviewed 17 residents (9-Random/8-Targeted). The 8 residents represented targeted categories of 5-Cognitive Disability; 1-Physical Disability; 2-LGBTI; 1-Reported Sexual Abuse at this facility; 3-Reported Prior Sexual abuse during risk screening. Several residents qualified for multiple targeted categories but was only counted once in the number of residents interviewed calculation. All youth interviewed had a solid understanding of all aspects of the agency's zero-tolerance policy, ways to stay safe and methods of reporting. All confirmed to have a thorough understanding of all aspects of sexual abuse and harassment prevention and reporting processes. Residents confirmed during interviews that they received the PREA information and education the same day they were admitted to the facility and that they participated in the orientation with their Case Worker which included watching the PREA video. Most of them were

	aware that there are community services available for victims of sexual abuse. 115.333(e): The facility provided the "Initial Intake and Orientation Procedures" form for residents. The form requires the resident to sign stating they received orientation documents, including the resident handbook and PREA literature. The auditor's review of 26 completed forms confirmed that the agency maintains documentation of resident participation in PREA education sessions. 115.333(f): Review of the Sexual Abuse Prevention Handbook provided to residents and the sexual abuse helpline poster confirmed that the agency ensures that key information about the agency's PREA policies is continuously and readily available or visible through posters, resident handbooks, or other written formats. The auditor observed this information posted conspicuously in all housing units and common areas throughout the facility. Resident interviews confirmed their awareness of the resources available to them conveyed by this literature. The agency requires each facility to ensure that key information is continuously and readily available or visible to individuals. The auditor observed the agency's PREA posters and victim advocacy posters prominently posted on bulletin boards and walls in every building accessible by youth (common areas, recreation and work areas, living units, school, program areas, medical). The signage posted was of a size and text that is easy to read, and colorful and posted at a level that most people of average height could see from a distance. The information listed on the signage was accurate and represented the zero-tolerance message, reporting mechanisms, and victim advocate services. The auditor also observed the Audit Notices posted in these same areas in both English and Spanish. Detailed instructions beside the telephones provided call instruction to both the internal and external PREA hotline. Residents may place a phone call using the speed dial number and do not have to enter their PIN thereby remaining anonymous if they wish. A systematic review and analysis of the evidence concluded the facility and agency have demonstrated compliance with all provisions of this standard. The facility consistently delivers comprehensive education to new residents on the same day of their arrival exceeding the requirements of this standard.

115.334	**Specialized training: Investigations**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Evidence Reviewed by Auditor: Policy 107.005; List of Investigators; Special Investigation Training Records; Sexual Harassment Training Certificates; Information Obtained from Interviews. 115.334(a)(b)(c): Policy 107.005 requires that OSI Investigators with specialized training in sexual abuse investigations in confinement settings must conduct sexual assault investigations. All sexual abuse allegations are reported initially to the

	facility's assigned OSI Investigator. If the case is sexual harassment, the OSI Investigator will provide direction to a facility investigator who has specialized training in conducting sexual harassment investigations. The trained OSI Investigator will complete sexual abuse allegations. Training certificates were provided for 7 facility investigators and confirmation from the PREA Coordinator's office for 2 additional facility investigators who completed the PRC 115.334 Specialized Training on Sexual Harassment. The auditor reviewed the curriculum for the training and found that the Investigations training met all criteria required in provision (b). The auditor interviewed (3) facility investigators, including the newly appointed PCMA. They each explained they received the training for investigating sexual harassment in a confinement setting and were able to explain investigative protocol. Their training included techniques for interviewing sexual abuse victims, proper use of Miranda and Garrity warnings, and sexual abuse evidence collection in confinement settings. Additionally, they were all able to articulate to the auditor the criteria and evidence required to substantiate a case for administrative action. The auditor also interviewed the OSI Investigator assigned to Red Wing who will conduct sexual abuse allegations/criminal investigations and assist facility investigators with sexual harassment investigations. He advised the auditor that he has just been assigned to this position and is currently "working out of class". He has completed the PRC 115.34 Specialized Training on Sexual Harassment but has not yet completed the required NIC Investigating Sexual Abuse in Confinement Settings. He stated he will not be assigned an abuse/criminal case until this training has been completed. The auditor found during the interview that he is knowledgeable about investigative procedures, evidence protocols, investigative interviewing and report writing. The previous facility OSI Investigator had been assigned to Red Wing for over 20 years and conducted most all of the facility's investigations prior to retirement. She received training on conducting investigations in confinement settings and her certificate of completion was reviewed by the auditor. An interview with the Warden and AWO/PCM verified that until the assigned facility OSI Investigator completes his training, any sexual abuse allegations will be investigated by another trained OSI Investigator from another facility. Sexual harassment can be investigated by a trained facility investigator but will still be reviewed by OSI. There were 39 allegations reported. Of these, 5 were Resident/ Resident (R/R) Abuse; 30 were R/R Harassment; 2 were Staff(S)/R Abuse; 2 were S/R Harassment. There were 2 cases investigated both criminally and administratively and both were unfounded and investigated by specially trained investigators; An administrative investigation was conducted on all 39 cases by specially trained investigators except for 1. When the auditor requested the missing OSI Investigator's training records it was determined he had not completed the required training in investigating sexual abuse in confinement settings although he is an experienced and trained veteran investigator with OSI. The auditor's review of 15 investigation case files during the initial audit and 7 during the corrective action period determined that they were all investigated by investigators who have received the required training for conducting sexual abuse investigations in

	confinement settings with the exception of the 1 case mentioned above. The auditor determines the agency and facility has met substantial compliance. A systematic review and analysis of the evidence concluded the facility and agency have demonstrated compliance with all provisions of this standard.

115.335	Specialized training: Medical and mental health care
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Evidence Reviewed by Auditor: Policy 202.057; Policy 500.030; Staff Training Records; Contractor Training Records; Training Roster and Certificates for Specialized Training; FY2024 MN DOC Training Matrix; FY2024 Red Wing Training Plan; Information Obtained During Interviews. 115.335(a)(c)(d): Policy 500.030 requires that nursing staff, and full and part-time medical and mental health practitioners in health services, receive specialized training on how to detect and assess signs of sexual abuse and harassment, how to preserve physical evidence of sexual abuse, how to respond effectively and professionally to victims of sexual abuse and harassment, and how and to whom to report allegations or suspicions of sexual abuse and harassment. Staff must take the NIC Training PREA 201 for Medical and Mental Health Practitioners. Medical and mental health practitioners are also required to receive the same basic PREA training as all employees as discussed in the auditor’s narrative in 115.331; contracted providers comply with requirements of 115.332. Training curriculum for medical and mental health staff includes the basic training topics as well as specialized for this class of employees. Training records confirmed both specialized and basic PREA training was completed by all staff. A review of the FY2024 Red Wing Training Plan found that all staff is required to complete the Sexual Abuse & Assault Policy Review and annual in-service which includes a PREA module refresher. The facility provided a training roster and corresponding training certificates for (5) medical staff, (10) mental health staff, (1) contract CNA, and (3) contract mental health practitioners who completed the NIC training as well as training records for basic training. Interviews with (2) medical staff, (2) behavioral health staff, and (1) contract psychiatrist verified they have received specialized training regarding sexual abuse and sexual harassment and explained the training covers topics such as how to detect and assess signs of sexual abuse and sexual harassment; how to preserve physical evidence of sexual abuse; how to respond effectively and professionally to victims of sexual abuse and sexual harassment; and how and to whom to report allegations or suspicions of sexual abuse and sexual harassment. They also explained that they complete annual in-service which always includes a PREA refresher module.

	115.335(b): Policy 202.057 establishes that facility staff do not conduct sexual assault forensic examinations; therefore, this provision is not applicable. A systematic review and analysis of the evidence concluded the facility and agency have demonstrated compliance with all provisions of this standard.

115.341	Obtaining information from residents
	Auditor Overall Determination: Exceeds Standard
	Auditor Discussion
	Evidence Reviewed: Policy 115.341; Policy 202.040; Policy 202.057; Policy 203.011; Policy 500.050, Health Screenings and Full Health Appraisals; Screening Tool Matrix and Instructions; Sample Progress Report; Completed Initial PREA Screenings; Completed Reassessments; Investigative Case Files; Information Obtained from Interviews; Observations During Site Visit. Evidence Reviewed During CAP Period: List of New Arrivals; Completed Initial PREA Screenings; Completed Reassessments; Information Obtained from Interviews. 115.341(a): Policies 202.040 and 202.057 require that a staff member must complete a sexual assault risk screening within 24 hours of the resident's arrival to the facility. Health services staff must screen residents for potential vulnerability to sexual assault and/or tendencies to act out with sexually aggressive behavior using the MN DOC PREA screening tool in COMS; Designated staff review COMS daily for PREA subscriptions and complete follow-ups. The facility AWO and facility SART use the Screening Tool Follow-up Matrix as a guide to identifying the appropriate follow-up response and case-by-case decision making. Staff must complete PREA screenings in COMS Obligation. All follow-up responses are documented in COMS Obligation. The facility indicates that 82 (100%) residents received screenings for risk of sexual victimization or risk of sexually abusing other residents within 24 hours of their entry into the facility. Policy 202.057 requires residents to be rescreened within 30 days of intake date and whenever an allegation of sexual abuse is made. Policy 115.341 establishes that the resident's assigned case worker is responsible for providing or coordinating case management activities, including case history reviews, needs assessments, Individualized Treatment Plans, program progress evaluations, 30-day Treatment Plan reviews, transition/aftercare planning, and individual and group counseling. The case worker schedules 30-day treatment plan reviews as well as quarterly progress reports, which provide periodic status checks throughout the resident's confinement. Interviews with medical staff confirm that they see each resident within two hours of arrival at the facility and conduct the PREA risk screening at that time. Interviews with case workers confirm that they meet with their assigned residents at a minimum every thirty days but generally have weekly contact. The cottage model of the facility allows residents to be housed in small groups, and each resident is

	afforded a single room. When residents need to be separated, this can be accomplished through a cottage reassignment. The auditor reviewed (22) initial screenings of youth who arrived within the audit period provided by the facility with the PAQ and determined that residents are screened within 24 hours of arrival. The auditor reviewed the agency's policy requirements for screening residents periodically throughout their confinement and found that Policy 202.057 requires that residents be rescreened within 30 days of intake and whenever an allegation of sexual abuse is made. The Auditor selected (17) youth files for review during the site visit, (6) had a documented 30-day reassessment for a 65% compliance rate. The Auditor reviewed (15) investigative case files and observed a clear pattern of reassessments being conducted (when warranted) on residents involved in PREA incidents. As a result of the 65% compliance rate for reassessments, the facility entered a 180-day corrective action period to remedy this deficiency. CORRECTIVE ACTION TAKEN: On July 1, 2024, the facility AWO instructed the Case Managers via memorandum to ensure the periodic reviews required by the standard are conducted within the time frame required by agency policy 202.057, within 30 days. This directive included instructions on setting up a reminder in the database (COMS) and through calendar reminder. During a periodic check-in with the PCMA on July 9, 2024, the auditor was advised that (13) youth were processed into the facility between April 26, 2024, and July 8, 2024. Of these, (11) were reassessed within 30 days and (2) were reassessed past the 30-day requirement. On August 14, 2024, the Auditor was provided a list of new arrivals between July 1, 2024, and August 1, 2024, which included (5) new youth. The Auditor's documentation review concluded, all (5) received an initial screening on their date of arrival and a reassessment within (18) days after their initial assessment which satisfies the rescreening requirement within 30 days. The facility has substantially demonstrated compliance with provision (a) and exceeded by consistently completing the initial screening of new intakes within two hours of their arrival at the facility. The facility has demonstrated that reassessments are now completed within 30 days. 115.341(b)(c): A review of the PREA Screening form indicates that risk assessments are conducted using an objective screening instrument. Questions include information regarding incarceration history; history of violence; sex offender history; sexual abuse perpetration history; disability information; age; appearance; physical build; LGBTI and gender non-conforming identification; and sexual abuse victimization history. All residents interviewed told the auditor that they were asked these screening questions upon intake at the facility by medical. 115.341(d): Policy 203.011 details the case management process that includes individual treatment plans and program progress reports. The resident's assigned case worker is responsible for providing or coordinating case management activities, including case history reviews, need assessments, transition/aftercare planning, and individual and group counseling. A review of the Progress Report shows a designated area for "risk areas to address." This report includes the resident's safety/vulnerability according to the PREA risk assessment. Policy 202.040 requires that a health care staff member weighs in on the sexual assault risk assessment regarding physical impairments/disabilities and any other medical,

	dental, behavioral health information. This information must be retained in the appropriate medical/behavioral health file. Resident interviews confirmed that they meet with their case worker regularly and have regular and frequent access to all levels of staff involved in their treatment needs. 115.341(e): Policy 202.057 requires confidentiality and professionalism at all times. Sharing of sensitive information is limited to those staff who must know in accordance with policy, state statute, professional licensure, and ethical standards. The policy further requires that staff must, to the extent possible, limit the release of information. Information collected during the risk screening is entered directly into the database and access to this information is restricted only to those who need to know. This was further confirmed through interviews with the HSA, Psychological Services Director, and the AWO/PCM. In addition, the PREA Checklist contains a pre-printed note in red at the bottom of the form: "Do not copy of place in medical health files. Private Data. Place completed form in Confidential File". Interviews with staff who conduct risk screenings confirmed their understanding that the information collected is sensitive and is to be protected and only shared with staff who need to know. A systematic review and analysis of the evidence concluded the facility and agency demonstrated partial compliance with provisions of this standard with provision (a) being out of compliance during the audit. During the 180-day corrective action period the facility implemented an effective corrective action plan to ensure that all youth admitted to the facility are assessed for risk of vulnerability and risk of aggressiveness within 30 days of the initial risk assessment (according to Agency policy). The facility demonstrated full compliance with provision (a) during the CAP period and exceeded provision (a) by consistently completing all initial assessments within (2) hours of the youth's arrival at the facility.

115.342	**Placement of residents**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Evidence Reviewed: Policy 202.040; Policy 301.085RW, Policy 202.045; Juvenile Sex Offender Treatment Program (SOTP) Needs Assessment; Administration Separation Approval Form; Memo: Resident Placement Procedures; Data Privacy Notice; Disciplinary Sanctions Evidence; Information Obtained from Interviews; Observations During Site Visit. 115.342(a): Multiple screening tools are used to assess risks and needs of the residents at MCF-RW and based on interviews with the Warden, PCM/AWO, staff who conduct risk screening, and staff who make placement decisions, the collective result of data from these instruments and observations shared among the Multi-Disciplinary Team is used to make housing, programming, and work assignment

	decisions. The primary goal is to keep residents safe while meeting their needs assessment goals. Resident interviews indicated a high level of safety at the facility and staff responsiveness to any incidents of incompatibility between residents. Residents expressed comfort with their housing and programming assignments and indicated that they have access to a team of people who can assist them with their needs if they have any problems. MCF-RW facility indicated that program placements are made following 201.100. The facility also provided a comprehensive description of how the screening tool impacted the classification placements of (7) residents. The comprehensive description was accompanied by documentation of a Successful Living Plan form, individual case notes and confidential incident report. 115.342(b)(h)(i): Based on interviews with the Warden, and the PCM/AWO, MCF-RW does not use isolation for those who are identified as potentially vulnerable to sexual victimization. An interview with the AWO/PCM and case managers confirmed these youth would be housed in a building that offers single room housing on the main floor as found in the cottage housing. 115.342(c): Policy 202.045 prohibits the placement of lesbian, gay, bisexual, transgender, gender non-conforming, or intersex residents in dedicated facilities, units, or wings solely on the basis of such identification or status unless such placement is in a dedicated facility, unit, or wing established in connection with a consent decree, legal settlement, or legal judgment for the purpose of protecting such residents from harm. The facility does not have any dedicated wings of this nature, and a review of the housing roster combined with interviews with Multi-Disciplinary Team members confirms that residents are not housed according to their sexual orientation. The PREA screening form indicates that the question regarding LGBTI status is under the sexual victimization considerations and not used to determine sexually aggressive behaviors. The facility indicated (5) residents who were gay or bisexual and no transgender or intersex residents housed at the facility in the last 12 months. The auditor interviewed (2) bisexual residents and both denied being housed in a dedicated wing based on their sexual orientation. 115.342(d): Policy 202.045 requires that in deciding whether to assign a transgender, gender non-conforming, or intersex resident to a facility for male or female residents, the department considers on a case-by-case basis whether a placement would ensure the resident’s health and safety and whether the placement would present management or security problems. There have been no transgender or intersex residents housed at the facility during the prior 12 months. The auditor conducted a virtual interview with the Statewide Medical Director who is the chair of the agency's Transgender Committee, and he explained that the committee is a Multi-Disciplinary Team that would evaluate and consider requests concerning the care, needs, and housing requirements for transgender residents and incarcerated persons. 115.342(e): The case worker schedules 30-day treatment plan reviews as well as quarterly progress reports which provide periodic status checks throughout the resident's confinement. Interviews with medical staff confirm that they see each resident within two hours of arrival at the facility and conduct the PREA risk

	screening at that time. Interviews with case workers confirm that they meet with their assigned residents at a minimum every thirty days but generally have weekly contact. There have been no transgender or intersex residents housed at MCF-RW during the prior 12 months but based on interviews with the case workers and the PCM/AWO, these placement and programming assignments for intersex and transgender residents would be reviewed during the quarterly progress reports reviews. 115.342(f): The PREA risk screening instrument includes a direct question regarding the resident's own perception of vulnerability, which extends to and includes transgender and intersex residents. Staff interviews confirmed that they have a clear understanding of the signs and behaviors of a resident who may be vulnerable, and any overt or covert expression of vulnerability is taken seriously, and necessary actions will be taken to maintain safety for all residents. An interview with the Statewide Medical Director confirmed that the Transgender Committee takes the transgender/intersex resident's own perception of vulnerability into serious consideration. 115.342(g): Policy 202.045 states that the transgender committee makes recommendations regarding facility placement and other matters that it deems necessary to maintain the resident’s safety, such as single-cell/room or shower restrictions. Residents at MCF-RW are afforded single cells based on the design of the facility. Shower stalls are equipped with shower doors, however, should a request for showering separately be received, accommodation would be made through scheduling at times when other residents are not present in the area based on the auditor's interview with the PCM/AWO, Captain, and (3) Watch Commanders. A systematic review and analysis of the evidence concluded the facility has demonstrated compliance with all provisions of this standard.

115.351	**Resident reporting**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Evidence Reviewed: Policy 103.420; Policy 202.057; Policy 203.115; Policy 300.300; Policy 302.020; Resident Handbook; PREA Hotline Posters; Zero-Tolerance Posters; PREA Brochure; I-Speak Poster; Ombudsman Information; Website Review of Resident Handbook; Observations During Site Visit; Information Obtained During Interviews. 115.351(a)(b): Policy 202.057 establishes that MN DOC offers multiple ways to report sexual abuse and sexual harassment. Reports can be made anonymously. Options include calling the Rape, Abuse, and Incest National Network (RAINN); reporting to any staff, volunteer, contractor, or medical or mental health staff; submitting a grievance or sick call slip; reporting to the PREA Coordinator or PCM;

	Telling a third-party to report at 651-603-6798; using the DOC public website, or contacting the Ombuds' Office. Residents are also informed that they may make a report on behalf of someone else. The hotline can be reached by dialing a speed dial number (instructions posted next to the phones) which is monitored by the agency's PREA Coordinator, who retrieves the calls and forwards calls to the appropriate investigator upon receipt. A systems test was conducted from a randomly selected telephone in one of the housing units and calls were successfully placed to RAINN and the DOC Hotline. The Sexual Abuse Prevention and Intervention Guide is provided to every resident upon arrival at the facility; this publication explains individuals are to report abuse to any staff member or supervisor. Policy 202.057 establishes that individuals may report sexual abuse/ harassment/staff sexual misconduct to an outside agency or through a third party. Special mail is governed through policy 302.020 and establishes that correspondence to or from those state federal officials, using the business address of the state or federal official, designated by the department mail committee. The destination or return address must clearly indicate it is to or from one of these sources in order to be treated as special mail. Special mail does not need to be logged as legal mail and is opened only in the individual’s presence. This policy further directs that outgoing special/legal mail must be submitted unsealed. The Special Mail List identifies those state and federal officials that may be corresponded with through the Special Mail procedures. Policy 203.115 establishes that individuals may arrange calls with consular officers, honorary consuls, and diplomatic officers in the same manner as attorney phone calls, and instructions for consular notifications are provided in the Offender Handbook. The Office of the Ombudsman for Corrections is a separate and independent agency and has the authority to take and investigate complaints from IPs. The facility provided a flyer for the Minnesota Office of the Ombudsman for Corrections (OBFC), which is a neutral and independent investigator of complaints regarding state correctional agencies. The OBFC is a separate agency that acts independently of the Department of Corrections and reports directly to the Governor. The filer of a complaint may remain anonymous, and the entity will forward to authorities any report of sexual abuse/harassment reported by an individual. Additionally, individuals can report to the National Sexual Assault Hotline, Available 24 hours at 1-800-656-4673 (RAINN); notices are posted in the living unit with the contact information for both of these external entities. The agency also provides Consular notification and International Prisoner Transfer information if a noncitizen is sentenced to MN DOC custody. The auditor verified during interviews with (17) resident that they were aware of the multiple methods by which a report of sexual abuse or sexual harassment could be made. When asked directly about the method they would use to make a report of sexual abuse or sexual harassment, (14) stated they would tell a staff member and (3) said they would use the hotline. They all knew that they could make a report anonymously by writing medical, the AWO or LT, or the Warden or they could have someone on the outside file a complaint on their behalf. None of the individuals interviewed had made a report of sexual abuse or sexual harassment at the facility.

	Interviews with (30) random staff verified they are aware of the various methods that a resident can make a report and their responsibilities if a report is made directly to them either in person or in writing. All were aware that 3rd party, and anonymous reports should be handled according to the same reporting procedures as other methods of reporting. The agency publishes and distributes a PREA brochure titled "End the Silence". This brochure notifies of the following reporting methods: "Telephone: Rape, Abuse, and Incest National Network (RAINN) *77; Report to any staff, volunteer, contractor, or medical or mental health staff; Submit a grievance or sick call slip; Report to the PREA Coordinator or the facility PREA Compliance Manager; Tell a family member, friend, legal counsel, or anyone else outside the facility. They can report on your behalf by calling the DOC Sexual Abuse Helpline at 651-603-6798; You also can submit a report on someone’s behalf, or someone at the facility can report for you." This brochure was observed in the dayroom and the Case Worker's office. The agency publishes and distributes an oversized Zero Tolerance for Sexual Abuse and Sexual Harassment poster with the following message: "MN DOC offers multiple ways to report sexual abuse and sexual harassment. Reports can be made anonymously; Call Rape, Abuse, and Incest National Network (RAINN) Dial *77. FREE Call; Report to any staff, volunteer, contractor, or medical or mental health staff; Submit a grievance or a sick call slip; Report to the PREA coordinator or PREA compliance manager; Tell a family member, friend, legal counsel, or anyone else outside the facility. They can report on your behalf by calling 651-603-6798; You also can submit a report on someone’s behalf; Use the DOC public website-anonymously; Contact the Ombudsman's Office." Additionally, the MN DOC Victim Services information is included on these posters which advise there are staff available for support services. "Victim Services can provide survivors of sexual abuse with emotional support services. To access these services, call 651-361-7666 or send a letter to: Victim Services at 1450 Energy Park Drive, St. Paul, MN 55108."The agency publishes and distributes an 8.5x11 color print poster for the PREA hotline that goes directly to the PREA Coordinator's office titled Do Not Live in Darkness and Fear. During the site review, the auditor observed the above referenced signage posted throughout the facility in recreation areas, work areas, common areas and living areas, including audit notices and access to outside victim emotional support services. The information provided on this signage was found to be readable and accessible, and placed throughout the facility to convey vital sexual safety information specific to the facility. All PREA signage is approved at the agency level, so it is consistent throughout all facilities within the MN DOC. The message is clear and easy to understand. Signage is provided in English and translated for Spanish, Hmong, Chinese which are the most commonly spoken in the facility. The signage text size, formatting, and physical placement accommodates most readers, including those of average height, low vision/visually impaired, or those physically disabled/in a wheelchair, etc. The information provided by the signage is not obscured, unreadable by graffiti, or missing due to damage. In some areas, signage has been painted on the walls where it is not easily removed. The information on the signage was found to be accurate and aligned with the information used by the auditor to conduct the internal systems testing. The auditor

	also observed notices for both of the external reporting entities prominently displayed in the common areas with the contact information for both of these external entities. The facility also has posted on the bulletin board the Consular notification and International Prisoner Transfer information in the event a non-citizen is sentenced to MN DOC custody; although there have been none assigned to the facility within the audit period. 115.351(c): Policy 202.057 lists methods of reporting which include anonymous and third-party reporting. Once notified, staff must immediately report all third-party reports in a confidential incident report to the watch commander who must then notify OSI. OSI will determine whether, and how, and investigation will proceed. Random staff (30) interviewed were knowledgeable about their responsibility to accept reports of sexual abuse and harassment if made verbally, in writing, anonymously, or by a third party. Staff were also aware of the multiple ways an individual may make a report, and this information is provided during pre-service and in-service training. No reports of sexual abuse or sexual harassment were received by line staff during the past 12 months. The policy also states that staff must report any communication, including rumors from staff or residents that may indicate sexual abuse. The agency requires staff to accept reports verbally and in writing and complete an incident report promptly. 115.351(d): Policy 202.057 states that anyone, including staff, may contact the sexual abuse helpline by dialing 651-603-6798 and following the prompts. Policy 300.300 establishes that staff can utilize a “Confidential report” to report staff misconduct information; however, this method does not necessarily ensure privacy. The auditor’s interview with the PREA Coordinator revealed that the agency has two options for reporting. The internal method is a link on iShare “Report Potential Employee Misconduct,” to which all staff have access; the external method is a link on the agency’s public website “Submit a Complaint about a[n] MN Correctional Facility,” which is directed to the Office of the Ombuds for Corrections. This office is a separate and independent agency and has the authority to take and investigate complaints from or about any MN DOC staff or facility. Staff revealed during interviews that they were aware they could go outside of their chain of command to report sexual harassment or abuse of individuals if they felt it was necessary and knew of the various methods, including contacting OSI directly. The agency also publishes and distributes a brochure titled Sexual Misconduct with Offenders and provides the Employee Assistance Program number to speak with a consultant at 651-259-3840 or 800-657-3719, or by visiting www.mylifematters.com.These brochures are distributed during new employee orientation and are also made available through the AWO/PCM. A systematic review and analysis of the evidence concluded the facility has demonstrated compliance with all provisions of this standard.

115.352	**Exhaustion of administrative remedies**
	Auditor Overall Determination: Meets Standard

	Auditor Discussion
	Evidence Reviewed: Policy 202.057; Policy 303.100; Information Obtained During Interviews. 115.352(a): Based on the auditor's review of policies 202.057 and 303.100 and interviews with the PREA Coordinator and AWO/PCM, the agency does not have administrative procedures to address sexual abuse grievances. Therefore, the remaining provisions (b-g) are not applicable. The facility meets this standard through non-applicability.

115.353	**Resident access to outside confidential support services and legal representation**
	Auditor Overall Determination: Exceeds Standard
	Auditor Discussion
	Evidence Reviewed: Policy 107.007; Policy 202.057; Policy 203.115; Resident Handbook; PREA Brochures with Victim Advocate Phone Number (English, Spanish, Hmong, Chinese) Advocacy Services Fact Sheet; MOU MN Indian Women's Resource Center; MOU Hope Center; MOU Rape Crisis Services Center; MOU Family Pathways; MOU: Hope Coalition; MOU: PAVSA; MOU: Sexual Violence Center; MOU: Southern Valley Alliance; MOU: Outfront MN; Information Obtained from Interviews; Observations During Site Visit. 115.353 (a)(c): Based on the auditor's interview with the PREA Coordinator, the MN DOC Victim Services & Restorative Justice (VSRJ) unit coordinates victim survivor advocacy services for residents. A Victim Services Specialist may be reached at 651-361-7666 (free call) or by mail at Victim Services, 1450 Energy Park Drive, St. Paul, MN 55108. The unit has secured either MOUs or contracts with 20 advocacy centers across the state who are able to provide services to residents. Based on the auditor's interview with the Victim Services Specialist, once she receives a referral for services or a request from an individual, she will make contact, usually within 24 hours, to assess the need. If available, she will connect the resident with outside community services, and if these are not available for the area, she will provide the advocacy directly. The Victim Services and Restorative Justice (VSRJ) unit holds MOUs and/or contracts with the programs listed below for the purpose of providing victim survivor advocacy services to those who are incarcerated or on supervised release with the DOC. Each request for services is reviewed by the Victim Services Specialist whose primary role is to provide support and information to sexual violence victim survivors as well as the Victim Services Coordinator. An advocacy program is offered to the resident victim survivor based on cultural needs, release date, facility location, county of historical ties, program capacity, and any other needs expressed by the victim survivor. Once a victim survivor selects a program and has signed a release of information a confidential call is set up with the

	advocate. Correspondence with the Victim Advocate is confidential to the extent of complying with the State's Mandatory Reporting Laws for Juveniles. The agency does not detain residents specifically for civil immigration purposes. The local victim advocate for Red Wing is Hope Coalition which was confirmed during a phone call with the Director at the center. She explained that they are available to assist sexual abuse victims at Red Wing whether or not the abuse occurred in confinement or prior. Services provided include counseling, education, support, and referrals as well as sexual assault advocacy and investigatory interviews. She said that she and her team have worked with the MN DOC Victim Advocate's office and with local staff at Red Wing in providing counseling services. There have been no SANE/SAFE exams that she is aware of, but counseling services have been provided for residents who have suffered abuse. Additionally, she explained that counselors at Hope Coalition will maintain confidentiality of communications with survivors who are living in a DOC facility following the Center's and DOC's policies and procedures but advises the client of their limitations with regard to state mandatory reporting laws with juveniles and incidents that occur in a state facility. Information containing the phone number and mailing address of Hope Coalition was observed on the dayroom bulletin boards in each housing unit. Interview with the AWO/PCM and facility investigator confirmed that the facility provides individuals at Red Wing with access to outside victim advocates for emotional support services related to sexual abuse and that requests to be connected with these services are handled as confidentially as possible. The auditor interviewed the Victim Services Specialist and learned that in addition to ensuring individual assistance is provided to resident victims and that they are connected with the services they require, she is qualified to provide interim advocacy until the individual can be connected with the appropriate community advocate. Posted throughout the facility is the Victim Advocate Services information poster that includes the address and phone number for Victim's Services and the address and phone number of National Sexual Violence Resource Center; and the speed dial number *77 f or the Rape, Abuse, and Incest National Network (RAINN) which is an option for the resident. The auditor observed signage by the phones in the living area advising that all calls may be monitored or recorded. The Victim Services Specialist explained that calls between the advocate and resident are scheduled and conducted on a telephone outside the dormitory, generally in the same area that a legal call would be made, to protect the sensitive nature of the call and to allow the call to be private and unmonitored. Interviews with 17 residents confirmed they are aware that these services are available and understand they can request a confidential call, and it will be arranged through their case manager or Behavioral Health. 115.353(b): The Victim Advocate Services poster advises individuals that MN DOC does not guarantee the confidentiality of communication to the outside party when placed from the housing unit phones; any communication from the facility is subject to normal communication monitoring unless otherwise noted. The Data Privacy/ Monitoring notice advises the resident that all resident communications (including mail, telephone, and person-to-person) are subject to monitoring.

	Based on analysis and evaluation of the evidence reviewed, the facility and agency have demonstrated compliance with this standard; additionally, the agency exceeds by having a dedicated agency victim advocacy unit to ensure individual assistance is provided to resident victims of sexual abuse both statewide and locally.

115.354	Third-party reporting
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Evidence Reviewed: Policy 202.057; Ombuds Information; Hotline Posters; PREA Brochures (Multiple Languages); Agency Website Review; Information Obtained from Interviews; Observations During Site Visit. 115.354(a): Policy 202.057 establishes that staff may receive an anonymous kite, hear a rumor, or other third-party information (including from an residents family or friend) that a resident has been the victim of sexual abuse/harassment/staff sexual misconduct at which time they must immediately report all information in a confidential incident report to the watch commander/duty officer. Based on the auditor's interview with the PREA Coordinator and AWO/PCM, family, friends, or any other person can report sexual abuse/harassment to any MN DOC staff at any time. The agency has established a method to receive third-party reports of sexual abuse and sexual harassment by providing a toll-free PREA Hotline at 1-651-603-6798, and callers may remain anonymous. This information is posted on the agency’s public website which also contains a link to email the PREA Coordinator directly. Signage containing this information was observed by the auditor posted throughout the facility in areas where residents and visitors have access and are published in English, Hmong, Chinese-Mandarin, and Spanish. The signage can be easily read by residents and is very clear and easy to understand. The size, formatting, and physical placement accommodates most readers, including those of average height, and low vision. Information provided by the signage is not obscured, unreadable by graffiti, or missing due to damage. The information on the signage was found to be accurate and consistent throughout the facility. Interviews with residents confirmed they are aware they can have a family member or friend report sexual abuse, sexual harassment, or retaliation on their behalf through third-party reporting. The auditor conducted a systems test by calling the PREA Hotline as it is the agency's established third-party method for reporting; the auditor left a message on the voicemail and received a call back from the Agency's PREA Coordinator confirming that the call was received and that if it would have been a third-party reporter, the information would be taken and forwarded to either the facility or OSI, as appropriate, for investigation. A systematic review and analysis of the evidence concluded the facility and agency have demonstrated compliance with all provisions of this standard.

115.361	Staff and agency reporting duties
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Evidence Reviewed: Policy 202.057; Policy 302.121; Policy 300.300 Incident Reports; Minn.R. 2960.0080; Information Obtained from Interviews. 115.361(a): Policy 202.057 requires that all staff, contractors, and volunteers must immediately report any knowledge, suspicion, or information regarding an incident of sexual abuse or sexual harassment or staff sexual misconduct that occurred in a facility; this includes medical and mental health practitioners unless otherwise precluded by law. Policy 302.121 specifically states that staff must immediately report knowledge, suspicion, or information received regarding retaliation against residents or staff that report PREA allegations. The policy further states that staff must immediately report any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation. The policy further directs that staff must, to the extent possible, limit the release of information to protect the victim and reporter of sexual abuse from retribution as per Minn Stat. section 13.82, sub d. 17. Training curriculum ensures that employees are trained on the required reporting procedures and are instructed to maintain the confidentiality of any information known regarding sexual abuse or harassment allegations outside of their responsibility to report the incident and aid the investigation or treatment or for security and management decisions as deemed necessary. Based on the auditor's interview with the AWO/PCM, the facility investigator is notified of these incidents as well as the PREA Coordinator, the Warden, the resident's parents/guardians (if appropriate), and the resident's probation officer. These notifications are made as soon as possible when there is enough information to share. If a juvenile court retains jurisdiction over the victim, notification will also be made to the county that placed the resident at the facility. Random staff interviews (30) confirmed that they are aware of this duty to protect the confidentiality of sensitive information. The auditor reviewed the Confidential Incident Report Routing Guideline Matrix and found that the first level routing includes notification to the OSI investigator for Sexual Abuse/Assault and Sexual Harassment incidents perpetrated by staff or another incarcerated person. Review of case files, SART Response Checklists, and Confidential Incident Reports confirms that staff immediately report any allegation received, regardless of the origin of the report. An interview with the facility investigator confirmed that the facility Watch Commander contacts her for notification purposes and further guidance when warranted any time that a PREA allegation is made. 115.361(b): Policy 302.121 requires mandatory reporting of maltreatment of minors or vulnerable adults housed at a licensed juvenile facility which includes sexual abuse as defined by Minn. Stat. 626.556, subd.2d and neglect as defined in Minn. Stat. 626.556, subd.2f. During the auditor's interviews with the facility's OSI Investigator and AWO/PCM, notifications would be made to the Department of

	Human Services (DHS) in accordance with State law. 115.361(c): Policy 302.121 states that staff must not reveal any information related to a sexual abuse report to anyone other than to the extent necessary to make treatment, investigation, and other security and management decisions. Random staff interviews verified that staff are well educated on maintaining strict confidentiality with regard to sexual abuse allegations. Interview with the Warden confirmed that disciplinary action is warranted for any staff who does not observe confidentiality of information. 115.361(d): Policy 202.057 states that if health services staff receive a direct report from a resident alleging sexual abuse, staff must notify the watch commander immediately and initiate the Health Services Sexual Abuse Response Checklist. If the alleged victim is a minor, a specific reporting requirement may apply. The staff must inform the reporting individual of his/her duty to report and the limits of confidentiality (prior to the initiation of services). The auditor's interview with the HSA and other medical staff confirmed they have been trained on the reporting requirements and understand their responsibility to report all incidents immediately according to policy and that the resident must be informed of the mandatory reporting requirements. Medical and mental health staff interviewed by the auditor confirmed that the mandatory reporting of incidents of sexual abuse and sexual harassment that occur during incarceration is a requirement and is not affected by any Federal, State, or local law to be withheld for confidentiality purposes. The HSA and Psychological Services Director confirmed that medical and mental health staff inform incarcerated persons of the limitations of confidentiality before delivery of services and that they would forward information about sexual abuse or sexual harassment that occurred at the facility immediately for investigation. They also stated that the OSI Investigator is the designee for making the notifications to DHS and as mandated reporters, they would verify that the notification was made according to state law through coordination with the Investigator. The facility provided the auditor with a copy of the Mental Health Informed Consent form as evidence that youth are notified of the limitations of confidentiality for practitioners related to abuse against youth. According to MN state statutes, staff in a licensed facility are legally required or mandated to report if there is reason to believe a child is being or has been neglected or physically or sexually abused within the preceding three years it must be reported immediately (within 24 hours) DHS. 115.361(e): Policy 302.121 requires that the warden/designee must promptly report the allegation to the alleged victim's parent/legal guardian unless the facility has official documentation showing the parent/legal guardian should not be notified. If the alleged victim is under the guardianship of the child welfare system, the report is made to the case worker instead. If the juvenile court retains jurisdiction over the alleged victim, the report is made to the probation officer within 14 days. An interview with the Warden, AWO/PCM, and OSI Investigator confirmed their awareness of this policy and advised notifications are made according to the policy requirements which are aligned with the PREA requirements. The auditor observed in case files notifications made to the appropriate party.

	115.361(f): Policy 302.121 requires that all allegations of sexual abuse and sexual harassment are reported to the facility's OSI Investigator. During the interview with the Warden and AWO/PCM, they both verified that all allegations involving residents are reported to the facility's OSI Investigator and the PREA Coordinator. The auditor's review of the (14) case files and a data report of (44) allegations verified the facility refers all allegations for investigation. A systematic review and analysis of the evidence concluded the facility and agency have demonstrated compliance with all provisions of this standard.

115.362	**Agency protection duties**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Evidence Reviewed: Policy 202.057; Information Obtained from Interviews; Personal Observations During the Site Visit. 115.362(a): Policy 202.057 states that if the agency learns that a resident is subject to a substantial risk of imminent sexual abuse, it must take immediate action to protect the resident. The facility reports no incidents where an individual was subject to a substantial risk of imminent sexual abuse in the past 12 months. Staff interviews confirmed that staff had been educated on the requirement to protect individuals at substantial risk of imminent sexual abuse. All (30) random staff interviews confirmed that they would ensure the individual remained in direct presence of staff in a safe location and would contact the Watch Commander immediately. The auditor's interviews with (3) Watch Commanders verified that they would take whatever action is required to ensure the safety of the individual and would consult with the AWO/PCM, Warden, and OSI Investigator for assistance with determining the next steps if necessary. The Warden explained that if a report is made that an individual is subject to a substantial risk of imminent sexual abuse, they will immediately review the individual’s placement, check-in with the individual to conduct an assessment, and take into consideration the individual's views of the situation, then make a decision based on the information available. Interviews with the PREA Coordinator and Agency Head further confirmed that individuals who are subject to a substantial risk to imminent sexual abuse are to be protected immediately and separated from the threat which may involve a transfer to another facility. Staff interviews confirmed that staff have been educated on the requirement to protect individuals at substantial risk of imminent sexual abuse. A systematic review and analysis of the evidence concluded the facility and agency have demonstrated compliance with all provisions of this standard.

115.363	**Reporting to other confinement facilities**

	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Evidence Reviewed: Policy 107.007; Policy 202.057; Information Obtained During Interviews 115.363(a)(b)(c): Policy 202.057 states that upon receiving an allegation that a resident was sexually abused while confined at another facility, the head of the facility that received the allegation must notify the head of the facility or appropriate office of the agency where the alleged abuse occurred. Presumptively, valid recipients are the facility head, the facility's PREA Compliance Manager, the agency's PREA Coordinator, or the Office of the Agency Head. Such notification must be provided as soon as possible, but no later than 72 hours after receiving the allegation and must be documented. In addition, the OSI Investigator is to receive notification of the allegation. The Warden and AWO/PCM confirmed during interviews that there were (3) allegations received within the audit period that allegedly occurred at another facility; notifications were provided for the auditor's review to indicate that the appropriate authority was notified within 72 hours of the allegation for each incident. An interview with the facility's OSI investigator found that if it is determined this is the first report of the incident, that DHS or the appropriate external law enforcement entity, as appropriate, would be notified. 115.363(d): Policy 202.057 requires that the facility head or agency office that receives such notification must ensure that the allegation is investigated in accordance with the standards. Interviews with the Warden, AWO/PCM, and OSI Investigator confirmed that any report received of this nature would be investigated according to the same protocols noted in 115.322. The facility received no reports of sexual abuse or sexual harassment from another facility within the audit period, which was further corroborated by review of the allegations tracking sheet and interviews with the Warden, AWO/PCM, and OSI Investigator. An interview with the Agency Head confirmed if another agency or a facility within another agency refers allegations of sexual abuse or sexual harassment that occurred within an MN DOC facility, the PCM would be contacted and an investigation would occur immediately, if one was not initiated already. A systematic review and analysis of the evidence concluded the facility and agency have demonstrated compliance with all provisions of this standard.

115.364	**Staff first responder duties**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Evidence Reviewed: Policy 202.057; First Responder: Sexual Abuse Response Checklist Template; Health Services Response Checklist Template; Information

	Obtained from Interviews. 115.364(a)(b): Policy 202.057 identifies a step-by-step process for first responder protocols as 1) Separate the alleged perpetrator and victim so that neither one can hear or see the other. 2) Remain with the victim to provide safety and support and ensure that the victim does not wash, shower, change clothes, or otherwise compromise physical evidence on the individual's body before the examination. 3) Except for health services staff and the watch commander, the staff receiving the report must initiate the First Responder Sexual Abuse Response Checklist. 4) Inform the watch commander/designee of the alleged sexual abuse. 5) Secure the crime scene and take photographs as needed. 6) Complete a confidential incident report. 7) Forward the First Responder Sexual Abuse Response Checklist and confidential incident report to the watch commander. The completed First Responder Sexual Abuse Response Checklist is retained in the investigative file. Form 202.057C Sexual Abuse Response Checklist is required to be completed upon notification of a sexual abuse allegation; Form 202.057E Health Services Sexual Abuse Response Checklist is required to be completed by health services upon notification of a sexual abuse allegation. Both of these forms provide guidance for SART members to ensure that all steps of the response to a sexual abuse allegation are completed and documented. The facility reported on the PAQ there were (7) allegations of sexual abuse reported. The auditor's review of the allegations and interview with the PCMA/ Investigator, PCM, and Warden determined that none of the (7) were reported to staff within a time period that still allowed for the collection of physical evidence; the alleged victim was no longer in contact with the alleged perpetrator, and there was no crime scene to protect. Interviews with (18) security staff learned they were well trained in their first responder duties and responsibilities. They verified actions include separating the alleged victim and abuser; preserving and protecting any crime scene until appropriate steps can be taken to collect any evidence; requesting that the alleged victim not take any actions that could destroy physical evidence (such as 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; ensuring that the alleged abuser does not take any of the above actions that could destroy physical evidence, if the abuse occurred within a time period that still allows for the collection of physical evidence; and immediately notifying medical and mental health practitioners. They also explained that they would contact the Watch Commander right away. Non-security staff (12) interviewed explained the same procedures as security staff except they would contact security to protect the crime scene and to escort the victim to medical. All staff were aware of the First Responder Checklist that must be completed by the person who first learns of a sexual abuse incident. The auditor compared the housing rosters with the allegation spreadsheet and concluded that there were no residents still at the facility who reported sexual abuse within the audit period; therefore, none were interviewed for this targeted category. A systematic review and analysis of the evidence concluded the facility and agency have demonstrated compliance with all provisions of this standard.

115.365	Coordinated response
	Auditor Overall Determination: Exceeds Standard
	Auditor Discussion
	Evidence Reviewed: Policy 202.057; SART Guide; First Responder Sexual Abuse Response Checklists; Health Services Sexual Abuse Response Checklist; Watch Commander Sexual Abuse Checklist; Coordinated Response Plan, Information Obtained from Interviews. 115.365(a): Policy 202.057 outlines the agency's expectations regarding a sexual abuse coordinated response plan which includes instructions on separating the alleged victim and abuser, protecting the crime scene for collection of evidence, advising both the alleged victim and alleged aggressor not to take any actions that could destroy physical evidence. Form 202.057C Sexual Abuse Response Checklist is required to be completed by the first responder upon notification of a sexual abuse allegation; Form 202.057E Health Services Sexual Abuse Response Checklist is to be completed by medical upon notification of a sexual abuse allegation; Form 202.057D Watch Commander Sexual Abuse Response Checklist is required to be completed by the Watch Commander upon notification of a sexual abuse allegation. These forms provide guidance for SART members to ensure that all steps of the response to a sexual abuse allegation are completed and documented. The Sexual Abuse Response Team Guide (202.057G) is completed to track relevant information that will be used to ensure all steps have been taken and to aid the SART in conducting the incident review once the investigation is completed. In addition to policy language and the sexual abuse response checklist, the facility has a documented Coordinated Response Plan that is signed by all designated SART members. The auditor interviewed (7) SART members and the PREA Coordinator and found that they are all knowledgeable of the Coordinated Response Plan requirements and their specific duties while working together as a cooperative team. A systematic review and analysis of the evidence concluded the facility and agency have demonstrated compliance with all provisions of this standard. The agency and facility exceed the minimum requirements by supplementing the Facility's Coordinated Response Plan with checklists for First Responders, Health Services, and Watch Commander and the requirement to have the Coordinated Response Plan signed by all designated SART members.

115.366	Preservation of ability to protect residents from contact with abusers
	Auditor Overall Determination: Meets Standard
	Auditor Discussion

	Evidence Reviewed: AFSCME, Council No.5, AFL-CIO Agreement; Commissioner's Plan; Managerial Plan; Middle Management Association Agreement; Minnesota Nurses Association Agreement; State Residential Schools Education Association Agreement; Unit 208 Council Agreement; Information Obtained During Interviews. 115.366(a): Based on interviews with the Commissioner and Warden and review of the labor agreements in place with the agency, it is determined that the Appointing Authority may place an employee who is the subject of a disciplinary investigation on investigatory leave with pay provided a reasonable basis exists to warrant such leave. A systematic review and analysis of the evidence concluded the facility and agency have demonstrated compliance with all provisions of this standard.

115.367	**Agency protection against retaliation**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Evidence Reviewed: Policy 202.057; Case Files; Information Obtained from Interviews. Evidence Reviewed During CAP Period: Case Files; Retaliation Monitoring Forms; Interviews. 115.367(a)(b)(c)(d)(e)(f): Policy 202.057 requires that staff must not engage in any form of retaliation against an individual who makes an allegation of sexual abuse/ harassment. The policy also dictates that the SART leader must ensure that staff or resident reporters of abuse are protected from retaliation from anyone, including staff or resident. The SART leader must follow up with the reporters and witnesses at 30, 60, and 90 days from the date of the alleged incident. Anyone who cooperates with an investigation is also protected from retaliation. If the allegation is determined to be unfounded, the obligation to follow up ends. All retaliation follow-ups must be documented in the PREA Incident Management System. The facility reports no instances of retaliation within the past 12 months. An interview with the Warden and Agency Head confirmed that retaliation against a resident or any other person who participates in an investigation is prohibited. Multiple measures may be taken to protect an individual from retaliation such as temporary or permanent reassignments (as necessary), housing changes, job changes, facility transfer. Any staff or resident who is found to commit retaliation will be disciplined, as appropriate to the situation. Emotional support services are available for staff through the agency's employee assistance program. The auditor interviewed (2) Lieutenants designated as retaliation monitors, and they were able to described the steps they take in monitoring a resident or staff for retaliation which were found to be in alignment with the requirements found in provision (c).

	The auditor's review of (15) case files found that the more recent cases had complete and well-documented retaliation monitoring; however, of the (39) cases investigated within the prior 12 months (11) were missing monitoring. While the facility demonstrated improvement since the last audit and over the course of the audit period in conducting retaliation monitoring, the auditor determined that the processes for retaliation monitoring were not institutionalized by the issuance of the Interim Report. As a result, the facility was found out of compliance with provisions (c)(d). The facility entered a 180-day corrective action period to correct this deficiency and was required to provide evidence that retaliation monitoring on alleged victims, reporters, and witnesses (where warranted) is conducted for 90 days following a report of sexual abuse. Corrective Action Taken: The Auditor coordinated with the AWO/PCM, PCMA, and Agency PREA Coordinator to develop a corrective action plan to monitor investigations for a minimum of 60 days from the last date of the site visit. The Auditor reviewed 7 additional cases files that were investigated during the Post-Audit/Corrective Action Period, between June 15, 2024, and October 1, 2024. Additionally, the Auditor conducted a follow-up interview with the agency's PREA Coordinator and the facility's APCM. Based on the file reviews and interviews, the facility demonstrated that retaliation monitoring was conducted and documented in all cases where required. The Auditor determined retaliation monitoring is now fulling implemented at the facility. A systematic review and analysis of the evidence, including evidence presented during the corrective action period, concluded the facility and agency have demonstrated compliance with provisions of this standard.

115.368	**Post-allegation protective custody**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Evidence Reviewed: Policy 202.057 and 301.085; Administrative Separation Approval Review Form; Case Files; Information Obtained from Interviews; Observations During Site Visit. 115.368(a): As noted in 115.343, the agency has written policy to govern the management of individuals placed in segregated housing, which is compliant with the requirements of this standard. Policy 202.057 states that following notice of activation, the facility SART leader must promptly take any action deemed necessary for the immediate safety needs of the alleged victim. Involuntary (administrative) segregation should only be assigned when another alternative cannot be found and must not exceed 30 days. Any use of segregated housing to protect an individual who is alleged to have suffered sexual abuse will be done so in accordance with policy 301.085 (also reference 115.343). The facility reported that

	there were no residents held in segregated housing for any period of time, either voluntarily or involuntarily, during the audit period. The auditor interviewed the Warden, AWO/PCM, Captain, Dayton Unit LT; and (3) Watch Commanders, (3) facility Investigators, and the OSI Investigator confirming that no resident was held in segregation for this purpose. The auditor reviewed (15) case files and found that no victim was placed in segregation as a result of the allegation or as a protective measure. The AWO/PCM provided the auditor with a blank Administrative Separation Approval and Review Form that would be used in the event a resident was placed in segregation for protection after a report of sexual abuse. A systematic review and analysis of the evidence concluded the facility and agency have demonstrated compliance with all provisions of this standard.

115.371	**Criminal and administrative agency investigations**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Evidence Reviewed: Policies 107.100, 202.057, 107.007, 103.218, 103.219, 103.225, 107.005; Case Files; Investigator Training Records; Information Obtained from Interviews 115.371(a)(b)(c)(d)(g)(h): The agency has multiple policies that direct criminal and administrative agency investigations. Policy 202.057 states that the agency investigates all matters of sexual abuse and harassment, including third-party and anonymous reports, vigorously through OSI, the facility discipline unit, facility supervisory staff, and outside law enforcement, as directed by the incident. Policy 107.005 establishes that criminal investigations must be conducted by OSI, including violations of the PREA, involving incarcerated persons. This policy also states that OSI must investigate allegations of serious employee, volunteer, and contractor misconduct that may involve criminal behavior or have significant security concerns. Policy 107.100 states that investigations must be completed within 60 days of the date of the complaint unless a shorter period is specified by an agreement or plan. If it appears the investigation will not be complete within 60 days, an extension must be sought through the OSI Deputy Director. Policy 107.005 requires that OSI Investigators with specialized training in sexual abuse investigations in confinement settings must conduct sexual assault investigations. All sexual abuse allegations are reported to the facility's assigned OSI Investigator. If the case is sexual harassment, the OSI Investigator will provide direction to a facility investigator who has specialized training in conducting sexual harassment investigations. The trained OSI Investigator will complete sexual abuse allegations and those that appear to have a criminal element. The two-day specialized training agenda was reviewed and included topics regarding a PREA overview, Trauma and Victim Response, Role of the Victim Advocate, First Responder and Evidence Collection, Agency Culture, Legal issues and Liability, Forensic Medical Exam, Sexual

	Harassment, Interviewing Victims of Sexual Misconduct, and Report Writing. A review of the training curriculum confirms that techniques for interviewing juvenile sexual abuse victims, proper use of Miranda and Garrity warnings, sexual abuse evidence collection in confinement settings, and the criteria and evidence required to substantiate a case for administrative action or prosecution referral is included in the training. Policy 202.057 establishes the requirement for investigations to be documented in written reports that include a description of the physical and testimonial evidence, the reasoning behind credibility assessments, and investigative facts and findings. Administrative investigations that result in a substantiated case of sexual abuse is to include an effort to determine whether staff actions or failures to act contributed to the abuse. The cases reviewed by the auditor were investigated by investigators who completed the specialized training. Policy 107.007 requires that investigators gather and preserve evidence, including any available physical and DNA evidence. Interviews with the AWO/PCM, OSI Investigator and 3 facility investigators confirmed that following an allegation (including anonymous or third-party reports) of sexual abuse or sexual harassment an investigation is initiated immediately. Based on the auditor's interviews with the OSI investigator and (3) facility investigators, an investigation would not be terminated based solely on the source of the allegation recanting, especially if there were other corroborating facts to support the continuation of the investigation. Interview with the OSI investigator and (3) facility investigators confirmed that the investigative written reports will include, when applicable, documentation of DNA evidence, anything of evidentiary value from the crime scene or personal property, photographs of injuries, crime scene photographs, video recordings, interview recordings, telephonic recordings, financial statements, mail, or electronic mail, written statements from victims, witnesses, or perpetrators, staff documentation or incident reports, prior incident documentation, medical records, SANE exam, or forensic evidence. Interviews with the Warden and the OSI Investigator confirmed that cases are reviewed to identify if any staff actions or inactions contributed to abuse findings. Additionally, these interviews found that the credibility of an alleged victim, suspect, or witness is based individually and not determined by the person's status. An individual who alleges sexual abuse will not be required to submit to a polygraph examination or other truth-telling device as a condition to proceed with the sexual abuse investigation. A review of the facility's Investigations Tracking spreadsheet revealed there were 12 allegations reported during the audit period of April 1, 2023, through March 31, 2024. During the site visit the Auditor was informed that The auditor's review of 15 investigative files found in some cases the allegations were not promptly forwarded for investigation (1-referred same day; 6-referred on the next day; 2-referred on the second day; 4-referred on the third day; and 1-was referred five days after the report. Each file contained an AWO/Warden Review Acknowledgement form, but none of them were completed or signed. And the auditor discovered there were several discrepancies in the reports related to dates entered by the investigators. Some of the investigative summaries indicated that an advocate was offered to the alleged victim prior to the interview but the files were not consistently documented with this information. All files did not include a credibility statement nor was there documentation in any

	investigative summary to indicate that staff actions or failures to act contributed to the incident. The auditor acknowledges that the facility has made substantial improvements in following proper investigative procedures and properly documenting their findings in the investigative reports since the last audit after going into corrective action for similar compliance issues. Additionally, the auditor observed that the more recent cases reviewed were improved from the older cases, which shows a clear pattern of progress. The standard requires that allegations of sexual abuse and sexual harassment be investigated promptly, thoroughly, and objectively for all allegations. Based on the auditor's findings the facility did not sufficiently meet all requirements of provision (a)(b)(g) and entered a 180-day corrective action period to remedy these deficiencies. CORRECTIVE ACTION TAKEN: The Auditor coordinated with the AWO/PCM, PCMA, and Agency PREA Coordinator to develop a corrective action plan to ensure allegations of sexual harassment and sexual abuse be investigated promptly, thoroughly, and objectively. The Auditor reviewed 7 additional cases files that were investigated during the Post-Audit/Corrective Action Period, between June 15, 2024, and October 1, 2024. Additionally, the Auditor conducted a follow-up interview with the agency's PREA Coordinator and the facility's APCM. Based on the case file reviews and interviews, the facility demonstrated that all allegations of sexual abuse and sexual harassment were investigated promptly, thoroughly, and objectively. These investigations were well-documented and contained credibility statements, lists of evidence evaluated during the investigations, written statements from witnesses and parties involved in the incident, and an assessment to identify if any staff actions or inactions contributed to the abuse or harassment. Based on these findings, the Auditor determined the facility has met the requirements of (a)(b)(g). The auditor reviewed the tracking spreadsheet for documented cases between February 21, 2023, through April 14, 2024. There were 39 allegations reported. Of these, 5 were Resident/Resident (R/R) Abuse; 30 were R/R Harassment; 2 were Staff(S)/R Abuse; 2 were S/R Harassment. There were 2 cases investigated both criminally and administratively and both were unfounded and investigated by specially trained investigators; An administrative investigation was conducted on all 39 cases by specially trained investigators except for 1. When the auditor requested the missing OSI Investigator's training records it was determined he had not completed the required training in investigating sexual abuse in confinement settings (This case is coded on the spreadsheet as a S/R Harassment but should have been S/R Abuse). Cases were closed with the following dispositions 19 substantiated; 14 unsubstantiated; 6 unfounded. It should be noted that the information entered into the PAQ during the Pre-Audit Period will not agree with the number presented due to incidents that were reported after the PAQ was finalized. The auditor was required to review 12 cases based on the requirements of the Auditor's Handbook. The auditor selected 15 cases for review 2 R/R Abuse; 11 R/R Harassment; 1 S/R Abuse; 1 S/R Harassment. Outcomes of these cases were 9 substantiated; 3 unsubstantiated; 3 unfounded. Outcomes of the investigations show a clear pattern that a preponderance of the evidence is used to substantiate investigations.

	115.371(e)(i): Policy 107.007 directs criminal investigations and requires that interviews are conducted adhering to the suspect's legal rights (Miranda, Scales, Garrity rulings). Policy 107.007 further establishes that substantiated sexual abuse allegations will be presented to the appropriate county attorney’s office for criminal prosecution. OSI investigators are trained criminal investigators who administer compelled interviews only when deemed to be no obstacle to potential prosecution. Based on the interview with the OSI Investigator, when the quality of evidence appears to support criminal prosecution and in consultation with OSI Director, he would consult with and work closely with prosecutors prior to conducting compelled interviews. He is trained in Garrity but will consult prosecuting agencies when and if a case supports criminal prosecution. He further explained that all substantiated allegations of conduct that appears to be criminal will be referred for prosecution. The OSI Investigator assigned to Red Wing confirmed that he is the point of contact who would work with the external law enforcement entity, Red Wing PD on criminal cases and would work collaboratively to stay abreast of developments and informed about the status of any on-going case. 115.371(f): The OSI Investigator and (3) facility investigators confirmed during interviews that the credibility of an alleged victim, suspect, or witness is based individually and not determined by the person's status as an employee or resident. An individual who alleges sexual abuse will not be required to submit to a polygraph examination or other truth-telling device as a condition to proceed with the sexual abuse investigation. These interviews also found that credibility assessments are made on an individual basis and include consideration of past incidents, the motive for reporting, work schedules, living and work assignments, communications, medical/behavioral health data, video and electronic evidence, testimony statements. They further confirmed that under no circumstance would the alleged victim be required to submit to a polygraph examination to proceed with an investigation. The case files reviewed by the auditor documented unbiased credibility assessments. The auditor interviewed (1) resident who reported an abuse allegation was told that the investigator contacted him soon after his report and conducted an interview. The youth stated he was advised of the outcome of the investigation in writing. He was not subjected to a polygraph and said that he was treated fairly throughout the investigation although he disagreed with the outcome. He said that the investigator and lieutenant helped him understand the investigation procedures and why the case was unsubstantiated. He stated that he has been separated where he does not have contact with the other resident. He also stated that the investigator offered him information to contact a victim advocate, but he declined. 115.371(j): Policy 202.057 requires that all documentation related to sexual abuse/ harassment is retained in the individual’s confidential file and aggressor/alleged perpetrator’s confidential file. If the aggressor/alleged perpetrator is a staff member, documentation must be retained as directed by human resources and/or OSI. Policy 107.007 requires that the agency must retain all written reports of investigation of sexual abuse for as long as the alleged abuser is incarcerated or employed by the agency, plus five years. The agency uses an electronic tracking

	and filing system for OSI investigations. The case and any dispositional paperwork received from the county attorney’s office are scanned into this system. The system will keep the information permanently, thus exceeding the requirement that reports are retained for as long as the alleged abuser is incarcerated or employed by the agency, plus five years. These investigations are retained accordingly based on the interview with the PREA Coordinator and OSI Investigator. 115.371(k): Policy 103.225 states that resignations submitted by employees under active investigation must not be accepted without review by the agency human resource manager and the appropriate deputy/assistant commissioners. Policy 107.100 establishes that the departure of the alleged abuser or victim from the custody of the department shall not provide a basis for terminating the investigation. If the alleged abuser is an employee of the department and terminates their employment the investigation shall continue. Interviews also confirmed that departure of the alleged abuse or victim from the employment or control of the facility or agency shall not provide a basis for terminating an investigation. Interviews with the OSI Investigator and Warden confirmed that a thorough investigation will be completed regardless of whether the staff member is still employed, or the individual is incarcerated or released. 115.371(l)(m): Policy 107.007 directs that any law enforcement entity that conducts an investigation into sexual abuse of a resident is made aware of the PREA requirements, and the OSI investigator is the liaison for law enforcement who will communicate and coordinate with the investigating agency to ensure these elements are followed. Policy 107.007 governs criminal investigations and directs that the facility shall cooperate with outside investigators and endeavor to remain informed about the progress of the investigation when conducted by an outside agency. This was confirmed through the auditor's interview with the OSI investigator, Warden, AWO/PCM and PREA Coordinator. They all explained that the facility's OSI Investigator would be lead and would remain in contact with the external investigating entity through the entirety of the investigation. There were no cases referred to external investigating authority during the audit period. A systematic review and analysis of the evidence concluded the facility and agency have demonstrated compliance with all provisions of this standard.

115.372	**Evidentiary standard for administrative investigations**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Evidence Reviewed: Policies 103.225; 202.057; Case Files; Information Obtained from Interviews. 115.372 (a): Policy 103.225 states that for violations of PREA Policy 202.057, no standard higher than the preponderance of the evidence is used in determining

	whether allegations of sexual abuse or sexual harassment are substantiated. Interviews with the OSI Investigator, 3 facility investigators, AWO/PCM and the PREA Coordinator confirmed the facility uses no standard higher than the preponderance of the evidence in substantiating a case of sexual abuse or sexual harassment. There were 39 allegations reported. Of these, 5 were Resident/Resident (R/R) Abuse; 30 were R/R Harassment; 2 were Staff(S)/R Abuse; 2 were S/R Harassment. There were 2 cases investigated both criminally and administratively and were unfounded. Administrative investigation was conducted on all (39) cases by specially trained investigators. Cases were closed with the following dispositions 19 substantiated; 14 unsubstantiated; 6 unfounded. It should be noted that the information entered into the PAQ during the Pre-audit Period will not agree with the number presented due to incidents that were reported after the PAQ was finalized. The auditor was required to review 12 cases based on the requirements of the Auditor's Handbook and selected 15 for review. The cases selected for review were 2 R/R Abuse; 11 R/R Harassment; 1 S/R Abuse; 1 S/R Harassment. Outcomes of these cases were 9 substantiated; 3 unsubstantiated; 2 unfounded. Outcomes of the investigations show a clear pattern that a preponderance of the evidence is used to substantiate investigations. A systematic review and analysis of the evidence concluded the facility and agency have demonstrated compliance with all provisions of this standard.

115.373	**Reporting to residents**
	Auditor Overall Determination: Exceeds Standard
	Auditor Discussion
	Evidence Reviewed: Policy 202.057; Case Files; Completed Notification Forms; Information Obtained from Interviews. 115.373(a)(c)(d)(e)(f): Policy 202.057 states that OSI or the AWO must notify the alleged victim of the outcome of an investigation once it has been determined whether the allegations are substantiated, unsubstantiated, or unfounded. OSI provides the alleged victim relevant information if another agency conducts the investigation. OSI also informs the alleged victim regarding actions taken as a result of an allegation against another resident or staff when the staff/resident is indicted on a related charge; If/when the staff/resident is convicted on a related charge; If/ when the resident has received disciplinary sanctions. The AWO must notify the alleged victim regarding actions taken as a result of an allegation against staff when the staff is no longer in the unit and staff is no longer employed at the facility. The agency’s obligation to report to the resident terminates if/when the allegation is unfounded, or the resident is released from custody. The facility provided (3) examples of notifications to alleged victims with the PAQ for the auditor's review. The auditor interviewed the OSI Investigator and AWO/PCM who both verified they understand their responsibility to notify the victim of the outcome of the

	investigation and any subsequent action taken against the perpetrator in accordance with agency policy and 115.373. The Auditor's review of (15) case files confirmed notifications were made to the alleged victim, and reporter where applicable, in every case for both abuse and harassment allegations. The facility tracks their allegations on a spreadsheet that includes tracking of all associated actions that are required at the onset of the investigation, during the investigation, and post investigation. This spreadsheet indicates that out of (39) cases reported within the review period, only (1) outcome memo was missing and (1) memo had not been generated yet due to the case just being closed. The facility has exceeded by providing notification of the investigative outcome to reporters and alleged victims for harassment cases. 115.373(b): There were (2) cases investigated criminally by an OSI Investigator but neither warranted referral to external law enforcement nor contained a prosecutable criminal element. A systematic review and analysis of the evidence concluded the facility and agency have demonstrated compliance with all provisions of this standard. The facility exceeds provision (a) by providing notification to victims and reporters of sexual harassment investigation outcomes.

115.376	**Disciplinary sanctions for staff**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Evidence Reviewed: Policy 103.218, Discipline Sanctions for Staff; Policy 103.219, Employee Misconduct Investigation and Discipline; Case Files; Policy 103.220, Code of Conduct; Policy 202.057; Information Obtained from Interviews 115.376(a)(b)(c): Policy 202.057 states that residents, staff, contractors, visitors, volunteers, or any other individuals who have business with the DOC are subject to disciplinary action and/or criminal sanctions, including dismissal or termination of contracted services, if determined to have engaged in sexual abuse or sexual harassment of a resident. Agency policy further establishes that termination is the presumptive disciplinary sanction for staff who engage in sexual abuse. No standard higher than a preponderance of the evidence is used to determine whether allegations of sexual abuse or sexual harassment are substantiated. Policy 103.218 establishes that the office of professional accountability is responsible for investigations into allegations of an employee, volunteer, student worker, or contractor misconduct. These investigations are conducted in compliance with collective bargaining agreements, compensation plans, and policies, as well as any applicable state or federal law. Interviews with the HRD confirmed that once an investigation is completed, HR will gather information from the agency database on similar incidents, information on any past disciplinary action against the employee,

	past performance reviews, and supervisor notes. A small committee will convene with the Appointing Authority to review the investigation results and the HR collection of data. The committee will make a recommendation, with the Appointing Authority having the final right of decision, for disciplinary action to be taken. This action is commensurate with the nature and circumstances of the act committed, the staff member's disciplinary history, and the sanctions imposed for comparable offenses by other staff with similar histories. Of the (39) allegations reported within the audit period, (2) were Staff/Resident Sexual Abuse; (2) were Staff/Resident Sexual Harassment. Based on prompt, thorough, and objective investigations, (3) cases were unfounded and (1) was unsubstantiated. The auditor reviewed (2) case files and verified that all investigative procedures were followed. As a result, no discipline was applied to any staff. An interview with the Warden, HRD, and AWO/PCM further confirmed that there were no violations of PREA related policies by staff within the reporting period. 115.376(d): Based on an interview with the Agency Head, OSI Investigator, PREA Coordinator, and Warden, 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, are reported to law enforcement agencies unless the activity was not criminal and to any relevant licensing bodies. A systematic review and analysis of the evidence concluded the facility and agency have demonstrated compliance with all provisions of this standard.

115.377	**Corrective action for contractors and volunteers**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Evidence Reviewed: Policy 300.040; Policy 300.045; Case Files; Volunteer Suspension Guidelines; Information Obtained from Interviews. 115.377(a)(b): Policy 300.040 states that, in compliance with the PREA standards, any volunteer who engages in sexual abuse must be prohibited from contact with residents. The individual must also be reported to law enforcement agencies and relevant licensing bodies unless the activity was clearly not criminal. The DOC also considers incidents of sexual harassment in determining whether to enlist or terminate the services of a volunteer who may have contact with residents. Policy 300.045 establishes that any contractor, physical plant contractor, or design team consultant who engages in sexual abuse must be prohibited from contact with residents. The individual must also be reported to law enforcement agencies and relevant licensing bodies unless the activity was clearly not criminal. Designated facility staff must also take appropriate remedial measures and consider whether to

	prohibit an individual from further contact with residents in the case of any other violation of agency sexual abuse or sexual harassment policies. Of the (39) allegations reported within the audit period, none were alleged against a contractor or volunteer. An interview with the Warden verified that he has the authority to remove a contractor or volunteer from contact with residents during an investigation. Interviews with the Warden and OSI Investigator confirmed that no volunteer or contractor has engaged in or otherwise violated the facility's sexual abuse/harassment policies. An interview with the medical contract manager confirmed that a contract employee would be immediately removed from contact with residents until the conclusion of the investigation. A systematic review and analysis of the evidence concluded the facility and agency have demonstrated compliance with all provisions of this standard.

115.378	**Interventions and disciplinary sanctions for residents**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Evidence Reviewed: Policy 301.078, Safety-Based Separation of Juveniles and Strength-Based Behavioral Interventions (Draft); Policy 202.057; Memo from Commissioner, DOC Licensed Juvenile Detention Facilities; Information Obtained from Interviews; Case Files. 115.378(a)(b): Residents are subject to disciplinary sanctions only pursuant to a formal disciplinary process following an administrative finding that the resident engaged in resident-on-resident sexual abuse. Under 202.057 A resident is afforded due process prior to receiving sanctions for violation of the rules of conduct. The facility indicated they have recently removed their formal discipline process for juveniles based on agency directive. They now utilize "Safety Stabilization Period" and "Administrative Separation" if the need arises to remove a resident from his living unit. Based on a memorandum from the MN DOC Commissioner, effective January 1, 2024, juvenile detention facilities are statutorily prohibited from using isolation as discipline. Safety-based separation can occur when a child is separated by facility staff from other juveniles and by themselves. Administrative separation is used when a facility is looking into serious behavioral offense, evaluating, or investigating criminal activity, or placing youth in individualized modified environment, and determining next steps and requiring administrative approval. Documentation of why Administrative Separation was necessary and other alternatives attempted or considered are required and the instances of Administrative Separation must be tracked and documented. Safety stabilization period (SSP) is staff-initiated separation in a locked or unlocked room when the youth is not free to leave and is used to ensure the safety of youth, staff, and/or facility operations and requiring repeated attempts to reintegrate youth and

	increasing escalated levels of administrative approval if it exceeds 1 hour, 4 hours, and every hour thereafter. SSP must not exceed 24 hours, excluding sleeping hours. Neither safety-based separation methods are intended to be punitive. Youth must still have access to all services required by law, including appropriate medical and mental health care, education, large muscle exercise, leisure time, living conditions, and other basic rights. Safety-based separation must be documented, tracked, reviewed, and reported. The auditor's review of Policy 301.078 found that sexual conduct is listed as one of the behaviors that may result in SSP. If a resident is placed on SSP staff must complete a welfare check and reintegration assessment at 1, 2, 4, and 16 hours, and document the reason SSP is needed to alleviate the ongoing risk to safety and stability; reason reintegration is not possible; specific interventions that were unsuccessful; and name of the supervisor who approved continued SSP. At 4 hours staff and youth create reintegration plan; At 16 and 24 hours – staff and youth update reintegration plan. The auditor reviewed 13 case files involving resident/resident incidents including 2 R/R sexual abuse and 11 R/R sexual harassment. Outcomes of these cases were 9 substantiated; 2 unsubstantiated; 1 unfounded. One R/R abuse case was substantiated and 8 R/R harassment cases were substantiated. Documentation in these files indicated use of Strength-based behavioral interventions to deal with the inappropriate behaviors. These interventions include staff modeling pro-social skills/ behaviors; providing informal verbal feedback and unit log entries; providing formal recognition through positive behavior awards; and giving out extra privileges. Staff use interventions to help youth recognize, evaluate, and alter their inappropriate behavior with guidance of youth to focus on the skills they have learned to change their behavior; support and guidance from peers and staff to process behaviors and/ or challenging situations. These interventions include individualized treatment assignments; review of Aggression Replacement Training® (ART®) skills; asking youth what would help them manage their behavior; asking youth to identify a "Strength for Success" that would help them; youth-defined and natural consequences; and loss of privileges. An interview with the PREA Coordinator, Warden, and OSI Investigator the auditor was advised that sexual assault or sexual abuse that is found to have a criminal element after the investigation will be presented for prosecution. 115.378(c): An interview with the PCMA and Disciplinary Hearing Officer advised that the resident's Behavioral Health Therapist will be consulted to consider whether the resident's mental disabilities or mental illness contributed to his behavior when determining what type of sanction, if any, should be imposed. The auditor's interview with the Psychological Services Director and with the PCM/AWO found that the Multi-Disciplinary Treatment Team weighs in on disciplinary violations and sanctions. 115.378(d): An interview with the Psychological Services Director informed that every youth at the facility is assigned a Behavioral Health Therapist upon arrival to the facility. Regular check-ins promote positive behavior. All residents have Individual Treatment Plans, and updates and modifications are made as needed by their treatment team. The facility has an in-house Sex Offender Program, and

	treatment services are available if deemed appropriate after identification of need and assessment for eligibility. 115.378(e): Interview with the Warden confirmed that residents are not to be disciplined for contact with staff, volunteers, or contractors unless the investigation reveals that the staff, volunteer, or contractor did not consent to the contact. Based on the case file review no resident received disciplinary action or adverse action as a result of the allegation, as there were no substantiated cases of Staff/Resident abuse. 115.378(f): Policy 202.057 states if the investigation reveals that a resident has made a false accusation that the resident, in good faith, could not have believed to be true, the facility may take disciplinary action against the resident through all means available. Residents who falsely report information are reviewed for a violation of the resident discipline regulations and/or criminal statutes. Interviews with the investigator and APCM confirmed that a resident is not punished or disciplined for making an allegation in good faith. 115.378(g): MCF-RW Juvenile Resident Rules of Conduct indicates an infraction code for Sexual Behavior and includes requesting or participating in sexual behavior or sexual contact, kissing, embracing, holding hands, touching intimate parts, exposure of intimate parts, inappropriate masturbation. This behavior is considered a major infraction. A systematic review and analysis of the evidence concluded the facility has demonstrated compliance with all provisions of this standard.

115.381	**Medical and mental health screenings; history of sexual abuse**
	Auditor Overall Determination: Exceeds Standard
	Auditor Discussion
	Evidence Reviewed: Policy 202.057; Policy 500.303, Mental Health Assessment; PREA Screening Forms; MH Referrals & Follow-ups; PREA Checklist; PREA Clinical Note; Mental Health Assessment; Informed Consent Flow Chart; Information Obtained During Interviews. 115.381(a)(b): Policy 500.303 establishes that a qualified staff person must complete the Sexual Violence Prevention (PREA) Checklist as directed in DOC Policy 202.057, “Sexual Abuse/Harassment Prevention, Reporting, and Response” on a resident each time the resident arrives at a facility, and must enter it into the correctional operations management system (COMS). Staff must offer to make a referral for mental health review for a resident with a potential sexual vulnerability; Staff must forward the referral to mental health service if the resident accepts the offer; Mental health staff must provide in-person follow-up services within 14 days of the referral date for residents who accept the offer for a review for potential sexual

	violence vulnerability issues. The policy additionally states that within 14 days of admission to the department, all residents receive a thorough mental health appraisal by a qualified mental health provider, to include a review of sexual abuse victimization and predatory behavior. The initial risk screening is conducted by the medical staff. Interview with the HSA confirmed that the required screening occurs within (2) hours of the youth's arrival at the facility. She further explained that information disclosed about prior sexual abuse victimization or perpetration is forwarded to mental health staff for an evaluation. An interview with the Psychological Services Director confirmed that she and her staff see each new resident on the same day of arrival and if they have disclosed sexual abuse victimization or perpetration they will be offered an evaluation and treatment. Each youth is assigned a Behavioral Health Therapist for the duration of their stay at Red Wing whether or not they indicate a diagnosis. The facility operates a Sex Offender Program and has qualified staff to provide treatment to residents who are identified to have treatment needs. The facility indicated (18) youth reported prior victimization during the last 12 months. The Auditor reviewed (6) screening reports and verified the screening questions attempt to capture any information regarding prior victimization. The facility also provided several follow-up documents for categories including OSI, Lieutenant, 30-day and medical/MH. Resident interviews confirmed that when prior sexual victimization or abusiveness was disclosed during the screening, they were offered a follow-up with a mental health professional. The Auditor interviewed (3) youth who reported prior victimization and determined they met with mental health the day they arrived and were offered counseling. 115.381(c)(d): Policy 202.057 requires that if health services staff receive a direct report from a resident alleging sexual abuse, staff must notify the watch commander/designee immediately and initiate the Health Services Sexual Abuse Response Checklist. If the alleged victim is a minor, specific reporting requirements apply. The staff must inform the reporting individual of his/her duty to report and the limits of confidentiality prior to the initiation of services. The facility provided a sample of the informed consent form with the PAQ informing residents of the mandatory reporting requirement. Information related to sexual victimization or abusiveness occurring in the institutional setting is limited to only those parties who have a need to know in order to conduct a proper investigation and to inform housing, bed, work, education, and program assignments. State law requires notification to Child Protective Services if the victim is under the age of 18. Informed consent is obtained from residents 18 and older before disclosing sexual victimization that did not occur in an institutional setting. Medical and mental health staff utilize the Informed Consent Flow Chart in order to provide appropriate information to residents, based on the specific circumstances of disclosure. Conversations between medical and mental health providers related to informed consent are documented in the clinical charts. Resident interviews confirmed that they understand information related to sexual victimization or abusiveness must be reported by staff, regardless of their position. A systematic review and analysis of the evidence concluded the facility has

	demonstrated compliance with all provisions of this standard.

115.382	Access to emergency medical and mental health services
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Evidence Reviewed: Policy 202.057; Policy 500.100; Health Services Sexual Abuse Response Checklist; Screening and Assessment Samples; Information Obtained from Interviews. 115.382(a): Policy 202.057 establishes that a resident who alleges sexual abuse is offered access to psychological services, medical services, and a sexual abuse advocate. If health services staff are on duty, they must be immediately notified. If health services staff are not on duty, the on-call provider must be notified; if necessary, the designated health care facility or local ER will be notified of the need for a sexual assault forensic exam; and the facility will transport the resident to a health care facility. If behavioral health staff are present, they must be notified. After hours, staff must notify the on-call behavioral health staff, pursuant to 500.303. During interviews with the HSA, AWO/PCM, and PCMA the auditor verified that the MCF-Red Wing utilizes Mayo Clinic Hospital - St. Mary's for Sexual Assault Nursing Exams (SANE). Mayo Clinic Hospital - St. Mary's has (17) certified SANE nurses. MCF-Red Wing Health Services staff or the Watch Commander would contact the St. Mary's Admission Transfer Center and a time of arrival will be coordinated. The auditor contacted the coordinator at St. Mary's and verified that services would be provided to residents from MCF-Red Wing. The auditor additionally learned from an interview with the Psychological Services Director that all residents are assigned a therapist upon arrival to MCF-Red Wing whether they have a history of mental illness or not. She further explained that following a PREA allegation a confidential incident report is written and distributed to her attention, typically on the next day. This information is provided to the primary therapist of the victim. The assigned therapist offers mental health services. If a SART is activated, she will assign the victim to the member of the mental health team who is trained to respond to a SART activation. The facility had (7) sexual abuse allegations reported during the audit period; however, none of these required SART activation. The facility reports there have been no incidents that emergency medical or mental health services to a victim of sexual abuse have been necessary within the audit period, which was corroborated during interviews with the HSA and Psychological Services Director. The HSA and Psychological Services Director are both SART members and were well informed on the Coordinated Response Plan and all procedures that would be followed in the event a sexual abuse incident occurred. Medical and behavioral health staff explained that they would use the Health Services Sexual Abuse Response Checklist to document all actions and notifications and track the specific steps taken to

	ensure unimpeded access to emergency medical treatment and crisis intervention services. The checklist includes the date, time, and initials of the person completing the action item. Steps include activation of the ICS if the victim is seriously injured; ascertaining if the abuse occurred within the last 120 hours and if evidence preservation measures have been observed; ascertaining the type of sexual contact; offering the victim a sexual assault forensic examination (FME) at an area hospital; communicate to the ER/clinic nurse. After the resident's return from the hospital (or if the resident refuses the FME), staff provide education on the risk of sexually transmitted infections and the availability of testing; ensure site practitioner reviews post-examination recommendations for any follow-up testing or treatment. 115.382(b): Policy 202.057 states that in the event of a sexual abuse incident, alleged victims are separated from the alleged perpetrator and all individuals involved in the incident will be kept under constant observation, and a psychological referral will be submitted to the mental health provider by the shift supervisor with details of the incident. Interviews with (30) random staff indicated they were well-trained on the requirement to separate the victim and perpetrator and to ensure the appropriate medical and mental health practitioners are notified immediately in the event of a sexual abuse incident. 115.382(c): Policy 202.057 states that staff must offer the alleged victim support and explain the options related to the SANE exam. The resident must be examined for injuries, sexually transmitted infections (STI), and biological specimens are collected. The resident must be provided with education on the risk of STIs and the availability of STI testing. The Health Services Sexual Abuse Response Checklist confirms that (with consent) the victim undergoes a sexual assault forensic exam, including checks for injuries, STIs, and biological specimen collection. During an interview with the HSA, she explained that victims of sexual abuse are 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; additionally, any orders from an attending physician would be carried out upon return to the facility. 115.382(d): Policy 500.100 states that co-payments are not assessed for initial testing, treatment, and follow-up for reportable communicable diseases, for emergencies, or for any report of an alleged sexual assault, or abuse, or harassment. Based on interviews with medical staff and individuals who have received healthcare services after a report of sexual abuse, individuals receive these services at no cost, whether or not they cooperate with the investigation. A systematic review and analysis of the evidence concluded the facility and agency have demonstrated compliance with all provisions of this standard.

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

	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Evidence Reviewed: Policy 202.057; Policy 202.051; Memo Regarding Ongoing Medical and Mental Health Care; Information Obtained from Interviews. 115.383(a)(b)(c): MCF-RW offers medical and mental health evaluation and, as appropriate, treatment to all individuals who have been victimized by sexual abuse, regardless of where the abuse occurred. Policy 202.057 requires the evaluation and treatment of a victim of sexual abuse/harassment and includes appropriate follow-up services, a treatment plan, and referral for continued care following transfer to/placement in another facility. Referrals may also be provided when the resident is released from custody. The auditor additionally learned from an interview with the Psychological Services Director that all residents are assigned a therapist upon arrival to MCF-Red Wing whether they have a history of mental illness or not. She further explained that following a PREA allegation a confidential incident report is written and distributed to her attention, typically on the next day. This information is provided to the primary therapist of the victim. The assigned therapist offers mental health services. If a SART is activated, she will assign the victim to the member of the mental health team who is trained to respond to a SART activation. Based on interviews with medical and mental health staff, interviews with residents, and a review of protocols, services provided to individuals at MCF-RW are consistent with the community level of care. 115.383(d)(e): MCF-RW houses only male individuals; therefore, these provisions are not applicable. 115.383(f): Policy 202.057 states that health services staff must ensure that the alleged victim is examined for injuries, sexually transmitted infections and biological specimens are collected. Tests for sexually transmitted infections will be conducted at the emergency room at the time of the FME. In cases where the lapse of time does not permit evidence collection or when the victim refuses the FME, the tests will be conducted by MCF-Red Wing medical department, as indicated by the medical provider. This procedure was confirmed during an interview with the HSA. 115.383(g): Policy 500.100 establishes that individuals are not charged a co-pay for initial testing, treatment, and follow-up for reportable communicable diseases; nor for services provided after a report of an alleged sexual assault, abuse, or harassment. Based on interviews with medical staff, individuals receive these services at no cost, whether or not they cooperate with the investigation. 115.383(h): Policy 202.057 requires that a sexual abuse risk assessment be conducted upon being informed that a resident perpetrator has been identified and the allegation has been substantiated. As deemed appropriate, this assessment includes psychological testing, scoring of actuarial tools, and information regarding possible interventions, including the appropriateness of sex abuse-specific mental health treatment, as available at the facility. The risk assessment report is provided to the AWO and Psychological Services Director at the facility housing the alleged

	perpetrator within 60 days of the initial report. The auditor's interviews with the Psychological Services Director and the AWO/PCM confirmed there was one evaluation of a resident who was referred to his assigned Behavioral Health Therapist to deal with inappropriate behavior after a substantiated sexual abuse investigation. The auditor reviewed this referral during the investigative case file review. The auditor additionally learned from the interview with the Psychological Services Director that following a PREA allegation a confidential incident report is written and distributed to her attention, typically on the next day. This information is provided to the primary therapist of the victim and aggressor. The assigned therapists offer mental health services to both. If a SART is activated, she will assign the victim and aggressor to the member of the mental health team who is trained to respond to a SART activation. A systematic review and analysis of the evidence concluded the facility and agency have demonstrated compliance with all provisions of this standard.

115.386	**Sexual abuse incident reviews**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Evidence Reviewed: Policy 202.057; Sexual Abuse Incident Review (SAIR) Report Template; Information Obtained from Interviews. 115.386(a)(b): Policy 202.057 requires an incident review to be conducted at the conclusion of sexual abuse investigations within 30 days of the conclusion of an investigation unless the incident is deemed unfounded. 115.86(c): The review team consists of the Warden, AWO/PCM, OSI Investigator, Captain, HSA, and an area supervisor. Policy 202.057 further requires the team to consider during this review, any needed policy changes; motives which may include such examples as race, ethnicity, gender identity, LGBTI, gang affiliation, or whether the incident was motivated or otherwise caused by group dynamics; assess the physical area where the abuse occurred; assess staffing levels; assess needs for monitoring technology; document information in the PREA Incident Management System under Incident Panel. The auditor interviewed 3 members of the review team and the Warden and AWO/PCM regarding the review team's responsibilities, and each member was knowledgeable about the purpose and importance of the incident reviews. They were able to walk the auditor through the steps the team uses to conduct reviews of closed sexual abuse investigations, which demonstrated a multi-disciplinary team approach. 115.386(d): Policy 202.057 requires the review team to prepare a report of its findings and any recommendations for improvement and to submit the report to the Warden and PCM, and for the facility to implement the recommendations from the review or document the reason(s) for not making the recommended changes. The

	agency has created a form for the review team to complete when conducting a review. This form is comprehensive and covers every element required to be considered in provision (c), which prompts the team to cover all areas. The completed form is distributed to the Warden, PCM, and PREA Coordinator. The Warden explained during this interview that he would implement any recommendations made by the review team provided they were feasible and budgetarily supported. The auditor reviewed the tracking spreadsheet for documented cases between February 21, 2023, through April 14, 2024. A total of 39 allegations were reported during the audit period. Of these, 5 were Resident/Resident (R/R) Abuse; 30 were R/R Harassment; 2 were Staff(S)/R Abuse; 2 were S/R Harassment. Two cases investigated both criminally and administratively and were unfounded. An administrative investigation was conducted on all 39 cases by specially trained investigators. Cases were closed with the following dispositions 19 substantiated; 14 unsubstantiated; 6 unfounded. Of 7 alleged abuse cases, 3 were unfounded. The facility provided an incident review for the 1 substantiated case and the 3 unsubstantiated abuse cases. Recommendations were made during 2 of the reviews and documented; an interview with the Warden confirmed that both recommendations made by the review team were implemented. A systematic review and analysis of the evidence concluded the facility and agency have demonstrated compliance with all provisions of this standard.

115.387	**Data collection**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Evidence Reviewed: Policies 102.050 and 202.057; 2022 Annual Report (Draft); Annual Report; 2022 SSV; MDOC Website; Interviews with the PREA Coordinator. 115.387(a)(b)(d)(e): Policy 102.050 requires the DOC to collect accurate, uniform data for every allegation of sexual abuse at facilities under its direct control using a standardized instrument. The DOC also collects data provided by contracted community partners. The data is collected as needed from all available incident-based documents, including reports, investigation files, and sexual abuse incident reviews, and is stored in the DOC central office communications unit. The DOC aggregates incident-based sexual abuse data annually. Incident-based data collected includes the data necessary to answer all of the questions from the DOJ SSV. The agency's PREA Coordinator aggregates incident-based sexual abuse data annually. Each facility maintains local records of their individual and aggregated data; additionally, each facility's PCM is responsible for entering all incident data into the PREA database, which the PREA Coordinator maintains. Information entered into this system allows the PREA Coordinator to abstract data used to prepare the

	agency's annual report. As of the Interim Report date, an interview with the PREA Coordinator confirmed that the 2022 data has been compiled and reviewed by her office and the 2022 Annual Report has been developed but is in review by the legal office and pending the Agency Head's review and signature. During the corrective action period the 2022 Annual Report was published and posted to the agency's public website. 115.387(c)(f): Policy 102.050 establishes the DOC aggregates incident-based sexual abuse data annually. Incident-based data collected includes the data necessary to answer all questions from the DOJ SSV. The most recent SSV requested by the DOJ was in 2022. The auditor reviewed the completed SSV and SSV-IA; both were submitted as required and by the deadline. A systematic review and analysis of the evidence concluded the facility and agency have demonstrated compliance with all provisions of this standard.

115.388	**Data review for corrective action**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Evidence Reviewed: Policy 102.050; Annual Report; Review of MN DOC's Website; Interviews with PREA Coordinator and Agency Head 115.388(a)(b)(c)(d): Policy 102.050 requires the DOC to collect accurate, uniform data for every allegation of sexual abuse at facilities under its direct control using a standardized instrument. The agency also collects data provided by contracted community partners. The data is collected as needed from all available incident-based documents, including reports, investigation files, and sexual abuse incident reviews, and is stored in the agency's central office communications unit. The agency aggregates incident-based sexual abuse data annually. Incident-based data collected includes the data necessary to answer all of the questions from the DOJ SSV. The policy further requires that the local SART at each facility review data and aggregate it to assess and improve the effectiveness of sexual abuse prevention, detection, and response in policies, practices, and training throughout the department. The SART review includes identifying problem areas, detailing corrective action on an ongoing basis, and preparing an annual report of findings and corrective actions for each facility, as well as the agency as a whole. Information from this meeting is also presented for review, if relevant, to the Security and Camera Committee for consideration. A spreadsheet is maintained by the AWO/PCM for all PREA allegations reported to the facility, and the auditor was provided a copy of the detailed report. Furthermore, the facility enters each allegation into the agency's PREA database, where the PREA Coordinator can extract data to produce the information used in developing the agency's annual report. The annual report includes a comparison of the current

	year's data and corrective actions reported by the SART with those from prior years and provides an assessment of the DOC's progress in addressing sexual abuse. The auditor reviewed the MN DOC Annual Reports and found they include an assessment addressing sexual abuse. The most recent document published contains 2021 data. The PREA Coordinator explained during her interview that she has developed the 2022 report and submitted it for approval but has not received authorization to publish yet. The Agency Head confirmed during his interview that he reviews the annual report developed by the PREA Coordinator and approves it for publication. Once approved, the annual report is electronically stored in the agency's central office communications unit and made available to the public through the agency's public website. The agency may redact specific material from the report when publication would present a clear and specific threat to the safety and security of a facility but must indicate the nature of the material redacted. Additionally, the agency provides on its public website instructions for "Requesting Government Data" at the link https://mn.gov/doc/data-publications/data-practices/. The interview with the PREA Coordinator confirmed the practices are followed as outlined in the agency's policy. During the corrective action period the agency published the 2022 Annual Report and posted it to the agency's public website. A systematic review and analysis of the evidence concluded the facility and agency have demonstrated compliance with all provisions of this standard.

115.389	**Data storage, publication, and destruction**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Evidence Reviewed: Policies 102.050, 107.007, 106.300; 202.057; 301.035; 106.210; Minnesota Records Retention Schedule; Information Obtained from Interviews; Agency's Website Search; Annual Report. 115.389(a): Policy 102.050 requires that the MN DOC retains sexual abuse data in the MN DOC central office communications unit as established in the OSI-PREA retention schedule. The auditor's interview with the PREA Coordinator confirms that this data is collected electronically in the PREA database managed by her office and is securely retained. 115.389(b)(c): Policy 102.050 requires the DOC to collect accurate, uniform data for every allegation of sexual abuse at facilities under its direct control using a standardized instrument. The DOC also collects data provided by contracted community partners. The data is collected as needed from all available incident-based documents, including reports, investigation files, and sexual abuse incident reviews, and is stored in the DOC central office communications unit. Additionally, the agency provides on its public website instructions for "Requesting Government

	Data" at the link https://mn.gov/doc/data-publications/datapractices/. The interview with the PREA Coordinator confirmed the practices are followed as outlined in the agency's policy. 115.389(d): Minnesota Records Retention Schedules were provided for the auditor's review. Additionally, the DOJ SSV; OSI Investigative Files; OSI Evidence Management; OSI PREA Standard Violations (E-files); Human Resources Reports and Documents 1/2/3 involving allegations of sexual assault and harassment are retained in electronic format for as long as the alleged abuser is incarcerated or employed, plus five years. A systematic review and analysis of the evidence concluded the facility and agency have demonstrated compliance with all provisions of this standard.

115.401	**Frequency and scope of audits**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	Evidence Reviewed: Observations During Site Visit; Date Stamped Photographs of Postings; Agency's Website; Interviews; Agency’s Projected PREA Audit Schedule. 115.401(a): The MN DOC ensures that each facility operated by the agency or by a private organization was audited on behalf of the agency at least once in the prior three-year audit period. The agency operates 13 facilities (1-juvenile/12-adult). The facility indicates 12 contracts for the confinement of incarcerated persons that the agency entered into or renewed with private entities or other government agencies. 115.401(b): MN DOC is in the second year of the current audit cycle. During an interview with the agency’s PREA Coordinator, the auditor confirmed that audits are scheduled following the requirements of §115.401, to include those entities under contract with the agency. The projected audit schedule provided to the auditor indicates consistent scheduling to have at least one-third of facilities audited each year. A review of the agency’s website and prior PREA audit reports found the agency consistent and systematic with ensuring audits are completed and posted to their public website promptly. The facility was last audited April 24-26, 2022. The facility was not due for an audit until the third year of the current cycle, but the PREA Coordinator realigned the audit schedule for logistical reasons. 115.401(h)(i): The auditor was allowed access to all areas of the facility and staff and had the ability to observe all processes. The facility provided all documentation and information requested to the auditor in either paper or electronic format. 15.401(m): The auditor was allowed unimpeded access to all residents and allowed to conduct private interviews.

	115.401(n): During the site visit, the auditor observed the Notice of Audit posted in all housing units and other facility common areas. These notices, posted in both English and Spanish, provided scheduled dates of the audit, the purpose of the audit, name of the auditor, accurate contact information for the auditor, and an explicit and factually accurate statement regarding the confidentiality of any communication and limitations to that confidentiality under mandatory reporting laws, with the auditor and anyone who may respond to the notices. The auditor provided the notices on March 15, 2022, and received verification of posting March 26, 2024, via photographs. As this was four weeks prior to the audit, the audit requested that the signs remain posted until the Final Report is issued to allow ample time for anyone to correspond with the auditor if they desire. During interviews, individuals stated they were aware of the audit, and all of them said they had seen the audit notices posted. An interview with mailroom staff confirmed that residents could send mail to the PREA auditor according to the same rules applied to special correspondence. A systematic review and analysis of the evidence concluded the facility and agency have demonstrated compliance with all provisions of this standard.

115.403	**Audit contents and findings**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	115.403(f): The auditor's review of the agency's public website found Final Audit Reports for all facilities posted with links to view the reports.

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.)	yes
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".)	yes
115.313 (a)	**Supervision and monitoring**	
	Does the agency ensure that each facility has developed a staffing plan that provides for adequate levels of staffing and, where applicable, video monitoring, to protect residents against sexual abuse?	yes
	Does the agency ensure that each facility has implemented a staffing plan that provides for adequate levels of staffing and, where applicable, video monitoring, to protect residents against sexual abuse?	yes
	Does the agency ensure that each facility has documented a staffing plan that provides for adequate levels of staffing and, where applicable, video monitoring, to protect residents against sexual abuse?	yes
	Does the agency ensure that each facility’s staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: The prevalence of substantiated and unsubstantiated incidents of sexual abuse?	yes
	Does the agency ensure that each facility’s staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: Generally accepted juvenile detention and correctional/secure residential practices?	yes
	Does the agency ensure that each facility’s staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: Any judicial findings of inadequacy?	yes
	Does the agency ensure that each facility’s staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: Any findings of inadequacy from Federal investigative agencies?	yes
	Does the agency ensure that each facility’s staffing plan takes into consideration the 11 criteria below in calculating adequate	yes

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

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

	functions of the facility? (N/A for non-secure facilities)	
115.315 (a)	**Limits to cross-gender viewing and searches**	
	Does the facility always refrain from conducting any cross-gender strip or cross-gender visual body cavity searches, except in exigent circumstances or by medical practitioners?	yes
115.315 (b)	**Limits to cross-gender viewing and searches**	
	Does the facility always refrain from conducting cross-gender pat-down searches in non-exigent circumstances?	yes
115.315 (c)	**Limits to cross-gender viewing and searches**	
	Does the facility document and justify all cross-gender strip searches and cross-gender visual body cavity searches?	yes
	Does the facility document all cross-gender pat-down searches?	yes
115.315 (d)	**Limits to cross-gender viewing and searches**	
	Does the facility implement policies and procedures that enable residents to shower, perform bodily functions, and change clothing without nonmedical staff of the opposite gender viewing their breasts, buttocks, or genitalia, except in exigent circumstances or when such viewing is incidental to routine cell checks?	yes
	Does the facility require staff of the opposite gender to announce their presence when entering a resident housing unit?	yes
	In facilities (such as group homes) that do not contain discrete housing units, does the facility require staff of the opposite gender to announce their presence when entering an area where residents are likely to be showering, performing bodily functions, or changing clothing? (N/A for facilities with discrete housing units)	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	yes

	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?	
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:	yes

	Residents who have speech disabilities?	
	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	yes

	safety, the performance of first-response duties under §115.364, or the investigation of the resident's allegations?	
115.317 (a)	**Hiring and promotion decisions**	
	Does the agency prohibit the hiring or promotion of anyone who may have contact with residents who: Has engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility, or other institution (as defined in 42 U.S.C. 1997)?	yes
	Does the agency prohibit the hiring or promotion of anyone who may have contact with residents who: Has been convicted of engaging or attempting to engage in sexual activity in the community facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse?	yes
	Does the agency prohibit the hiring or promotion of anyone who may have contact with residents who: Has been civilly or administratively adjudicated to have engaged in the activity described in the bullet immediately above?	yes
	Does the agency prohibit the enlistment of services of any contractor who may have contact with residents who: Has engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility, or other institution (as defined in 42 U.S.C. 1997)?	yes
	Does the agency prohibit the enlistment of services of any contractor who may have contact with residents who: Has been convicted of engaging or attempting to engage in sexual activity in the community facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse?	yes
	Does the agency prohibit the enlistment of services of any contractor who may have contact with residents who: Has been civilly or administratively adjudicated to have engaged in the activity described in the two bullets immediately above?	yes
115.317 (b)	**Hiring and promotion decisions**	
	Does the agency consider any incidents of sexual harassment in determining whether to hire or promote anyone, or to enlist the services of any contractor, who may have contact with residents?	yes
115.317	**Hiring and promotion decisions**	

(c)		
	Before hiring new employees who may have contact with residents, does the agency: Perform a criminal background records check?	yes
	Before hiring new employees who may have contact with residents, does the agency: Consult any child abuse registry maintained by the State or locality in which the employee would work?	yes
	Before hiring new employees who may have contact with residents, does the agency: Consistent with Federal, State, and local law, make its best efforts to contact all prior institutional employers for information on substantiated allegations of sexual abuse or any resignation during a pending investigation of an allegation of sexual abuse?	yes
115.317 (d)	**Hiring and promotion decisions**	
	Does the agency perform a criminal background records check before enlisting the services of any contractor who may have contact with residents?	yes
	Does the agency consult applicable child abuse registries before enlisting the services of any contractor who may have contact with residents?	yes
115.317 (e)	**Hiring and promotion decisions**	
	Does the agency either conduct criminal background records checks at least every five years of current employees and contractors who may have contact with residents or have in place a system for otherwise capturing such information for current employees?	yes
115.317 (f)	**Hiring and promotion decisions**	
	Does the agency ask all applicants and employees who may have contact with residents directly about previous misconduct described in paragraph (a) of this section in written applications or interviews for hiring or promotions?	yes
	Does the agency ask all applicants and employees who may have contact with residents directly about previous misconduct described in paragraph (a) of this section in any interviews or written self-evaluations conducted as part of reviews of current	yes

	employees?	
	Does the agency impose upon employees a continuing affirmative duty to disclose any such misconduct?	yes
115.317 (g)	**Hiring and promotion decisions**	
	Does the agency consider material omissions regarding such misconduct, or the provision of materially false information, grounds for termination?	yes
115.317 (h)	**Hiring and promotion decisions**	
	Unless prohibited by law, does the agency provide information on substantiated allegations of sexual abuse or sexual harassment involving a former employee upon receiving a request from an institutional employer for whom such employee has applied to work? (N/A if providing information on substantiated allegations of sexual abuse or sexual harassment involving a former employee is prohibited by law.)	yes
115.318 (a)	**Upgrades to facilities and technologies**	
	If the agency designed or acquired any new facility or planned any substantial expansion or modification of existing facilities, did the agency consider the effect of the design, acquisition, expansion, or modification upon the agency's ability to protect residents from sexual abuse? (N/A if agency/facility has not acquired a new facility or made a substantial expansion to existing facilities since August 20, 2012, or since the last PREA audit, whichever is later.)	yes
115.318 (b)	**Upgrades to facilities and technologies**	
	If the agency installed or updated a video monitoring system, electronic surveillance system, or other monitoring technology, did the agency consider how such technology may enhance the agency's ability to protect residents from sexual abuse? (N/A if agency/facility has not installed or updated a video monitoring system, electronic surveillance system, or other monitoring technology since August 20, 2012, or since the last PREA audit, whichever is later.)	yes
115.321 (a)	**Evidence protocol and forensic medical examinations**	

	If the agency is responsible for investigating allegations of sexual abuse, does the agency follow a uniform evidence protocol that maximizes the potential for obtaining usable physical evidence for administrative proceedings and criminal prosecutions? (N/A if the agency/facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations.)	yes
115.321 (b)	**Evidence protocol and forensic medical examinations**	
	Is this protocol developmentally appropriate for youth? (N/A if the agency/facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations.)	yes
	Is this protocol, as appropriate, adapted from or otherwise based 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.)	yes
115.321 (c)	**Evidence protocol and forensic medical examinations**	
	Does the agency offer all residents who experience sexual abuse access to forensic medical examinations, whether on-site or at an outside facility, without financial cost, where evidentiarily or medically appropriate?	yes
	Are such examinations performed by Sexual Assault Forensic Examiners (SAFEs) or Sexual Assault Nurse Examiners (SANEs) where possible?	yes
	If SAFEs or SANEs cannot be made available, is the examination performed by other qualified medical practitioners (they must have been specifically trained to conduct sexual assault forensic exams)?	yes
	Has the agency documented its efforts to provide SAFEs or SANEs?	yes
115.321 (d)	**Evidence protocol and forensic medical examinations**	
	Does the agency attempt to make available to the victim a victim advocate from a rape crisis center?	yes

	If a rape crisis center is not available to provide victim advocate services, does the agency make available to provide these services a qualified staff member from a community-based organization, or a qualified agency staff member?	yes
	Has the agency documented its efforts to secure services from rape crisis centers?	yes
115.321 (e)	**Evidence protocol and forensic medical examinations**	
	As requested by the victim, does the victim advocate, qualified agency staff member, or qualified community-based organization staff member accompany and support the victim through the forensic medical examination process and investigatory interviews?	yes
	As requested by the victim, does this person provide emotional support, crisis intervention, information, and referrals?	yes
115.321 (f)	**Evidence protocol and forensic medical examinations**	
	If the agency itself is not responsible for investigating allegations of sexual abuse, has the agency requested that the investigating entity follow the requirements of paragraphs (a) through (e) of this section? (N/A if the agency is responsible for investigating allegations of sexual abuse.)	yes
115.321 (h)	**Evidence protocol and forensic medical examinations**	
	If the agency uses a qualified agency staff member or a qualified community-based staff member for the purposes of this section, has the individual been screened for appropriateness to serve in this role and received education concerning sexual assault and forensic examination issues in general? (Check N/A if agency attempts to make a victim advocate from a rape crisis center available to victims per 115.321(d) above.)	yes
115.322 (a)	**Policies to ensure referrals of allegations for investigations**	
	Does the agency ensure an administrative or criminal investigation is completed for all allegations of sexual abuse?	yes
	Does the agency ensure an administrative or criminal investigation is completed for all allegations of sexual harassment?	yes

115.322 (b)	**Policies to ensure referrals of allegations for investigations**	
	Does the agency have a policy in place to ensure that allegations of sexual abuse or sexual harassment are referred for investigation to an agency with the legal authority to conduct criminal investigations, unless the allegation does not involve potentially criminal behavior?	yes
	Has the agency published such policy on its website or, if it does not have one, made the policy available through other means?	yes
	Does the agency document all such referrals?	yes
115.322 (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?	yes
	Is this information presented in an age-appropriate fashion?	yes
115.333 (b)	**Resident education**	
	Within 10 days of intake, does the agency provide age-appropriate	yes

	comprehensive education to residents either in person or through video regarding: Their rights to be free from sexual abuse and sexual harassment?	
	Within 10 days of intake, does the agency provide age-appropriate comprehensive education to residents either in person or through video regarding: Their rights to be free from retaliation for reporting such incidents?	yes
	Within 10 days of intake, does the agency provide age-appropriate comprehensive education to residents either in person or through video regarding: Agency policies and procedures for responding to such incidents?	yes
115.333 (c)	**Resident education**	
	Have all residents received such education?	yes
	Do residents receive education upon transfer to a different facility to the extent that the policies and procedures of the resident's new facility differ from those of the previous facility?	yes
115.333 (d)	**Resident education**	
	Does the agency provide resident education in formats accessible to all residents including those who: Are limited English proficient?	yes
	Does the agency provide resident education in formats accessible to all residents including those who: Are deaf?	yes
	Does the agency provide resident education in formats accessible to all residents including those who: Are visually impaired?	yes
	Does the agency provide resident education in formats accessible to all residents including those who: Are otherwise disabled?	yes
	Does the agency provide resident education in formats accessible to all residents including those who: Have limited reading skills?	yes
115.333 (e)	**Resident education**	
	Does the agency maintain documentation of resident participation in these education sessions?	yes
115.333 (f)	**Resident education**	

	In addition to providing such education, does the agency ensure that key information is continuously and readily available or visible to residents through posters, resident handbooks, or other written formats?	yes
115.334 (a)	**Specialized training: Investigations**	
	In addition to the general training provided to all employees pursuant to §115.331, does the agency ensure that, to the extent the agency itself conducts sexual abuse investigations, its investigators have received training in conducting such investigations in confinement settings? (N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.321(a).)	yes
115.334 (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?	yes
115.341 (b)	**Obtaining information from residents**	
	Are all PREA screening assessments conducted using an objective screening instrument?	yes
115.341 (c)	**Obtaining information from residents**	
	During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Prior sexual victimization or abusiveness?	yes
	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?	yes
	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	yes

	the agency attempt to ascertain information about: Age?	
	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	yes

	pursuant to this standard in order to ensure that sensitive information is not exploited to the resident's detriment by staff or other residents?	
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	yes

	making facility and housing placement decisions and programming assignments?	
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	yes

	entity or office that is not part of the agency?	
	Is that private entity or office able to receive and immediately forward resident reports of sexual abuse and sexual harassment to agency officials?	yes
	Does that private entity or office allow the resident to remain anonymous upon request?	yes
	Are residents detained solely for civil immigration purposes provided information on how to contact relevant consular officials and relevant officials at the Department of Homeland Security to report sexual abuse or harassment?	yes
115.351 (c)	**Resident reporting**	
	Do staff members accept reports of sexual abuse and sexual harassment made verbally, in writing, anonymously, and from third parties?	yes
	Do staff members promptly document any verbal reports of sexual abuse and sexual harassment?	yes
115.351 (d)	**Resident reporting**	
	Does the facility provide residents with access to tools necessary to make a written report?	yes
115.351 (e)	**Resident reporting**	
	Does the agency provide a method for staff to privately report sexual abuse and sexual harassment of residents?	yes
115.352 (a)	**Exhaustion of administrative remedies**	
	Is the agency exempt from this standard? NOTE: The agency is exempt ONLY if it does not have administrative procedures to address resident grievances regarding sexual abuse. This does not mean the agency is exempt simply because a resident does not have to or is not ordinarily expected to submit a grievance to report sexual abuse. This means that as a matter of explicit policy, the agency does not have an administrative remedies process to address sexual abuse.	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?	yes
	Does the facility provide persons detained solely for civil immigration purposes mailing addresses and telephone numbers, including toll-free hotline numbers where available of local, State, or national immigrant services agencies?	yes
	Does the facility enable reasonable communication between residents and these organizations and agencies, in as confidential a manner as possible?	yes
115.353 (b)	**Resident access to outside confidential support services and legal representation**	
	Does the facility inform residents, prior to giving them access, of the extent to which such communications will be monitored and	yes

	the extent to which reports of abuse will be forwarded to authorities in accordance with mandatory reporting laws?	
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	yes

	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?	
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	yes

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

	accordance with these standards?	
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	yes

	of sexual abuse, does the agency: Act promptly to remedy any such 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: 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	**Criminal and administrative agency investigations**	

(f)		
	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	yes

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

	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?	
	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?	yes

	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	yes

	cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident?	
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	yes

	cooperates with any investigation arising out of the incident?	
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	yes

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

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

	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