PREA AUDIT REPORT ☐ INTERIM ☒ FINAL

JUVENILE FACILITIES

Date of report: July 5, 2016

Auditor Information			
Auditor name: Shirley L. Turner			
Address: 3199 Kings Bay Circle, Decatur, GA 30034			
Email: shirleyturner3199@comcast.net			
Telephone number: 678-895-2829			
Date of facility visit: June 15, 2016			
Facility Information			
Facility name: Northern Ohio Juvenile Community Corrections Facility			
Facility physical address: 1338 Tiffin Ave., Sandusky, OH 44870			
Facility mailing address: *(if different from above)* Click here to enter text.			
Facility telephone number: 419-627-7611			
The facility is:	☐ Federal	☐ State	☒ County
	☐ Military	☐ Municipal	☐ Private for profit
	☐ Private not for profit		
Facility type:	☐ Correctional	☐ Detention	☒ Other
Name of facility's Chief Executive Officer: Krista Collins			
Number of staff assigned to the facility in the last 12 months: 22 (who may have contact with residents)			
Designed facility capacity: 30			
Current population of facility: 23			
Facility security levels/inmate custody levels: Minimum			
Age range of the population: 14-17			
Name of PREA Compliance Manager: Eric Mathews		**Title:** Intake/Aftercare Coordinator	
Email address: emathews@eriecounty.oh.gov		**Telephone number:** 419-627-7611, ext. 2130	
Agency Information			
Name of agency: Northern Ohio Juvenile Community Corrections Facility			
Governing authority or parent agency: *(if applicable)* Governing Board of Judges			
Physical address: 1338 Tiffin Ave., Sandusky, OH 44870			
Mailing address: *(if different from above)* Click here to enter text.			
Telephone number: 419-627-7611, ext. 2110			
Agency Chief Executive Officer			
Name: Krista Collins		**Title:** Superintendent of Corrections	
Email address: kcollins@eriecounty.oh.gov		**Telephone number:** 419-627-7611, ext., 2110	
Agency-Wide PREA Coordinator			
Name: Eric Mathews		**Title:** Intake/Aftercare Coordinator	
Email address: emathews@eriecounty.oh.gov		**Telephone number:** 419-627-7611, ext. 2130	

AUDIT FINDINGS

NARRATIVE

The Northern Ohio Juvenile Community Corrections Facility is a minimum security facility and is located in Sandusky, Ohio. It functions as an alternative to placing adjudicated male felony offenders in an Ohio Department of Youth Services (ODYS) correctional facility. The Northern Ohio Juvenile Community Corrections Facility serves a five county catchment area, consisting of Erie, Huron, Seneca, Sandusky, and Ashland counties and referrals are accepted statewide. A Governing Board provides oversight to the facility and consists of five judges, one from each county within the catchment area. The facility is accredited by the American Correctional Association (ACA) through compliance with a set of standards designed to improve the management of correctional facilities and the conditions of confinement. The average length of stay in the program is 10.6 months.

There are various treatment modalities used in the program; however, a main focus on the daily program is cognitive behavioral therapy. The goal of this therapy is for the residents to learn how their beliefs and values lead to thoughts; that lead to behaviors; and to consequences that may be positive or negative. Victim awareness activities are offered through the Restorative Justice program and assist residents in exploring how different types of delinquent offenses have real effects on victims as well as collateral effect on families and the community. Residents are also involved in Living Skills, a program component where they are involved in activities such as writing resumes; job hunting; budgeting; managing a household; banking; and buying a car. Through Living Skills sessions, residents learn about things that are important and necessary in everyday living situations. During the period of the resident's stay in the program where he is allowed to go on home passes, there is the requirement for the resident to obtain, complete and submit job applications.

An individualized treatment plan is developed for each resident. During the tour of the facility, one resident was observed to be participating in a treatment team meeting. The facility provides specialized treatment services through sexual offender treatment groups; chemical dependency groups; and trauma groups. The sexual offender treatment groups also include relapse prevention planning. The chemical dependency groups centers on a cognitive approach to drug and alcohol treatment, focusing on how the thought process may affect behavior. In addition to the chemical dependency groups, a weekly Alcoholics Anonymous (AA) group is held in the facility. Trauma treatment includes group and individual therapy and grief therapy. The trauma treatment services allows the resident to work through traumatic experiences.

Medical services are provided through a contract with the Erie County Helath Department with the provision of a nurse onsite at the facility Monday through Friday and on-call medical services are provided seven days a week. A medical screening is conducted by the nurse on each resident during the admission process and a physician visits the facility once a week. Forensic medical examinations will be conducted by a Sexual Assault Nurse Examiner (SANE) at the Firelands Regional Medical Center located in Sandusky. Mental health services are provided onsite by Therapists and a Counselor. Residents are involved in individual, group and family counseling. One of the Therapists conducts the sex offender treatment groups and the Counselor conducts the chemical dependency groups. Additional program services provided to the residents include education; case management; social activities; recreation and physical fitness; religious activities; and transition/re-entry services. Youth Specialists provide direct supervision of the residents and Senior Youth Specialists ensure the proper management and supervision of the residents during the program activities and throughout the facility operations. Staff members were observed during the tour and at other times to be actively engaged with the residents.

A behavior management system exists for the residents that includes a token economy. The resident may earn points for positive behavior and he is able to purchase items using the points earned. The facility also provides community service work and restitution programs. The community service work is provided through opportunities for residents to volunteer in various agency and organization projects and activities in the surrounding communities. The parents or guardians of each resident are also involved in parent education groups.

The facility's documented mission is ". . . to serve juvenile residents, their families, and their communities. This facility offers a safe and secure, nurturing environment. Treatment consists of specialized programs facilitated by a dedicated team. The treatment is designed to fit the needs of the residents and families along with the expectations of their local juvenile courts. It is the center's hope and goal that upon completion of the multi-phased programming, the residents will lead a more positive, productive, lawful, and healthy lifestyle."

DESCRIPTION OF FACILITY CHARACTERISTICS

The Northern Ohio Juvenile Community Corrections Facility (NOJCCF) is located approximately one hour and five minutes from Cleveland. The designed facility capacity is 30 with single occupancy cells. The program is maintained in one building that houses two distinct and separated facilities, the NOJCCF and the juvenile detention center. The lobby which is the primary entrance contains a reception area where visitors may sign in and sign out. Beyond the lobby are administrative offices; conference room; and staff break room. A hallway leads to the area that includes two classrooms, two interview rooms; central control; living units; multi-purpose room; kitchen and dining area; intake area; medical clinic; and gymnasium. Central control is basically located in the center among the three living units and the multi-purpose room. A small laundry room is located behind the central control area. Two living units or pods contain 12 rooms and one pod contains six rooms. In general, the names of the pods identifies the residents status in the program: Orientation, Pre-release, and Release.

The facility has an intake area that includes a sallyport entrance and the intake area contains three single occupancy cells. The Superintendent of Corrections provides oversight to the NOJCCF and the detention center. She reports that the NOJCCF does not use the cells for disciplinary isolation and that isolation is not used within the NOJCCF. Cameras have been strategically placed inside and outside of the facility and are monitored from central control. There is visibility by the cameras throughout each pod. All day burning lights and mirrors have been installed in various offices and storage closets to increase visibility for the protection of residents and staff. Signs are posted in various areas identifying the restricted areas where residents are not allowed at all and where residents are not allowed without staff supervision. There were no residents observed to be in any of the restricted areas. The facility is maintained in a clean and orderly manner. A telephone is located on each pod for the residents to directly report, through the crisis hotline, allegations of sexual abuse and sexual harassment.

There are bathrooms on each pod and they contain showers where only one resident shower at a time. A reasonable amount of privacy are provided to residents while they shower, change clothes and use the toilet. Residents may also place paper curtains in the windows of their room doors when they are using the toilet. The paper curtain is strategically placed in the window in a manner where the whole window is not completely covered. This method provides reasonable privacy to the resident when he is using the toilet or changing clothes in his room. Access to the medical clinic is obtained by a combination lock and only the Superintendent of Corrections, Administrative Assistant, and the nurses have access to the coded lock. Appropriate space exists in the facility for counseling sessions and visitation. The living units and the entrance lobby contain PREA reporting information. A garden is located on the outside grounds that is tended to by residents under the supervision of a staff member. Twenty-five youths were admitted to the facility during the past year. There are 22 individuals currently employed at the facility who may have contact with the residents. Seven staff members were hired by the facility in the past 12 months who may have contact with residents.

SUMMARY OF AUDIT FINDINGS

The notifications of the site visit were posted in various parts of the facility prior to the site visit. Photographs were taken of the the posted notices and forwarded to this Auditor. The Pre-Audit Questionnaire and the supporting documentation were uploaded to a flash drive and mailed. After an initial review of the information, notes were sent to the ODYS statewide PREA Coordinator requesting clarification on some of the information provided and additional information and a reponse from the facility was provided. The Intake/Aftercare Coordinator serves as the PREA Coordinator for the facility and the ODYS statewide PREA Coordinator, PREA Administrator, provides guidance regarding the PREA audit process.

The site visit was conducted June 15, 2016 and Flora Boyd, Certified PREA Auditor, assisted during the site visit. The Superintendent of Corrections greeted the auditors and the ODYS PREA Administrator upon arrival to the facility. Prior to the entrance meeting, two staff members were interviewed from the overnight shift. After those interviews were completed an entrance meeting was held and it included the Superintendent of Corrections, Intake/Aftercare Coordinator, ODYS PREA Administrator, and both PREA Auditors. A comprehensive tour of the facility was conducted by the Superintendent of Corrections and the Intake/Aftercare Coordinator at the conclusion of the entance meeting. The tour covered all areas of the facility including living units or pods; classrooms; medical clinic; gymnasium; dining room; closets and storage areas; offices; centrol control area; intake area; and the outside grounds. During the tour, staff members were observed interacting with and providing direct supervision to the residents.

Twenty-three residents were in the facility on the day of the site visit and 10 were interviewed. Six direct care staff members were interviewed and the interviewed staff covered each shift. There were 15 specialized staff interviews conducted and included a contractor. Staff and resident interviews revealed that they received initial PREA training and refresher training. Staff members were knowledgeable of their duties and responsibilities as they relate to the PREA standards. The residents interviewed were clear on how to report an allegation of sexual abuse and sexual harassment.

The file folders containing additional supporting documentation for each standard were constructed in an organized and neat manner. A close-out meeting was held at the conclusion of the the site visit and a summary of the audit findings was provided. The facility staff included in the meeting were the Superintendent of Corrections; Intake/Aftercare Coordinator; Bureau Chief of Community Facilities; ODYS PREA Administrator; and the assisting PREA Auditor. An additional ODYS central office staff member, the Bureau Chief of Quality Assurance & Improvement, participated in the close-out meeting by telephone.

Number of standards exceeded: 0

Number of standards met: 38

Number of standards not met: 0

Number of standards not applicable: 3

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

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The Zero-Tolerance/Coordinator Policy outlines the facility's mandate of zero-tolerance for all forms of sexual abuse and sexual harassment. This Policy, along with an array of other policies that specifically addresses each standard, provide the guidelines for preventing, detecting, and responding to incidents or allegation of sexual abuse or sexual harassment. The service areas addressed by the PREA related policies include: prevention and responsive planning; training and education; risk screening; reporting; official response following a resident's report; investigations; discipline; medical and mental care; and data collection and review.

Prohibited behaviors, sanctions for those who participate in such behaviors, and PREA related definitions are included in the Zero-Tolerance/Coordiantor Policy. The Intake/Aftercare Coordinator serves as the PREA Coordinator and he reports to the Superintendent of Corrections. The job description for the Intake Coordinator identifies this position as the PREA Coordinator and it confirms that the position reports directly to the Superintendent of Corrections. According to the interview with the PREA Coordinator, he has sufficient time and the authority to serve as the PREA Coordinator.

Standard 115.312 Contracting with other entities for the confinement of residents

☐ Exceeds Standard (substantially exceeds requirement of standard)

☐ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

This standard in not applicable. The facility does not contract with other agencies for the confinement of their residents.

Standard 115.313 Supervision and monitoring

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These

recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The Supervisor and Monitoring Policy provides for the required staffing ratios of 1:8 during the waking hours and 1:15 during the sleeping hours as outlined on work schedules. The Policy states that any deviation from the staffing ratios should be documented on the daily log in central control. The facility reports no deviations from the staffing patterns and this practice was confirmed by the Superintendent of Corrections. The documents reviewed and observations provide that an adequate level of staffing is provided. The Superintendent of Corrections explained the set and rotating schedule of the direct care staff and that she routinely reviews the work schedule. When a scheduled staff member is unable to report to work another staff member will be called in to work during that particular shift. Administrative staff members may be utilized during an emergency.

The facility's staffing levels are based on general practices for juvenile residential facilities, including taking into consideration the population type; number of supervisory staff; and program activities. The average daily number of residents since August 20, 2012 is 23.3 and the average daily number of residents on which the staffing plan was predicated since that time is 24. A review of the staffing patterns was an agenda item for discussion during the staff meeting held in March 2016. However, a form has since been adapted to also document this annual assessment to validate the completion of the staffing plan assessment. The form provides for a review of the level of staffing, prevailing staffing patterns; resources to commit to the staffing plan to ensure compliance; deployment of cameras; and other related areas.

The Supervisor and Monitoring Policy states that unannounced rounds will be conducted by the Superintendent of Corrections or designee, PREA Coordinator, and Senior Youth Specialists to include unoccupied areas of the facility on each shift. The documentation of the unannounced rounds confirmed that they occur. The Unannounced Program Visit report completed by staff, includes such observations as whether groups are in appropriate locations of the facility; assessment of blind spots; staff positioning; and staff/resident interactions. An assessment is conducted annually by the Ohio Department of Youth Services (ODYS) PREA Administrator which reviews the physical plant regarding practices and physical barriers that may impact the protection of residents from sexual abuse and sexual harassment. The completed report, Facility PREA Vulnerability Assessment Recommendations, provided observations regarding opportunities for improvement within the facility that increases visibility and reduce blind spots in various areas of the facility. During this vulnerability assessment, it was noted that the facility is safety and security conscious. The facility adhered to the recommendations in the report through the addition of posted mirrors in offices which increased visibility and supervision and the additions of signs identifying restricted areas.

Standard 115.315 Limits to cross-gender viewing and searches

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Staff members are prohibited from conducting cross-gender strip searches or cross-gender visual body cavity searches of residents except in exigent circumstances or when performed by a medical practitioner as addressed in the Crossgender Searches Policy. Pat down searches are conducted by the same sex staff and searches using a wand may be conducted by staff. All searches are documented on the Control of Contraband form. Any cross-gender pat-down searches conducted due to exigent circumstances must be approved by the Superintendent of Corrections and documented. Random staff interviews revealed that a cross-gender pat down search would only occur during an emergency such as a fire or the safety of a resident is at risk.

A signed and dated training roster; staff and resident interviews; and the facility Policy document that staff receive training in conducting searches in a safe and respectful manner, including the searches of cross-gender, transgender and intersex residents. The facility reports and staff interviews support that during the past year there have been no type of cross-gender searches conducted in the facility. Policies, procedures and practices exist that ensure residents are able to shower, change clothes and perform bodily functions without being viewed by the opposite gender or being directly viewed by staff. The design of the shower rooms provide residents a reasonable amount of privacy while performing bodily functions. Interviews with staff and residents and observations confirmed the practices and that the policies are

followed. Residents are provided paper curtains that they may strategically place in the windows of their rooms so that they may not be directly viewed while using the toilet. The placement of the curtain allows for staff to still monitor the resident while he is in his room and it is not left up for an extended length of time.

Staff members of the opposite gender are directed by policy to announce their presence when entering the housing units, where residents may be showering, changing clothes or performing bodily functions. A door bell is located outside of the living units that female staff must push prior to entering the living areas to alert the residents of their presence. Residents and staff reported that the door bell is routinely used prior to female staff entering the living unit. Staff members are prohibited by policy from searching transgender or intersex residents to determine the resident's genital status and this expectation is understood by staff as evidenced through the interviews. The staff members interviewed understand the prohibition of searching transgender and intersex residents solely to determine their genital status and are aware that, where it is unknown, learning this information would be part of a broader medical examination conducted by a medical practitioner in private..

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

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Support services for residents with disabilities and who are limited English proficient will be provided as needed according to the Resident With Disabilities Policy. The facility has documentation from the Office Coordinator/Interpreter of the Cleveland Hearing and Speech Center confirming the facility's access to the agency's services and documentation confirming the availability of services from the Finance Administrator at the International Service Center regarding language interpreters. The Policy states that all residents will have an equal opportunity to participate in or benefit from the PREA education sessions that aids in detecting, preventing and responding to sexual abuse and sexual harassment. The Policy identifies the Cleveland Hearing and Speech Center, International Service Center, and the facility's education staff for providing support services for residents with disabilities and residents who are limited English proficient. The Policy also provides that interpreter services may be obtained through the Erie County Sheriff's Office and that a TDD machine (Telecommunications Device for the Deaf) is available to the facility through the County.

The Resident With Disabilities Policy prohibits the use of resident readers, resident interpreters, or other types of assistance from residents except in limited circumstances where an extended delay in obtaining an effective interpreter could compromise the resident's safety, the performance of the first-response duties, or the investigation of the resident's allegations. The facility does not rely on resident interpreters or resident readers which was confirmed through random staff interviews and the Policy. The facility reports that during the past 12 months there have been no instances where residents were used as interpreters or readers in any capacity.

Standard 115.317 Hiring and promotion decisions

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance

determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The Hiring and Promotion Policy provides the details regarding the hiring process, coordinating and reviewing background checks, and the grounds for termination as per the standard. Criminal background checks are conducted on new employees through the Ohio Bureau of Criminal Identificaiton and the Federal Bureau of Investigation and the personnel files contain documented confirmation of the completed background checks. The state child abuse registry and prior employment record checks are also conducted. A log is maintained of completed background checks for employees showing the initial check and the five-year period check. Documentation is also maintained on the background checks for contractors. The Policy, interview with the Superintendent of Corrections, and a review of documented job interviews confirmed that the facility considers any incidents of sexual abuse or sexual harassment in determining whether to hire an employee or contractor or to promote an employee.

The interview process for new hires includes the inquiry about whether the potential hire may have engaged in sexual abuse in a prison, jail, lockup, community confinement facility, institution or juvenile facility; convictions of engaging in or attempting to engage in sexual assault; civil or administrative adjudications regarding the aforementioned. The interview with the Superintendent of Corections and a review of a sample of personnel records revealed that the personnel practices meet the requirements of the standard and are in accordance with the facility policy. In the past 12 months, there have been seven new hires who have contact with residents that had criminal background checks conducted. The Hiring and Promotion Policy provides that staff members have a continuing duty to report related misconduct and that material omissions of such conduct or providing false information will be grounds for termination.

Standard 115.318 Upgrades to facilities and technologies

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The facility is not new and there has not been a substantial expansion made to the facility since the August 2012 date included in the standard. Direct staff supervision is supplemented with a camera system and the addition of mounted mirrors and all day burning lights. Additional cameras have been installed in the facility and there have been upgrades, including the digital video recording (DVR) ability since the August 2012 date as identified in the standard. During the comprehensive tour of the facility, the addition of cameras, mirrors, all day burning lights, and other upgrades were pointed out to the Auditors and were explained by the facility staff.

Standard 115.321 Evidence protocol and forensic medical examinations

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific

corrective actions taken by the facility.

The Policy, Medical Exams, in the Responsive Planning Chapter of the policies and procedures address this standard. The facility has identified staff members who will conduct administrative investigations and have ensured their training through the National Institute of Corrections as evident through an investigative staff interview and the review of training certificates. The Erie County Sheriff's Office is responsible for conducting investigations of allegations of sexual abuse that may be criminal in nature. The Policy provides that the Sheriff's Office will conduct the criminal investigations in accordance with the guidelines set forth in the PREA standards. A letter from the Erie County Sheriff's Office from the Chief Deputy supports that the Sheriff's Office will provide response services to the facility regarding allegations of sexual abuse. The letter provides an overview of the training of the personnel that will conduct such investigations, which would be the Chief Deputy and two Detective Sergents. The letter documents special training such as courses related to criminal investigations; crime scenes; and interviewing and interrogations, including the foresic interviewing of juvenile victims of sexual offenses.

There is a Memorandum of Understanding (MOU) between the facility and the Safe Harbour First Response Team for the provision of the crisis hotline to the facility. Residents may use this hotline to directly report sexual abuse or sexual harassment and there may be a connection made to a Sexual Assault Nurse Examiner (SANE) where requested by the caller, Erie County Sheriff's Office or facility staff. The facility has a MOU with the Tri-County SANE Unit for forensic medical examinations to be conducted at the Firelands Regional Medical Center and at no cost to the victim regarding an allegation of sexual abuse. The facility also has a MOU with the Erie County Prosecutor's Office Victim Assistance Program to provide victim advocacy services such as accompaniment to the hospital for the forensic medical examination and during interviews with the Sheriff's Office and/or child protective services.

The facility has posted a list in each living unit stating what advocates from the Erie County Prosecutor's Office Victim Assistance Program can and cannot do. In addition to accompaniment to the examination and during investigative interviews, the advocate can provide a referral for counseling services while the resident is in the facility and after his release; discuss victim's rights, including legal actions that can be taken; work with facility staff to ensure the safety of the resident; and provide other advocacy services. The list informs the resident that, among other things, the advocate cannot provide legal advice; cannot investigate the allegation; and cannot violate the facility rules such as providing unapproved phone calls or bringing items to the facility without permission. The Superintendent of Corrections confirmed that victim advocacy services will be provided and the services to be provided were confirmed by the Director of Victim Services of the Erie County Prosecutor's Office Victim Assistance Program. Information regarding advocacy services is provided to the residents during the intake process and is posted in each living unit. The residents have unimpeded access to the crisis hotline as supported through resident and staff interviews and observations.

Standard 115.322 Policies to ensure referrals of allegations for investigations

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The Referrals for Investigations Policy provides that an administrative or criminal investigation is completed for all allegations of sexual abuse and sexual harassment and staff members are to report all allegations of sexual abuse or sexual harassment. The facility has identified and trained investigators to conduct administrative investigations. The facility has a letter from the Erie County Sheriff's Office, signed by the Chief Deputy, confirming that allegations of sexual abuse will be investigated and identifies the personnel who will conduct the investigations. The letter, Policy and staff interviews confirmed that allegations of sexual assault and sexual harassment will be referred for an administrative or criminal investigaion as required by Policy and the standard. The facility reports that during the past 12 months there were no allegations of sexual abuse or sexual harassment.

The agency will document all referrals of allegations of sexual abuse or sexual harassment for criminal investigation on an incident report form. The staff interviews confirmed the requirement of documentation of verbal allegations of sexual abuse or sexual harassment. The Policy provides that staff members adhere to the response plan regarding allegations of sexual abuse or sexual harassment allegations which

provide directions regarding administrative investigations or allegations that are criminal in nature. Agency policy and other information regarding reporting allegations of sexual abuse and sexual harassment are available on the facility's website and within the facility, accessible to the public. During the past 12 months there were no allegations of sexual abuse or sexual harassment received and there were no administrative or criminal investigations conducted.

Standard 115.331 Employee training

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The Employee Training Policy provides that all staff working at the facility receive PREA related training and provides information on the type of training required. The training curriculum and other training materials were reviewed, including signed acknowledgement statements indicating participation and understanding of the PREA training that was provided. The staff interviewed reported receiving initial PREA training and refresher training that assists staff in remaining knowledgeable and aware of current issues. The review of the training material and interviews with staff verify that the training includes the subjects identified in the Policy and standard that include but are not limited to zero-tolerance policies; staff responsibilities; the right for staff and residents to be free from retaliation; the dynamics of sexual abuse and sexual harassment in juvenile facilities; common reactions of juvenile victims; and mandatory reporting.

Standard 115.332 Volunteer and contractor training

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The Volunteer and Contractor Policy requires that volunteers and contractors who have contact with residents receive the required PREA training on their responsibilities regarding sexual assault prevention, detection, and response to any allegation. The facility maintains a binder that contains the signed acknowledgement statements of volunteers and contractors regarding receipt and understanding of the PREA training. The training was confirmed through an interview with a contractor who was able to express knowledge of the zero-tolerance policies regarding sexual abuse and sexual harassment and how to report such incidents.

Standard 115.333 Resident education

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The Resident Education Policy provides that all residents admitted to the facility receive information about the facility's zero-tolerance policies, including how to report allegations of sexual abuse or sexual harassment and the right to be freee from retaliation for reporting. Residents are provided PREA education verbally through the review of a pamphlet which they also are given a copy. Within 10 days of admission the residents receive additional PREA information. The Resident Handbook contains PREA related information. A review of the education materials, an interview with the Intake/Aftercare Coordinator, and the resident interviews revealed that the PREA education sessions occur.

The residents and the Intake/Aftercare Coordinator sign their names and write the date on the pamphlet indicating the provision and receipt of PREA education. While the residents were aware that victim advocacy services were available, they were not familiar with the specific advocacy services that would be provided if they ever needed them. A corrective action was implemented by the Superintendent of Corrections and a refresher PREA education session was conducted with the residents. The training specifically covered and emphasized the services that would be available to a victim of sexual abuse that would be provided by the Erie County Prosecutor's Office Victim Assistance Program. A roster with the date, signed name of each resident and the Superintendent of Corrections was submitted, along with a copy of the posted itemized list of what the advocates can and cannot do were submitted to document that the corrective action of the refresher training had been completed.

The Resident Education Policy directs staff to access the interpreters and other support services as needed to provide the PREA education in formats accessible to all residents and this includes those who may be limited English proficient; deaf; visually impaired, or otherwise disabled, and residents with limited reading skills. The support services that may be provided by the Cleveland Hearing and Speech Center; International Service Center; facility staff; Erie County Sheriff's Office; and the TDD machine (Telecommunications Device for the Deaf) enures disabled residents the opportunity to participate in PREA education sessions. PREA information is posted in each living unit and in other areas of the facility. The random staff interviews support that residents are not used as interpreters or readers for other residents.

Standard 115.334 Specialized training: Investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The Specialized Training Policy addresses the required training for facility staff identified as investigators to conduct administrative investigations. The letter from the Erie County Sheriff's Office documenting that the Office will conduct investigations that are criminal in nature provides that the Office also has trained personnel that will conduct such investigations. The facility maintains the training certificates for the investigative staff who have completed the National Institute of Corrections course, PREA: Investigating Sexual Abuse in a Confinement Setting. The interview with one of the five identified staff members responsible for administrative investigations indicated that she had received the required training. The training certificates from the National Institute of Corrections were reviewed for the facility investigative staff members.

The document from the Erie County Sheriff's Office states that the identified investigators, Chief Deputy and two Detective Sergents, have received special training and they have an array of experience in conducting investigations in sex offenses and in obtaining and collecting evidence related to such crimes. According to the Sheriff's Office's letter, the training for the Chief Deputy and the Detective Sergents includes courses related to criminal investigations; crime scenes; and interviewing and interrogations, including the foresic interviewing of juvenile victims of sexual offenses.

Standard 115.335 Specialized training: Medical and mental health care

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The Medical and Mental Health Care Policy requires medical and mental health staff members to receive the initial PREA training and the specialized training developed for medical and mental health staffs. The facility provides the specialized training through completion of the online course through the National Institute of Corrections. Training certificates were reviewed and interviews with medical and mental health personnel confirmed the general PREA training and the specialized training. The training certificates were for the completion of PREA: Medical Health Care for Sexual Assault Victims in a Confinement Setting for medical staff and the certificate for the mental health staff is for PREA: Behavioral Health Care for sexual Assault Victims in a Confinement Setting. Forensic medical examinations are not conducted at the facility; such examinations will be conducted at the Firelands Regional Medical Center by a Sexual Assault Nurse Examiner.

Standard 115.341 Screening for risk of victimization and abusiveness

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The Policy, Obtaining Information from Residents, requires that the screening for risk of sexual abuse victimization or sexual abusiveness toward other residents be conducted on each resident admitted to the facility within 24 hours of their arrival and during confinement in the facility. A screening instrument is used by Intake/Aftercare Coordinator to assess and obtain information that will assist straff in reducing the risk of a resident being sexually abused or perpetrating sexual abuse. Recommendations were made regarding the risk screening instrument that was being used that would increase its objectivity. A corrective action was implemented that has enhanced the objectivity of

the instrument. The improved instrument provides increased measures and weights in determining a resident's risk level of sexual victimization or abusiveness. The instrument continues to provide for the reassessment of a resident's risk level due to an incident of sexual abuse; a referral or request that is made; or when there is new information that bears on the resident's risk of sexual victimization or abusiveness.

The screening instrument obtains personal information that includes but is not limited to prior sexual victimization or abusiveness; the resident's identification as gay, straight, bisexual, transgender, or intersex; intellectual or developmental disabilities; the resident's concern for his own safety; and age. The Intake/Aftercare Coordinator obtains the required information to complete the assessment through a review of the referral packet; youth interview; and communication with the court. The Intake/Aftercare Coordinator meets with the resident prior to his coming to the facility, while he is in the detention facility. He shared that the initial meeting helps him to establish a rapport with the youth. The interviews with the Intake/Aftercare Coordinator and residents and a review of documentation verified that risk screenings are being conducted for all residents and that the initial risk screening is conducted within 24 hours of admission to the facility.

Standard 115.342 Use of screening information

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The Screening Chapter of the policies and procedures provide guidance to staff on how the information obtained from the screening instrument is to be used. The information from the screening instrument is intended to assist staff in determining housing and program assignments with the goal of keeping all residents safe and free from sexual abuse or sexual harassment. The interview with the Intake/Aftercare Coordinator revealed that the information obtained through the screening is used in determining housing; safety and security measures to be taken; and to identify special needs. The residents' views of their own safety, as confirmed through resident interviews, are considered by staff in placement and programming assignements.

The Policy within the Screening Chapter prohibits placing gay, bisexual, transgender, or intersex residents in separate housing based solely on such identification or status; assignments will be made on a case-by-case basis. The Policy also prohibits considering gay, bisexual, transgender or intersex identification or status as an indicator of likelihood of being sexually abusive and provides for consideration of the resident's concern for his own safety. A Policy requirement is that a transgender or intersex resident will be reassessed at least twice a year . Transgender and intersex residents will shower separately, as do all residents. The Intake/Aftercare Coordinator is familiar with the tenets of the Policy. During this audit period, there were no allegations made regarding sexual abuse or sexual harassment and no residents were determined to be at risk of sexual victimization.

Standard 115.351 Resident reporting

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance

determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The Resident Reporting Policy provides for multiple internal ways for a resident to report allegations of sexual abuse; sexual harassment; retaliation for reporting; and staff neglect or other violation that may lead to abuse. According to the Policy, residents may talk to any staff member that they feel confortable with or submit a grievance form. The facility provides a designated telephone on each unit for unfettered access to residents for directly reporting, through the sexual assault hotline, allegations of sexual abuse or sexual harassment. Residents have access to writing utensils, paper, and the forms for completing written requests and submitting allegations of sexual abuse and sexual harassment. Staff members are required to call the Program Director and the Superintendent of Corrections when there is an allegation of sexual abuse or sexual harassment and to document verbal reports on the Significant Incident Report form.

Each living unit and other areas contain the posted PREA related information. Resident interviews revealed that they are aware of the different ways they can report and are aware that reports will be received from anonymous or third-party reporting of sexual abuse and sexual harassment. Staff interviews revealed that they are aware of the resident's reporting methods and how staff can anonymously and privately report allegations of sexual abuse and sexual harassment. Staff members are informed of resident reporting methods through policy, training and posted information. The facility does not hold residents soley for civil immigration purposes.

Standard 115.352 Exhaustion of administrative remedies

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

This standard is addressed in the Exhaustion of Administrative Remedies Policy and provides that an administrative process is used in resolving grievances and also provides details regarding any third-party assistance to the resident and how to appeal the initial decision in response to the grievance. Third party reporting or assistance to the resident means the help with or the filing of the grievance by a parent/guardian, another resident, staff member, or anyone else. There is no time limit for filing a grievance related to an allegation of sexual abuse and residents are not required to use an informal process or give the grievance to any staff member regarding such allegations. The residents are directed to place the grievance in the locked grievance box that is located on each living unit. The grievance box is checked Monday through Friday by the Program Director and on the weekends and holidays by the Senior Youth Specialist. Residents have access to grievance forms and writing materials. The Policy contains the timelines regarding the grievance procedure for the initial response to the grievance; the appeal; and an extension that the facility may claim, with written notice to the resident. The grievance form provides for the resident to appeal the initial decision and for a response to the appeal.

The Resident Handbook and the Parent Handbook contain information regarding the grievance process. Interviews with residents revealed that they are aware of how they would submit an emergency grievance alleging sexual abuse. The residents know that they would write their name on the grievance, check the box alleging sexual abuse and place it in the grievance box. They are not required to use an informal grievance process or otherwise attempt to resolve a PREA related issue with staff. An emergency grievance is immediately provided to the Program Director and/or the Superintendent of Corrections. The Resident Handbook informs residents that they will face new charges or a loss of privileges when false accusations are made. No grievances have been completed during this audit period alleging substantial risk of imminent sexual abuse. Resident interviews revealed that the grievance system may be used to report allegations of sexual abuse or sexual harassment.

Standard 115.353 Resident access to outside confidential support services

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The Reporting Chapter of the policies and procedures contain the Policy that provide residents 24-hour accesss to outside victim advocacy services through an abuse reporting hotline number. Emotional support services will be provided to victims of sexual abuse by the Erie Copunty Prosecutor's Office Victim Assistance Program. The crisis hotline number is provided through a Memorandum of Understanding with the Safe Harbour First Response Team. The Victim Assistance Program may be contacted through this hotline number along with the services of a Sexual Assault Nurse Examiner (SANE), if needed. The address for the Victim Assistance Program and the crisis hotline number provided by the Safe Harbour First Response Team are provided to the resident during the intake process and is posted in each unit.

The information sheet posted in each unit includes the duties the victim advocate may perform and those things that the victim advocate cannot do. A review of documentation, posted information and interviews with residents support that residents are provided information regarding access to victim advocacy services, including the reporting process and the limitations of confidentiality. While the residents were aware that victim advocacy services were available and how to make contact, they were not familiar with the specific services the agency would provide if they ever needed them. A refresher PREA education session was conducted with the residents by the Superintendent of Corrections where the focus was on the specific services offered by the Erie County Prosecutor's Office Victim Assistance Program.

The advocacy services that will be provided to a victim of sexual abuse include accompaniment and support through the forensic medical examination and the investigatory interviews; counseling referrals; working with facility staff to ensure the victim's safety; and discussing victim rigths, including legal actions that the victim can take. The Erie County Prosecutor's Office Victim Assistance Program may be contacted for advocacy services through the Safe Harbour First Response Team's crisis hotline number from a telephone call made by the victim; facility staff; Erie County Sheriff's Office; or the Tri-County SANE Unit.

Interviews with the Superintendent of Corrections and residents and documented policy and procedures revealed that residents are provided confidential access to their attorney or Probation Officer and reasonable access to their parents or legal guardian. Information regarding visitation is provided in the Resident Handbook. The facility has space that can accommodate visitation activities and also provide a confidential setting during visits from attorneys, Probation Officers and/or other legal representatives. There have been no allegations or incidents of sexual abuse or sexual harassment at the facility during this audit period.

Standard 115.354 Third-party reporting

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The Third Party Reporting Policy provides for someone other than the victim to report allegations of sexual abuse and sexual harassment. The third-party reporting information is posted on the facility's website; forms are available in the lobby of the facility; and a form is included in the Parent Handbook. Parents/guardians sign a Parenting Orientation Checklist acknowledging receipt of the Parent Handbook which, in addition to the third-party reporting form, contains information about PREA and the reporting of sexual abuse. Additional information on how to report allegations of sexual abuse and sexual harassment is posted in the facility accessible to staff; contractors; residents; volunteers; and visitors. Staff and resident interviews confirmed their knowledge of the meaning of third-party reporting and how it may be done. The resident interviews revealed that there was someone that they had contact with on the outside that they could report to about sexual abuse or sexual harassment if they needed to.

Standard 115.361 Staff and agency reporting duties

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The Staff and Agency Reporting Duties Policy require all staff members to immediately report all allegations of sexual abuse to the Superintendent of Corrections or the Program Director and to document reported allegations. The Nurse is directed to report knowledge or suspicion of an incident of child abuse to her supervisor at the Erie County Health Department, Superintendent of Corrections or the Program Director, and Erie County Childrens Services. The facility staff members are also required by facility policy to report allegations that were made anonymously or by a third-party. The mental health and medical providers initially inform residents of their duty to report, as confirmed by staff interviews and stated in the Policy. Directions are provided through the Policy to staff regarding reporting duties and prohibits staff from revealing any information related to a sexual abuse report to anyone, other than those persons required to make treatment, investigation, security or administrative decisions.

Administrative investigations are investigated by facility investigators and allegations that are criminal in nature are referred for investigation to the Erie County Sheriff's Office. The Staff and Agency Reporting Duties Policy, forms that have been created, and staff interviews support that proper notifications will be made to parents/legal guardians; child welfare agency where indicated; and attorney or legal representative where there is court jurisdiction. The Superintendent of Corrections or the Program Director will be responsible for making the required reports to the Erie County Juvenile Court Judge and the Ohio Department of Youth Services, Bureau of Community Corrections.

Standard 115.362 Agency protection duties

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific

corrective actions taken by the facility.

The Agency Protection Duties Policy address the components of this standard. According to the Policy, when a grievance is received from a resident indicating that he is the subject for substantial risk of imminent sexual abuse the Program Director and/or the Superintendent of Corrections will be contacted immediately. The Policy provides that the resident will be seen by treatment staff and that protective measures may include but are not limited to housing changes; classroom changes; and allowing the resident to work in the group room which is located on the hallway with offices and the classrooms. The responses in the interviews with direct care staff and the Superintendent of Corrections were aligned with the Policy regarding the protective measures that would be implemented to keep residents safe. During the past 12 months, no residents were identified as subject to substantial risk of imminent sexual abuse.

Standard 115.363 Reporting to other confinement facilities

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The Reporting to Other Confinement Facilities Policy provides that upon the facility receiving an allegation that a resident was sexually abused while confined in another facility, the staff will notify the facility where the alleged abuse occurred and treatment staff will notify the Erie County Job and Family Services, Children Services Division. The Policy provides that the notification is made as soon as possible but no later than 72 hours of receipt of the allegation. The allegation would be documented on a dedicated form by facility staff and a request would be made that the allegation be investigated by the facility where the allegation originated from. Administrative staff would request the results of the investigation from that facility. The Superintendent of Corrections is knowledgeable of the Policy. During the past 12 months, there were no allegations of a resident being sexually abused while confined in another facility.

Standard 115.364 Staff first responder duties

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The first responder duties are contained in policies and procedures and are outlined in the policy chapter, Official Response Following a Resident Report. The requirements of the first responder include: separate the victim from the abuser; preserve and protect the scene; request that the alleged victim and alleged perpetrator do not take any action that would destroy physical evidence such as shower, brush teeth, drink, eat, etc. Security and non-security staffs report that they are aware of their duties if they should be in a situation to act as a first

responder. The duties of the first responder were provided during the interviews with direct care staff. The non-security staff that was interviewed understood that the request should me made to the victim to not take any actions that could destroy physical evidence and to notify security staff. During this audit period there has not been an incident or an allegation of sexual abuse or sexual harassment.

Standard 115.365 Coordinated response

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The policies and procedures chapter, Official Response Following a Resident Report, outlines the responsibilities of staff regarding the actions to take in responding to an incident of sexual abuse. The facility has a written coordinated response plan that supports the standard and that identifies the duties for specific staff members. The coordinated response plan outlines, in a diagram, steps to be taken in response to an incident of sexual abuse. The plan identifies the staff positions, their required responses, and the required notifications that must be made for a comprehensive facility response to sexual abuse. The plan coordinates actions that should be taken by staff including the Superintendent of Corrections; Program Director; direct care staff; medical and mental health practitioners; and investigators. The staff interviewed revealed that they are aware of their duties in response to an incident of sexual abuse or sexual harassment.

Standard 115.366 Preservation of ability to protect residents from contact with abusers

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☐ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

This standard is not applicable. The facility does not conduct collective bargaining and there are no collective bargaining agreements.

Standard 115.367 Agency protection against retaliation

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The Agency Protection Against Retaliation Policy provides direction regarding protection against retaliation from others for residents and staff who report sexual abuse or sexual harassment or cooperate with investigations. The Policy includes the areas to monitor such as housing issues; staffing re-assignments; program changes by staff; job performance; and Significant Incident Reports. The retaliation monitor will be a Senior Youth Specialist that is assigned by the Program Director or the Superintencent of Corrections during any sexual abuse investigation. The Policy provides that when retaliation is identified disciplinary actions up to and including termination may occur.

Retaliation monitoring will be conducted for at least 90 days, longer if needed, following a report of sexual abuse or sexual harassment, according to the Policy. A Senior Youth Specialist was interviewed regarding retaliation monitoring and he expressed various measures that would be taken to protect residents and staff from retaliation such as housing changes; referring resident to the Counselor; or transferring a resident if needed. He stated in the interview that the retaliation monitoring would be initiated for 90 days but will continue as long as necessary. The facility reports that there have been no incidents or allegations of sexual abuse or sexual harassment during this audit period.

Standard 115.368 Post-allegation protective custody

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☐ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

This standard is not applicable. Segregation is not used in this facility.

Standard 115.371 Criminal and administrative agency investigations

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The policy chapter, Official Response Following a Resident Report provides the requirements for conducting all administrative and criminal investigations including retention of reports and staffs' cooperation with investigations. Administrative investigations will be conducted by the facility investigators who have been identified as the Program Director and the Intake/Aftercare Coordinator. There are other staff

members identified as investigators that work in the detention center; the investigative staffs may be used interchangeably. The investigations that are criminal in nature will be investigated by the Erie County Sheriff's Office, as confirmed in a letter, signed by the Chief Deputy of the Sheriff's Office The policy provides that the facility will remain informed about the progress of an investigation conducted by the Sheriff's Office.

All allegations of sexual abuse or sexual harassment occurring at the facility will be investigated promptly, thoroughly and objectively as evident through a review of documentation, including the letter from the Sheriff's Office, current facility practices, and training for the facility and law enforcement investigators. The Policy Chapter requires that an investigation not be terminated solely because the source of the allegation recants the allegation. The Policies and interviews with the Senior Youth Specialist and the Superintendent of Corrections provide information that ensures that administrative and criminal investigations will be conducted in accordance with the requirements of the investigations policy and standard.

Standard 115.372 Evidentiary standard for administrative investigations

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The policy chapter, Official Response Following A Resident Report provides that the investigations completed by the investigative staff will be conducted using no standard higher than a preponderance of the evidence in determining whether allegations of sexual abuse or sexual harassment are substantiated. The facility investigative staff member that was interviewed is familiar with the concept of a preponderance of the evidence.

Standard 115.373 Reporting to residents

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The chapter of policies and procedures regarding responding to a resident contains the policy that requires notification to the resident that the investigation has been completed and the outcome of whether it was determined to be substantiated, unsubstantiated or unfounded. Where the facility did not conduct the investigation, the results will be obtained from the Erie County Sheriff's Office. The policy states that the staff will request the information from the Sheriff's Office in order to inform the resident and parent/guardian. Following the completion of an investigation, the resident will be notified of the findings in writing.

The notification letter regarding the outcome of an investigation requires the date and signatures of the Program Director, Superintendent of Corrections and the resident. Where an investigation will be conducted by the Erie County Sheriff's Office, the Superintendent of Corrections and the PREA Coordinator will remain abreast of the investigation through contact with the Sheriff's Office as provided according to policy and the interviews. The facility reports no allegations of sexual abuse or sexual harassment during this audit period.

Standard 115.376 Disciplinary sanctions for staff

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The Policy, Disciplinary Sanctions for Staff, provide that staff members are subject to disciplinary santions up to and including termination for violation of sexual abuse or sexual harassment policies. All terminations for violations of sexual abuse or sexual harassment policies or resignations by staff who would have been terminated if not for their resignation, will be reported as required to the Erie County Sheriff's Office, unless the activity was clearly not criminal, and to relevant licensing bodies where applicable. Additionally, the Policy provides that disciplinary sanctions for violations relating to sexual abuse or sexual harassment, other than engaging in sexual abuse, will be subject to the facility's progressive disciplinary procedures. During this audit period, no staff member was terminated or disciplined due to substantiated findings of an investigation regarding allegations of sexual abuse or sexual harassment. There were no allegations or incidents of sexual abuse or sexual harassment.

Standard 115.377 Corrective action for contractors and volunteers

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The Corrective Action for Contractors and Volunteers Policy addresses this standard and requires that when a contractor or volunteer engages in sexual abuse with a resident, contact with residents will be prohibited and contact will be made with the Erie County Sheriff's Office, unless the activity was clearly not criminal, and relevant licensing bodies. The Policy provides that appropriate remedial measures will be taken and further contact prohibited if there are violations of other PREA related policies. During the past 12 months, there have been no contractors or volunteers who have been reported for a violation of PREA policies. The interview with the Superintendent of Corrections was aligned with the general information found in the Policy.

Standard 115.378 Disciplinary sanctions for residents

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The Interventions and Disciplinary Sanctions for Residents Policy address this standard and provide that residents may be subject to disciplinary sanctions only after a formal disciplinary process regardimg resident-on-resident sexual abuse or following a criminal finding of guilt. The consequences for such behavior may include sanctions up to and including removal from the program. The Policy also provides that the disciplinary sanctions be commensurate with the nature and circumstances of the abuse committed; the resident's disciplinary history; similar histories of other residents; and consideration of mental disabilities or mental illness contributing to the behavior. Following the facility's formal disciplinary process, the sanctions will be documented on the Intervention and Disciplinary for Residents form. The Resident Handbook also contains information regarding the application of disciplinary sanctions and a formal disciplinary hearing.

Disciplinary isolation is not used at the facility; however, the Policy positions that if a resident is separated from other residents for safety measures, the resident will still receive programming services and activities including daily large muscle exercise, education, medical, and mental health services. The Policy provides that interventions and treatment plans will be developed by treatment staff, in collaboration with the Program Director, to address the motivations for the abuse. Residents are required to participate in interventions but not as a condition to access general programming and education, according to the Policy and the interviews with the mental health and medical saffs. The facility reports that a resident may be disciplined for sexual contact with staff only upon a finding that the staff member did not consent to such contact.

According to the Policy, when an allegation is unsubstantiated, a resident will not be disciplined or considered to have made a false report if the allegation was determined to have been made in good faith. The facility prohibits sexual activity between residents and deems such activity to constitute sexual abuse only if it determines that the activity was coerced. The residents are initially made aware of the facility rules during the intake process, ongoing review, and through their continual access to the Resident Handbook. During this audit period, there were no allegations made or investigations conducted regarding sexual abuse or sexual harassment.

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

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Policy, Medical and Mental Health Screenings, addresss this standard and requires that when a resident discloses prior victimization or abusiveness during the intake screening process, the Intake/Aftercare Coordinator will contact medical and mental health staffs and a follow-

up meeting is provided within 14 days. The Policy states that any information related to sexual victimization or abusiveness occurring in an institutional setting is limited to medical and mental health staffs and other staff as required to inform treatment plans and security management decisions.

A review of records show that medical and mental health notes are maintained by mental health and medical staffs that document the services provided to residents. A review of records also included the informed consent form which is to be completed for residents 18 years of age or over before staff reports information about prior sexual victimization that did not occur in an institutional setting. There were 12% of the residents who disclosed, during the intake process, prior victimization and were provided follow-up meetings with mental health and medical staffs within the prescribed time period. The facility reports that 44% of the residents disclosed previously perpetrated sexual abuse and were provided follow-up services. A program component of the facility is sex offender treatment.

Standard 115.382 Access to emergency medical and mental health services

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The Access to Emergency Medical and Mental Health Services Policy and interviews with medical and mental health staffs ensure that timely and unimpeded emergency services regarding sexual abuse will be provided at no cost to the victim and whether or not the victim names the accuser or cooperates with the investigtion. The facility also has a Memorandum of Understanding (MOU) with the Tri-County SANE Unit and a MOU with the Erie County Prosecutor's Office Victim Assistance Program. The Tri-County SANE Unit will provide the services of a Sexual Assault Nurse Examiner (SANE) to conduct the forensic medical examinations which will be conducted at the Firelands Regional Medical Center. According to the MOU, the practitioner assigned to provide the services has been screened and has received the education and/or training regarding sexual assault and forensic examinations. The victim advocacy and supportive services will be provided by the Erie County Prosecutor's Office Victim Assistance Program.

The Therapist and the Nurse interviews revealed that emergency services will be provided based on their professional judgment. A review of records showed that the medical and mental health practitioners maintain documentation, including timelines, of the services provided to the residents and demonstrate that appropriate records would be maintained regarding emergency medical and mental health services related to a PREA incident. Additionally, the Access to Emergency Medical and Mental Health Services Policy provides that timely information about and timely acess to preventive actions for sexually transmitted infections will be provided, where medically appropriate, by the Sexual Assault Nurse Examiner.

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

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These

recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The Ongoing Medical and Mental Health Care for Sexual Abuse Victims and Abusers ensures medical and mental health evaluations and treatment for residents as needed. The medical and mental health care may include follow-up services; treatment plans; and referrals for ongoing care. The mental health and medical services are consistent with the community level of care based on observations, a review of records, and interviews with the medical and mental health staffs. The facility Medical and Mental Health policies and the interview with the Nurse confirmed that resident victims will be offered tests for sexually transmitted infections as medically appropriate. The Policies and the MOU support that treatment services will be provided at no cost to the victim.

The Policy provides that the facility will 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 staff. The interview with the Therapist indicated that the mental health evaluation would be conducted upon admission on all known resident-on-resident abusers and treatment would be offered as deemed appropriate.

Standard 115.386 Sexual abuse incident reviews

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The Sexual Abuse Incident Reviews Policy provides the details regarding the role of the incident review team and identifies the team members that would conduct the review of the incident where the allegation was either substantiated or unsubstantiated. The incident reviews are to generally occur within 30 days of the conclusion of the investigation. The incident team members have been identified as the Superintendent of Corrections; Program Director; and as needed the medical and mental health practitioners; line staff supervisors; and the investigator.

A form has been developed that would capture the the required considerations while assessing the incident. The form requires documentation of the considetations by the team such as the need to change policy or practice; motivation factors that may have contributed to the incident; physical barriers; adequacy of staffing levels; and adequacy of monitoring technology. The interviews with the Superintendent of Corrections and the Program Director and a review of the Incident Review Checklist form support the guidelines for the incident review process outlined in the Policy. The Incident Review Checklist provides the documentation of the steps for the review process and its considerations; and recommendations for improvement. The Checklist and policy direct that the report be provided to the Superintendent of Corrections and the PREA Coordinator. The interviews and the documentation that support the standard also revealed the understanding of the purpose and role of the team and the incident review process. There have been no allegations or incidents of sexual abuse or sexual harassment during this audit period.

Standard 115.387 Data collection

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion

must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The Data Collection and Review Chapter of the policies and procedures provide directions for collecting accurate uniform data for every allegation of sexual abuse and provides for an annual report for the aggregated data. A review of the facility reports documents the collected data and allows for data regarding sexual abuse; however, there were not any PREA related incidents or allegations during the past year.

The facility has the capacity to collect data for allegations of sexual abuse and sexual harassment and create the required reports. The agency aggregates incident-based data at least annually as evident by documentation, including completion of the Survey of Sexual Violence. Upon request, as stated in Policy, the facility will provide the related data from the previous calendar year to the United States Department of Justice no later than June 30th. The interviews with the Superintendent of Corrections and the PREA Coordinator and a review of documentation confirmed the facility's data collection capabilities.

Standard 115.388 Data review for corrective action

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The Data Collection and Review Chapter of the policies and procedures provides for internal monitoring of the data to assess and improve the effectiveness of the PREA relsted policies, training and practices. The assessment will include identifying problem areas; taking corrective actions on an ongoing basis, as needed; and preparing an annual report which was done covering this audit period. The annual report is documented and it indicates that there have been no allegations or incidents of sexual abuse or sexual harassment during this audit period. The report is constructed to provide comparison of the data from the previous year. The annual report is approved by the Superintendent of Corrections and is made available to the public on the facility's website. Identifying information is not included in the posted report.

Standard 115.389 Data storage, publication, and destruction

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The Data Collection and Review Chapter of the policies and procedures addresses data storage, publication and destruction and provides for the required data to be maintained for 10 years unless a state, federal or local law requires otherwise. The incident-based and aggregate data

and other related documents are securely stored in the Therapist's Office and are accessible to the Superintendent of Corrections and the Intake/Aftercare Coordinator who also serves as the PREA Coordinator. The aggregated data is available to the public through the facility's website and it does not contain any personal identifiers.

AUDITOR CERTIFICATION

I certify that:

- ☒ The contents of this report are accurate to the best of my knowledge.
- ☒ No conflict of interest exists with respect to my ability to conduct an audit of the agency under review, and
- ☒ I have not included in the final report any personally identifiable information (PII) about any inmate or staff member, except where the names of administrative personnel are specifically requested in the report template.

Shirley L. Turner — July 5, 2016

Auditor Signature — Date