PREA AUDIT REPORT ☐ **INTERIM** ■ **FINAL**

COMMUNITY CONFINEMENT FACILITIES

NATIONAL PREA RESOURCE CENTER

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

Auditor Information			
Auditor name: Will Weir			
Address: 133 24th Ave NW, Suite 188; Norman, OK 73069			
Email: will@preaamerica.com			
Telephone number: 405-945-1951			
Date of facility visit: April 23 and 24, 2015			
Facility Information			
Facility name: Center Point OKLAHOMA CITY			
Facility physical address: 5245 S. I-35 Service Rd. OKC, OK 73129			
Facility mailing address: *(if different from above)*			
Facility telephone number: 405-605-2491			
The facility is:	☐ Federal	☐ State	☐ County
	☐ Military	☐ Municipal	☐ Private for profit
	■ Private not for profit		
Facility type:	☐ Community treatment center ■ Halfway house ☐ Alcohol or drug rehabilitation center	☐ Community-based confinement facility ☐ Mental health facility	☐ Other
Name of facility's Chief Executive Officer: Sushma D. Taylor, Ph.D.			
Number of staff assigned to the facility in the last 12 months: 23			
Designed facility capacity: 200			
Current population of facility: 182			
Facility security levels/inmate custody levels: Minimum			
Age range of the population: Adults			
Name of PREA Compliance Manager: Patricia J. Trail		**Title:**	Vice President
Email address: ptrail@cpinc.org		**Telephone number:**	405-605-2491
Agency Information			
Name of agency: Center Point, Inc.			
Governing authority or parent agency: *(if applicable)* Center Point, Inc.			
Physical address: 5245 S. I-35 Service Rd. OKC, OK 73129; or for California Corp. Office: 135 Paul Drive; San Rafael, CA 94903			
Mailing address: *(if different from above)*			
Telephone number: 415-492-4444			
Agency Chief Executive Officer			
Name: Sushma D. Taylor, Ph.D.		**Title:**	CEO
Email address: staylor@cpinc.org		**Telephone number:**	415-492-4444
Agency-Wide PREA Coordinator			
Name: Patricia J. Trail		**Title:**	Vice President
Email address: ptrail@cpinc.org		**Telephone number:**	405-605-2491

AUDIT FINDINGS

NARRATIVE

On 12-08-2014, Center Point, Inc., contracted with Will Weir of PREAmerica LLC for a PREA audit of their OKC facility. Notices announcing the audit went up by March 12, 2015. The Pre Audit Questionnaire was turned in by Center Point Oklahoma Vice President and PREA Coordinator Patricia Trail via flash drive on March 25, 2015. Additional information and clarification was provided by Ms. Trail by phone and email over the course of the next few weeks. Ms. Trail provided the auditor the current list of residents and staff by email on April 21. Residents and staff to be interviewed were selected randomly from these lists the morning of April 23.

The onsite audit was held, as planned, on April 23 and 24, 2015, starting at 9 a.m. with a review of logs, files and documentation in the administration, reception and control areas, and a tour of the entire facility, including a review of the capacity and scope of the video monitoring system. The facility is a remodeled hotel with all resident rooms facing a common area in the center of the facility where the pool and leisure areas used to be. All rooms have similar floor plans, housing either two or three residents, and the auditor was shown inside a couple of rooms as well. The auditor randomly selected 12 inmates and 6 staff for interviews and concluded inmate interviews the first day and staff interviews the second day.

Auditor Will Weir interviewed Vice President Patricia Trail, Program Director David Dobbs, Operation Supervisor Travis Cottrell, and Security Supervisor Mark Clayton, as well as 6 randomly selected staff, 2 randomly selected counselors, and two randomly selected case managers. When interviewing an employee with multiple responsibilities, these responsibilities were considered when selecting interview questions and topics. For example, all interviews were with staff who possibly might be first responders, so they were asked first responder questions.

Concluding the onsite portion of the audit, Mr. Weir met with Ms. Trail and Mr. Cottrell congratulating them on their hard work and the excellent organizational skills that made the audit process flow smoothly and seamlessly. The auditor was able to inform Ms. Trail later that evening that all the information obtained during the audit had been reviewed and a determination had been made that the facility had successfully demonstrated that they at least meet standards in all areas, and that the Auditor's Final Report would be ready within one week.

DESCRIPTION OF FACILITY CHARACTERISTICS

The facility is a two story re-purposed hotel at 5245 S I-35 Service Road in Oklahoma City, with all resident rooms facing inward toward a large open air common area with gardens, benches, tables and chairs, in the center of the facility, where the pool and leisure areas had been. This enclosed outdoor common area opens on the East into the Control Center, indoor dining and visitation areas and meeting rooms with multi media equipment for groups and programs. The indoor common areas open toward the lobby, Administration, and the entrance of the facility, and in other directions to the kitchen and offices. All resident rooms have similar floor plans, housing either two or three residents each. The hotel style rooms have not been structurally altered, so each have a private bathroom with a toilet, tub and shower just like typical hotel rooms. There are no wings or other housing quarters, and no areas around the outside of the facility where residents go unless they are leaving the facility to go to work or activities.

SUMMARY OF AUDIT FINDINGS

On April 23 and 24, 2015, the initial onsite PREA Audit was completed at Center Point, Inc.'s Oklahoma City facility. The results indicated the facility exceeded standards in two areas and met standards in 27 areas. The findings in each specific area are explained in pages 5 - 24 of this report.

Number of standards exceeded: 2

Number of standards met: 27

Number of standards not met: 0

Number of standards not applicable: 0

Standard 115.211 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.

Center Point OKC's written policy mandates zero tolerance and outlines how it will implement the agency's approach to preventing, detecting, and responding to sexual abuse and sexual harassment. The policy includes definitions of prohibited behaviors regarding sexual abuse and sexual harassment. The policy includes sanctions for those found to have participated in prohibited behaviors. The policy includes a description of agency strategies and responses to reduce and prevent sexual abuse and sexual harassment of residents. The agency employs an upper-level, agency-wide PREA coordinator who has sufficient time and authority to develop, implement, and oversee agency efforts to comply with the PREA standards in all of its community confinement facilities. PREA Coordinator Patricia Trail is Vice President of the company in charge of Oklahoma's operations. She has a trained back up PREA Coordinator for in the event of her absence. These policies and the organizational chart was provided to auditor in a flash drive along with the Pre-Audit Questionnaire and other documentation. During the onsite audit, the auditor verified these policies are in place and available to staff and inmates. Signs are posted around the facility. All staff and inmates interviewed indicated an understanding of the zero tolerance policy.

Standard 115.212 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.

The agency does not contract out for the confinement of its residents. Union City Community Corrections Center is Center Point's host Oklahoma Department of Corrections (DOC) facility and takes inmates back if they can no longer stay at Center Point.

Standard 115.213 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)

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Center Point OKC has developed and documented a staffing plan that provides for adequate levels of staffing, and video monitoring to protect residents against sexual abuse. Since August 20, 2012 the average daily number of residents has been 176. Since August 20, 2012 the average daily number of residents on which the staffing plan was predicated was 200. The agency has not deviated from the staffing plan. At least once every year the facility reviews the staffing plan to see whether adjustments are needed in (1) the staffing plan, (2) prevailing staffing patterns, (3) the deployment of video monitoring systems and other monitoring technologies, or (4) the allocation of facility/agency resources to commit to the staffing plan to ensure compliance with the staffing plan. The staffing plan was provided to the auditor, as well as policy that guides the plan. The onsite audit indicates the staffing plan is being followed. There is a log book ready to document deviations of the staffing plan in the event they occur. No staff or inmate interviews indicated any incidents of staffing plan deviations, or times when the facility was not adequately staffed. There is documentation of the staffing plan being reviewed.

Standard 115.215 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.

Center Point has not conducted cross-gender strip or cross-gender visual body cavity searches of residents for several years. Since this policy is institutionalized in the culture and training, and appears to be second nature, it appears the agency has exceeded standards in this area. Policies and procedures have been implemented that enable residents to shower, perform bodily functions, and change clothing without non-medical staff of the opposite gender viewing their breasts, buttocks, or genitalia, except in exigent circumstances or when such viewing is incidental to routine cell checks (this includes viewing via video camera). Policies and procedures require staff of the opposite gender to announce their presence when entering a resident housing unit. In addition, policy requires staff of either sex to announce themselves before entering inmate bathrooms. The facility has a policy prohibiting staff from searching or physically examining a transgender or intersex resident for the sole purpose of determining the resident's genital status. None of these searches have occurred. The onsite audit indicates these policies have been followed for more than 12 months without exception, as verified by inmate and staff interviews. The facility is a remodeled hotel with two or three residents in each room. No cameras are in the rooms, and female staff are announced verbally (by intercom as well as in person) as well as with signs visible to residents when they are on duty. Since rooms have bathtubs, standard issue shower curtains are not available for order. Ms. Trail and and Mr. Cottrell made curtains that are clear on the top and bottom, but are not clear in the middle, so room checks can be conducted appropriately in the event someone is showering at the time of the room check. Logs are in place alongside the other logs for staff to use just in case there is a circumstance when cross gender searching has to be performed, but nobody interviewed believes it will happen, since there is adequate male staff to perform searches at all times, and inmates can be searched at Union City, the host facility, in the event of unusual or exigent circumstances. All searches are documented except routine pat downs conducted when a resident returns to the facility without suspicion

Standard 115.216 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.

Center Point OKC has established procedures to provide disabled residents equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment. The agency has established procedures to provide residents with limited English proficiency equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment. Agency policy prohibits use of resident interpreters, resident readers, or other types of resident assistants except in limited circumstances where an extended delay in obtaining an effective interpreter could compromise the resident's safety, the performance of first-response duties under §115.264, or the investigation of the resident's allegations. The agency or facility documents the limited circumstances in individual cases where resident interpreters, readers, or other types of resident assistants are used. In the past 12 months, there have been no instances where resident interpreters, readers, or other types of resident assistants have been used, and it was not the case that an extended delay in obtaining another interpreter compromised the resident's safety, the performance of first-response duties under § 115.264, or the investigation of the resident's allegations. The onsite audit interviews confirmed that all residents can participate fully, with no exceptions found. All staff interviewed agreed that residents would not be used as interpreters and that appropriate interpretors can be readily located. Spanish interpretors are on staff and other interpretors are available through the Department of Corrections, the YWCA, and other services that can be utilized when a need is identified, but a log is available and will be used for documentation if exceptions occur. Case managers and counselors interviewed are also committed to making sure all residents have a support system identified, including any assistance needed, from the day of their admission to Center Point OKC. Professional staff have experience working with residents with disabilities.

Standard 115.217 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.

Center Point OKC policy prohibits hiring or promoting anyone who may have contact with residents and prohibits enlisting the services of any contractor who may have contact with residents who: (1) Has engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility, or other institution (as defined in 42 U.S.C. 1997); (2) Has been convicted of engaging or attempting to engage in sexual activity in the community facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse; or (3) Has been civilly or administratively adjudicated to have engaged in the activity described in paragraph (a)(2) of this section. Agency policy requires the consideration of any incidents of sexual harassment in determining whether to hire or promote anyone, or to enlist the services of any contractor, who may have contact with residents. Agency policy requires that before it hires any new employees who may have contact with residents, it (a) conducts criminal background record checks, and (b) consistent with federal, state, and local law, makes its best efforts to contact all prior institutional employers for information on substantiated allegations of sexual abuse or any resignation during a pending investigation of an allegation of sexual abuse. In the past 12 months there have been no persons hired who may have contact with residents who have not had criminal background record checks. Agency policy requires that a criminal background record check be completed before enlisting the services of any contractor who may have contact with residents. In the past 12 months, there have been 8 contracts for services where criminal background record checks were conducted on all staff covered in the contract who might have contact with residents. Agency policy requires that either criminal background record checks be conducted at least every five years for current employees and contractors who may have contact with residents or that a system is in place for otherwise capturing such information for current employees. Agency policy states that material omissions regarding such misconduct, or the provision of materially false information, shall be grounds for termination. The auditor

Standard 115.218 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.

There have been no new facilities and no substantial expansions or modifications of existing facilities have been made since August 20, 2012. The agency/facility has installed a video monitoring system since August 20, 2012, and it is documented that inmate safety has been taken into consideration as this was done. The modern high quality video monitoring system with 26 cameras was observed by the auditor. Interviews indicate this system is contributing to the safety of the facility and PREA will continue to be considered as reviews are conducted and if any future modifications and improvements are implemented.

Standard 115.221 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.

Each Center Point OKC Staff Identification Badge contains the First Responder protocol on the back, including the requirement to protect evidence and refer residents to forensic medical examinations by offering the service to alleged victims and calling the YWCA crisis line, as well as DOC, and then following through as appropriate to assure victims get services if they accept them. Oklahoma Department of Corrections (DOC) is responsible for conducting criminal and administrative investigations. Center Point OKC is not responsible for conducting administrative or criminal sexual abuse investigations (including resident-on-resident sexual abuse or staff sexual misconduct). Policy places accused staff on administrative leave pending the outcome of DOC's investigation. Center Point OKC conducts an administrative review as per personnel policies, and utilizes the outcome of DOC's investigation. The onsite audit interviews indicate that the staff understand that DOC will do the investigations and Center Point requests DOC follow PREA protocol for forensic medical examinations, as DOC policy prescribes. Center Point policy spells out the PREA standards for investigations, and security staff have reviewed this protocol and will assist the initial process of protecting the evidence and in referring the victim to advocacy and medical exams (SANE's/SAFE's) in a way that can be understood and utilized by the victim at no cost. Center Point has an MOU with the YWCA Rape Crisis Services that provides for the medical exams and other services.

Standard 115.222 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.

Center Point OKC ensures that an administrative or criminal investigation is completed for all allegations of sexual abuse and sexual harassment (including resident-on-resident sexual abuse or staff sexual misconduct). During the past 12 months, there have been no allegations of sexual abuse and sexual harassment that were received, and no investigations performed. The agency has a policy that requires that allegations of sexual abuse or sexual harassment be referred for investigation to an agency with the legal authority to conduct criminal investigations, unless the allegation does not involve potentially criminal behavior. The agency's policy regarding the referral of allegations of sexual abuse or sexual harassment for criminal investigation is published on the agency website and made publicly available. The agency documents all referrals of allegations of sexual abuse or sexual harassment for criminal investigation. The onsite audit staff interviews indicate there is an understanding that all allegations will be referred to DOC immediately for administrative and criminal investigation, even if the victim recants or changes the story. The policy is publicly available, and is also the DOC policy, which is published on the DOC website.

Standard 115.231 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.

Center Point OKC trains all employees (or sends them to DOC training) who may have contact with residents on the following matters: (1) Agency's zero-tolerance policy for sexual abuse and sexual harassment; (2) How to fulfill their responsibilities under agency sexual abuse and sexual harassment prevention, detection, reporting, and response policies and procedures; (3) The right of residents to be free from sexual abuse and sexual harassment; (4) The right of residents and employees to be free from retaliation for reporting sexual abuse and sexual harassment; (5) The dynamics of sexual abuse and sexual harassment in confinement; (6) The common reactions of sexual abuse and sexual harassment victims; (7) How to detect and respond to signs of threatened and actual sexual abuse; (8) How to avoid inappropriate relationships with residents; (9) How to communicate effectively and professionally with residents, including lesbian, gay, bisexual, transgender, intersex, or gender-nonconforming residents; and (10) How to comply with relevant laws related to mandatory reporting of sexual abuse to outside authorities. Training is tailored to the gender of the residents at the facility. Employees who are reassigned from facilities housing the opposite gender are given additional training. There are 23 staff currently employed by the facility, who may have contact with residents, who were trained or retrained on the PREA requirements enumerated above. Between trainings the agency provides all employees with information about current policies regarding sexual abuse and harassment every 90 days, exceeding standards. Policies are at Control Desk and Administration at all times. The agency documents that employees understand the training they have received through employee signature or electronic verification. The auditor reviewed the PREA training logs, which are maintained at Administration. Staff have first responder duties printed on the backs of all their name badges, exceeding PREA standards, and all staff that were interviewed knew the basics of these procedures from memory. Also, information provided indicates employees have been provided with PREA information and training for several years, indicating PREA concepts are institutionalized.

Standard 115.232 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.

All volunteers and contractors who have contact with Center Point residents have been trained on their responsibilities under the agency's policies and procedures regarding sexual abuse/harassment prevention, detection, and response. DOC volunteer training curriculum was provided to the auditor. The number of volunteers and individual contractors who have contact with residents who have been trained in agency policies and procedures regarding sexual abuse/harassment prevention, detection, and response: 5. The level and type of training provided to volunteers and contractors is based on the services they provide and level of contact they have with residents. All volunteers and contractors who have contact with residents have been notified of the agency's zero-tolerance policy regarding sexual abuse and sexual harassment and informed how to report such incidents. The agency maintains documentation confirming that volunteers and contractors who have contact with residents understand the training they have received. The auditor reviewed the records during the onsite audit. According to interviews with the Vice President, Program Director, Operation Supervisor, and counselors, DOC badged volunteers lead AA/NA meetings, take residents to church, Celebrate Recovery, and assist with other limited community activities.

Standard 115.233 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.

Center Point residents receive information at time of intake about the zero-tolerance policy, how to report incidents or suspicions of sexual abuse or harassment, their rights to be free from sexual abuse and sexual harassment and to be free from retaliation for reporting such incidents, and regarding agency policies and procedures for responding to such incidents. The number of residents admitted during past 12 months who were given this information at intake: 185. The facility provides residents who are transferred from a different community confinement facility with refresher information referenced in 115.233(a)-1.The number of residents transferred from a different community confinement facility during the past 12 months: 484. The number of residents transferred from a different community confinement facility, during the past 12 months, who received refresher information: 185. Resident PREA education is available in formats accessible to all residents, including those who are: Limited English proficient, Deaf, Visually impaired, Otherwise disabled, and Limited in their reading skills. The agency maintains documentation of resident participation in PREA education sessions. The agency ensures that key information about the agency's PREA policies is continuously and readily available or visible through posters, resident handbooks, or other written formats. During the onsite audit, the auditor observed the notices and posters, examined the training logs and materials, and interviewed 12 randomly selected inmates. All inmates reported multiple PREA trainings and full understanding of all questions asked of them. They know they can get help reporting and that they can be anonymous. They know they should not be retaliated against and do not believe they would be retaliated against at Center Point. Also, the staff interviews indicated that the residents have been educated about PREA and know they can report and that victims of sexual assault and harassment can get help.

Standard 115.234 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)

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Center Point does not perform its own investigations, but recognizes this standard in training and policies. Center Point policy was reviewed during the investigation and it includes the PREA standards for this section in reference to the agency (DOC) that is to complete investigations. Also, DOC policy includes the requirements of this section.

Standard 115.235 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)

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Center Point has a policy related to the training of medical and mental health practitioners who work regularly in its facilities. The MOU with the YWCA indicates that staff from the YWCA would have access to residents; then, after YWCA services are completed, in house services would be provided if continued counseling is needed. However, policy and DOC contract addresses DOC's responsibility for medical and mental health treatment for all offenders. The auditor interviewed Center Point Substance Abuse Counselors, who are Masters level therapists, and have training and experience treating victims of sexual abuse. They indicate they are willing and able to provide counseling for inmates who have been sexually abused in confinement.

Standard 115.241 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.

Center Point OKC has a policy that requires screening (within 72 hours of admission or transfer to another facility) for risk of sexual abuse victimization or sexual abusiveness toward other residents. The updated screening tool utilizing all the PREA standards has been used since March 1. 10 inmates have been screened using this objective screening risk assessment instrument so far. The other inmates currently at the facility were admitted before March and screening information was captured during the "biopsychsocial" screening, which included most of the information, but not all, in the updated screening tool. Policy requires the facility reassess each resident's risk of victimization or abusiveness within a set time period, not to exceed 30 days after the resident's arrival at the facility, based upon any additional, relevant information received by the facility since the intake screening. There have not been any residents reassessed so far because none have screened as being at risk according to the screening tool. The policy requires that a resident's risk level be reassessed when warranted due to a referral, request, incident of sexual abuse, or receipt of additional information that bears on the resident's risk of sexual victimization or abusiveness. Interviews with the Vice President, intake staff, and with the counselors, indicate that since the counselors do their own, separate, intake, where they have discussed the limits of confidentiality, they will be sure to report risk information to update/inform the screening. Policy prohibits disciplining residents for refusing to answer (or for not disclosing complete information related to) the questions regarding: Whether or not the resident has a mental, physical, or developmental disability; Whether or not the resident is or is perceived to be gay, lesbian, bisexual, transgender, intersex, or gender non-conforming; Whether or not the resident has previously experienced sexual victimization; and, The resident's own perception of vulnerability. During the audit, all inmate and staff interviews indicate these screenings are conducted and the information is used appropriately to protect inmates, but kept confidential among administrative employees to protect privacy. There is always at least one of these administrators on call or on duty

Standard 115.242 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 agency/facility uses information from the risk screening required by § 115.241 to inform housing, bed, work, education, and program assignments with the goal of keeping separate those residents at high risk of being sexually victimized from those at high risk of being sexually abusive. The agency/facility makes individualized determinations about how to ensure the safety of each resident. Center Point OKC makes housing and program assignments for transgender or intersex residents in the facility on a case-by-case basis. Information obtained during the audit indicates that inmates at high risk of being sexually abusive are not likely to be referred to Center Point OKC. Center Point is a halfway house only for residents ready and motivated to transition to the community. There are different levels of reentry, but not different levels of security, so if an inmate needs consequences and reduction of privileges, he goes back to DOC, or never arrives in the first place. All staff indicate an understanding that some residents are at higher risk of sexual abuse or abusiveness than others, although anyone can be a victim. Staff indicate an ability to be respectful of cultural diversity, as well as being sensitive to the needs of LGBTI residents even though they have no current residents who identify openly as LGBTI. In the past, some gay and bisexual residents did not disclose right away, choosing to wait until they knew staff better, and were working discretely on practical issues relating to discharge planning. Staff have recently completed training regarding searching transgender residents and several staff reported that the training was very helpful and improves their overall skills, not only in conducting searches of trans residents, but in communicating respectfully and effectively with anyone. Counselors and staff are also experienced with working with inmates who have other risk factors, such as having learning disabilities and communication difficulties. Any sensitive information obtained during the screening process is restricted to Administrative staff and counselors. Counselors and case managers do their own intake interviews with new residents, but are aware of the importance of admissions staff having an accurate screening assessment

Standard 115.251 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 agency has established procedures allowing for multiple internal ways for residents to report privately to agency officials about: • Sexual abuse or sexual harassment; • Retaliation by other residents or staff for reporting sexual abuse and sexual harassment; and • Staff neglect or violation of responsibilities that may have contributed to such incidents. The agency provides at least one way for residents to report abuse or harassment to a public or private entity or office that is not part of the agency. The agency has a policy mandating that staff accept reports of sexual abuse and sexual harassment made verbally, in writing, anonymously, and from third parties. Staff are required to document verbal reports within 24 hours. The agency has established procedures for staff to privately report sexual abuse and sexual harassment of residents verbally and in writing. Staff are informed of these procedures. The audit found that according to the DOC site: http://www.ok.gov/doc/documents/op030601.pdf "Staff may privately report allegations or incidents of sexual abuse/assault or harassment of an offender to the Inspector General's office, PREA Hotline at 405-425-2493 or 1-855-871-4139, as well as preareport@doc.state.ok.us." Auditor verified that these numbers, and the email option, are in working order, and have been posted around the facility. The phone numbers are not answered 24 hours per day, but are a message system. All inmates interviewed know they can report and all staff interviewed say they can take reports and know how to instruct and assist inmates to make reports. Also posted is the number to the YWCA Rape Crisis Line. The auditor spoke to Yvonne Sharp, Director of Sexual Advocacy at the YWCA, who stated the staff who answer the confidential Crisis Line will also make reports, if the inmate gives permission.

Standard 115.252 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.

Center Point OKC has an administrative procedure for dealing with resident grievances regarding sexual abuse. This policy allows a resident to submit a grievance regarding an allegation of sexual abuse at any time, regardless of when the incident is alleged to have occurred. Policy does not require a resident to use an informal grievance process, or otherwise to attempt to resolve with staff, an alleged incident of sexual abuse. A resident may submit a grievance alleging sexual abuse without submitting it to the staff member who is the subject of the complaint, and it will not be referred to the staff member who is the subject of the complaint. Policy requires that a decision on the merits of any grievance or portion of a grievance alleging sexual abuse be made within 90 days. In the past 12 months, no grievances have been filed that alleged sexual abuse. The agency always notifies a resident in writing when the agency files for an extension, including notice of the date by which a decision will be made. Agency policy and procedure permits third parties, including fellow residents, staff members, family members, attorneys, and outside advocates, to assist residents in filing requests for administrative remedies relating to allegations of sexual abuse, and file such requests on behalf of residents. Policy requires that if a resident declines to have third-party assistance in filing a grievance alleging sexual abuse, the agency documents the resident's decision to decline. Center Point OKC has a policy and established procedures for filing an emergency grievance alleging that a resident is subject to a substantial risk of imminent sexual abuse. Policy for emergency grievances alleging substantial risk of imminent sexual abuse requires an initial response within 48 hours. Policy for emergency grievances alleging substantial risk of imminent sexual abuse requires that a final agency decision be issued within five days. Policy limits the ability to discipline a resident for filing a grievance alleging sexual abuse to occasions where the agency demonstrates that the resident filed the grievance in bad faith. Statements made during the audit interviews are consistent with the information provided during the pre-audit phase. A grievance process is available, as stated, but no sexual abuse or

Standard 115.253 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.

Center Point OKC provides residents with access to outside victim advocates for emotional support services related to sexual abuse by having a Memorandum of Understanding (MOU) with the YWCA and providing the number to the Crisis Line. Center Point OKC enables reasonable communication between residents and the YWCA, and such organizations, in as confidential a manner as possible. The facility informs residents, prior to giving them access to outside support services, of the extent to which such communications will be monitored. Residents interviewed at Center Point OKC indicate no problems being able to participate in such communication freely, without being monitored. The facility informs residents, prior to giving them access to outside support services, of the mandatory reporting rules governing privacy, confidentiality, and/or privilege that apply to disclosures of sexual abuse made to outside victim advocates, including any limits to confidentiality under relevant federal, state, or local law. Auditor Weir reviewed the MOU and verified it with the YWCA. Yvonne Sharp, YWCA's Director of Sexual Advocacy states the YWCA staff will not report back to Center Point or DOC unless the caller gives permission, but, if they gain the resident's permission they will they will assist with the reporting process as appropriate, respecting the limits of confidentiality. The YWCA provides a full range of assistance including advocacy, sexual abuse exams, and counseling. Some of the Center Point posters had a section reworded to assure, as much as possible, a clear understanding of the difference between calling the YWCA for help and calling the PREA report line to report. A sticker with improved wording was applied to a section of the posters.

Standard 115.254 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 agency or facility provides a method to receive third-party reports of resident sexual abuse or sexual harassment. The agency or facility publicly distributes information on how to report resident sexual abuse or sexual harassment on behalf of residents. The onsite audit facility tour, as well as interviews with residents and staff, verified that staff and inmates are instructed about third party reporting, and the information is available publicly and on the agency's website. Inmates indicated they know about third party reporting and know how to do it, and can imagine circumstances where it would be the preferred way to report.

Standard 115.261 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.

Center Point OKC requires all staff to report immediately and according to agency policy any knowledge, suspicion, or information they receive regarding an incident of sexual abuse or sexual harassment that occurred in a facility, whether or not it is part of the agency. The agency requires all staff to report immediately and according to agency policy retaliation against residents or staff who reported such an incident. The agency requires all staff to report immediately and according to agency policy any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation. Apart from reporting to designated supervisors or officials and designated state or local services agencies, agency policy prohibits staff from revealing any information related to a sexual abuse report to anyone other than to the extent necessary to make treatment, investigation, and other security and management decisions. All staff interviewed indicate they will report immediately, and all inmates interviewed indicate they believe staff will report. Inmates, as well as staff, state they have not observed any sexual abuse or harassment at Center Point. Although they believe staff will report, some interviews indicate that it is believed that not all inmates would report abuse because, for some, reporting is like snitching. However, several inmates spontaneously indicated they have more confidence in staff at Center Point than staff at previous placements.

Standard 115.262 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.

Policy and established procedure requires that when the facility learns that a resident is subject to a substantial risk of imminent sexual abuse, it takes immediate action to protect the resident (i.e., it takes some action to assess and implement appropriate protective measures without unreasonable delay). In the past 12 months, there were no residents determined to be at substantial risk of imminent sexual abuse. Interviews conducted during the onsite audit indicated that both staff and residents believe Center Point staff will take appropriate and effective immediate steps to protect a resident. No interview indicated there has been a specific need for this kind of protective measure to be used at Center Point in the past 12 months.

Standard 115.263 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 auditor confirmed that the agency has a policy requiring that, upon receiving an allegation that a resident was sexually abused while confined at another facility, the head of the facility must notify the head of the facility or appropriate office of the agency or facility where sexual abuse is alleged to have occurred. For Center Point OKC, the facility head is Center Point Oklahoma Vice President Patricia Trail or her designee. During the past 12 months, the facility has not received any allegations that a resident was abused while confined at another facility. Agency policy requires the facility head to provide such notification as soon as possible, but no later than 72 hours after receiving the allegation. The facility documents that it has provided such notification within 72 hours of receiving the allegation. Facility policy requires that allegations received from other facilities and agencies are investigated in accordance with the PREA standards. Information received during the audit indicates that in the past 12 months, there have been no allegations of sexual abuse the facility received from other facilities. A log book has been designated in Administration area with the other log books to record these reports, but does not yet have any reports listed.

Standard 115.264 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 agency has a first responder policy for allegations of sexual abuse. The policy requires that, upon learning of an allegation that a resident was sexually abused, the first security staff member to respond to the report shall be required to: (1) Separate the alleged victim and abuser; (2) Preserve and protect any crime scene until appropriate steps can be taken to collect any evidence; (3) If the abuse occurred within a time period that still allows for the collection of physical evidence, request that the alleged victim not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating; and/or (4) If the abuse occurred within a time period that still allows for the collection of physical evidence, ensure that the alleged abuser does not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating. Agency policy requires that if the first staff responder is not a security staff member, that responder shall be required to (1) Request that the alleged victim not take any actions that could destroy physical evidence; and/or (2) Notify security staff. Interviews indicate that all security staff, counselors, and case managers have been trained on first responder duties, can recite these duties from memory, and have the steps printed on the backs of their badges as well. The duties listed on the badges also includes reporting. This was mentioned in the section on staff training (115.231) in this report in the context of Center Point exceeding standards in the area of training. No staff or resident indicates there have been any known incidents of sexual abuse in the past 12 months, so first responder services have not been required.

Standard 115.265 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 facility has developed a written institutional plan to coordinate actions taken in response to an incident of sexual abuse among staff first responders, medical and mental health practitioners, investigators, and facility leadership. This is indicated/summarized concisely on the backs of employee badges, and put to memory, as mentioned in the previous section, ready to be triggered by an incident or allegation. This is also provided for, prominently, in the MOU with the YWCA in Section 1, Part 1, where it states the designated YWCA personnel are "a component of the standard response to a report of sexual violence and/or a request for help from a survivor of sexual violence . . . " Policy indicates, and interviews substantiate, that DOC is a major part of the Coordinated Response as well, for numerous reasons, including the fact that the residents are all under DOC jurisdiction and that DOC is in charge of investigations. Several staff indicate significant prior experience with non-PREA coordinated responses in everything from previous law enforcement jobs and collaborative community based positions, to tornado related situations. They told the auditor that the PREA response makes perfect sense to them and is easy to remember because it is just common sense. These staff indicate confidence that their training and experiences with other kinds of crises situations will kick in to make their response to an incident of sexual abuse seem like second nature.

Standard 115.266 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.

The agency, facility, or any other governmental entity responsible for collective bargaining on the agency's behalf has not entered into or renewed any collective bargaining agreement or other agreement since August 20, 2012. This was verified during the onsite audit. The facility has the ability and authority to protect residents from contact with abusers.

Standard 115.267 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 has a policy to protect all residents and staff who report sexual abuse or sexual harassment or cooperate with sexual abuse or sexual harassment investigations from retaliation by other residents or staff. The agency designates staff member(s) with monitoring for possible retaliation. The agency monitors the conduct or treatment of residents or staff who reported sexual abuse and of residents who were reported to have suffered sexual abuse to see if there are any changes that may suggest possible retaliation by residents or staff. The agency monitors the conduct or treatment for at least 90 days. The agency acts promptly to remedy any such retaliation. The agency continues such monitoring beyond 90 days if the initial monitoring indicates a continuing need. There have been no known incidents of retaliation in the past 12 months. Who is in charge of monitoring retaliation at Center Point OKC? Official Response Policy states: "Center Point has designated the following staff member with monitoring for possible retaliation: Patricia Trail, David Dobbs, and Travis Cottrell. Staff Title(s): Vice President, Program Manager and Operations Supervisor." All of these administrators were interviewed and demonstrated an excellent grasp of the duties of the position and displayed a strong commitment to making sure the facility is free from retaliation, and that any incidents are discovered and handled appropriately and by PREA standards and policy.

Standard 115.271 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 agency/facility has a policy related to criminal and administrative agency investigations. Substantiated allegations of conduct that appear to be criminal are referred for prosecution. Since there have been no allegations, there have been no substantiated allegations of conduct that appear to be criminal that were referred for prosecution since August 20, 2012. The agency retains all written reports pertaining to the administrative or criminal investigation of alleged sexual abuse or sexual harassment for as long as the alleged abuser is incarcerated or employed by the agency, plus five years. The audit indicates allegations will be turned over to DOC immediately for investigation by qualified investigators following industry standards in collecting evidence and in reviewing all pertinent information. When the evidence supports prosecution, DOC will not compel interviews without first consulting with prosecutors. The credibility of a victim, witness, or suspect shall be assessed on an individual basis, not being determined by the person's status as resident or staff. Polygraph examinations will not be used as a condition of proceeding with an investigation. Investigations will be fully documented. Substantiated allegations of criminal conduct will be referred for prosecution. DOC and Center Point policy also states that the departure of a victim or abuser from the control of the institution, or from employment, does not provide a basis for terminating an investigation.

Standard 115.272 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.

As clearly stated in policy and in interviews with the administrators, the agency and DOC imposes a standard of a preponderance of evidence, or a lower standard of proof, when determining whether allegations of sexual abuse or sexual harassment can be substantiated.

Standard 115.273 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 agency has a policy requiring that any resident who makes an allegation that he or she suffered sexual abuse in the facility is informed, verbally or in writing, as to whether the allegation has been determined to be substantiated, unsubstantiated, or unfounded following an investigation. There were no criminal and/or administrative investigations of alleged resident sexual abuse that were completed in the past 12 months. If an outside entity conducts such investigations, as they do at Center Point OKC, the agency requests the relevant information from the investigative entity in order to inform the resident of the outcome of the investigation. Following a resident's allegation that a staff member has committed sexual abuse against the resident, the facility subsequently informs the resident (unless the facility has determined that the allegation is unfounded) whenever: • The staff member is no longer posted within the resident's unit; • The staff member is no longer employed at the facility; • The agency learns that the staff member has been indicted on a charge related to sexual abuse within the facility; or • The agency learns that the staff member has been convicted on a charge related to sexual abuse within the facility. There has not been a complaint of sexual abuse committed by a staff member against a resident in the facility in the past 12 months. Following a resident's allegation that he or she has been sexually abused by another resident in the facility, the agency subsequently informs the alleged victim whenever: the agency learns that the alleged abuser has been indicted on a charge related to sexual abuse within the facility; or the agency learns that the alleged abuser has been convicted on a charge related to sexual abuse within the facility. The agency has a policy that all notifications to residents described under this standard are documented.

Standard 115.276 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.

Staff are subject to disciplinary sanctions up to and including termination for violating agency sexual abuse or sexual harassment policies. In the past 12 months, there have been no staff from the facility who violated agency sexual abuse or sexual harassment policies, so the auditor had no terminations, resignations, or disciplinary actions to review. The disciplinary sanctions for violations of agency policies relating to sexual abuse or sexual harassment (other than actually engaging in sexual abuse) are commensurate with the nature and circumstances of the acts committed, the staff member's disciplinary history, and the sanctions imposed for comparable offenses by other staff with similar histories. All terminations for violations of agency sexual abuse or sexual harassment policies, or resignations by staff who would have been terminated if not for their resignation, are reported to law enforcement agencies (unless the activity was clearly not criminal) and to any relevant licensing bodies, but this has not happened in the past 12 months since there have been no reports or allegations.

Standard 115.277 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.

Agency policy requires that any contractor or volunteer who engages in sexual abuse be reported to law enforcement agencies (unless the activity was clearly not criminal) and to relevant licensing bodies. Agency policy requires that any contractor or volunteer who engages in sexual abuse be prohibited from contact with residents. In the past 12 months, there have been no contractors or volunteers reported to law enforcement agencies and relevant licensing bodies for engaging in sexual abuse of residents. The facility takes appropriate remedial measures and considers whether to prohibit further contact with residents in the case of any other violation of agency sexual abuse or sexual harassment policies by a contractor or volunteer. Ms. Trail states that any violation will cause a volunteer or contractor to be banned from contact with residents.

Standard 115.278 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.

Residents are subject to disciplinary sanctions only pursuant to a formal disciplinary process following an administrative finding that a resident engaged in resident-on-resident sexual abuse. Residents are subject to disciplinary sanctions only pursuant to a formal disciplinary process following a criminal finding of guilt for resident-on-resident sexual abuse. In the past 12 months, there have been no administrative findings of resident-on-resident sexual abuse that have occurred at the facility. There have been no criminal findings of guilt for resident-on-resident sexual abuse that have occurred at the facility. The facility offers therapy, counseling, or other interventions designed to address and correct the underlying reasons or motivations for abuse. The facility refers the offender back to DOC for consideration of whether to require the offending resident to participate in such interventions as a condition of access to programming or other benefits. The agency disciplines residents for sexual conduct with staff only upon finding that the staff member did not consent to such contact. The agency prohibits disciplinary action for a report of sexual abuse made in good faith based upon a reasonable belief that the alleged conduct occurred, even if an investigation does not establish evidence sufficient to substantiate the allegation. The agency prohibits all sexual activity between residents. The agency deems such activity to constitute sexual abuse only if it determines that the activity is coerced. Interviews with administrative staff indicate an offender would have to be transferred back to a DOC facility for any sanctions.

Standard 115.282 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.

According to policy, interviews with administrative staff, the contents of MOU with the YWCA, and the YWCA's understanding of the MOU: Resident victims of sexual abuse receive timely, unimpeded access to emergency medical treatment and crisis intervention services. The nature and scope of such services are determined by medical and mental health practitioners according to their professional judgment. Medical and mental health staff document: • The timeliness of emergency medical treatment and crisis intervention services that were provided; • The appropriate response by non-health staff in the event health staff are not present at the time the incident is reported; and • The provision of appropriate and timely information and services concerning contraception and sexually transmitted infection prophylaxis. Resident victims of sexual abuse while incarcerated are offered timely information about and timely access to emergency contraception and sexually transmitted infections prophylaxis, in accordance with professionally accepted standards of care, where medically appropriate. Treatment services are provided to every victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident.

Standard 115.283 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 facility offers medical and mental health evaluation and, as appropriate, treatment to all residents who have been victimized by sexual abuse in any prison, jail, lockup, or juvenile facility. Since this is an all male facility, the requirement to offer female victims pregnancy tests does not apply. Resident victims of sexual abuse while incarcerated are offered tests for sexually transmitted infections as medically appropriate. The facility attempts to conduct a mental health evaluation of all known resident-on-resident abusers within 60 days of learning of such abuse history and offers treatment when deemed appropriate by mental health practitioners.

Standard 115.286 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 facility conducts a sexual abuse incident review at the conclusion of every criminal or administrative sexual abuse investigation, unless the allegation has been determined to be unfounded. In the past 12 months, the number of criminal and/or administrative investigations of alleged sexual abuse is zero. The facility conducts a sexual abuse incident review within 30 days of the conclusion of the criminal or administrative sexual abuse investigation. The sexual abuse incident review team includes upper-level management officials and allows for input from line supervisors, investigators, and medical or mental health practitioners. The facility prepares a report of its findings from sexual abuse incident reviews, including but not necessarily limited to determinations made pursuant to paragraphs (d)(1)-(d)(5) of this section and any recommendations for improvement, and submits such report to the facility head and PREA Coordinator. The facility implements the recommendations for improvement or documents its reasons for not doing so. Interviews with Ms. Trail and other administrative staff indicate all administrative staff and the assigned counselor will be on the sexual incident review team, along with others who may be appropriate according to the nature of the allegations. The team will consider whether policies or practices need to be changed; whether the incident or allegation was motivated by race, ethnicity, LGBTI status or perceived status, or gang affiliation or other group dynamics at the facility; whether physical barriers in the area where the abuse allegedly occurred might enable abuse; and whether monitoring technology should be augmented or changed.

Standard 115.287 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 agency collects accurate, uniform data for every allegation of sexual abuse at facilities under its direct control using a standardized instrument and set of definitions. The standardized instrument includes, at a minimum, the data necessary to answer all questions from the most recent version of the Survey of Sexual Violence (SSV) conducted by the Department of Justice. The agency aggregates the incident-based sexual abuse data at least annually. The agency maintains, reviews, and collects data as needed from all available incident-based documents, including reports, investigation files, and sexual abuse incident reviews. The agency does not contract for the confinement of its residents. The data from private facilities complies with SSV reporting regarding content. DOJ did not ask for the previous year's data. Center Point has all zeros on it's report due to not having any allegations of sexual abuse or harassment. The DOC annual report can be found at http://www.ok.gov/doc/Organization/Inspector_General/PREA.html. The information is also on the Center Point website: http://www.cpinc.org/index.php?option=com_content&view=article&id=37:annual-reports&catid=8:news&Itemid=149 and: http://www.cpinc.org/images/pdfs/Center%20Point%20PREA%20Annual%20Report.pdf

Standard 115.288 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 agency reviews data collected and aggregated pursuant to §115.287 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, response policies, and training, including: • Identifying problem areas; • Taking corrective action on an ongoing basis; and • Preparing an annual report of its findings from its data review and any corrective actions for each facility, as well as the agency as a whole. The annual report includes a comparison of the current year's data and corrective actions with those from prior years. The annual report provides an assessment of the agency's progress in addressing sexual abuse. The agency makes its annual report readily available to the public at least annually through its website. Annual report has been sent to DOC. The annual reports are approved by the agency head. When the agency redacts material from an annual report for publication, the redactions are limited to specific materials where publication would present a clear and specific threat to the safety and security of the facility. The agency indicates the nature of material redacted.

Standard 115.289 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 agency ensures that incident-based and aggregate data are securely retained. Agency policy requires that aggregated sexual abuse data from facilities under its direct control be made readily available to the public at least annually through its website and the DOC. Before making aggregated sexual abuse data publicly available, the agency removes all personal identifiers. The agency maintains sexual abuse data collected pursuant to §115.287 for at least 10 years after the date of initial collection, unless federal, state, or local law requires otherwise. This report, with all zeros, was reviewed by the auditor.

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 resident or staff member, except where the names of administrative personnel are specifically requested in the report template.

D. Will Weir — 04/28/2015

Auditor Signature — Date

PREA AUDIT REPORT ☐ INTERIM ■ FINAL

COMMUNITY CONFINEMENT FACILITIES

NATIONAL PREA RESOURCE CENTER

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

Auditor Information			
Auditor name: Will Weir; DOJ certified PREA Auditor employed by PREAmerica, LLC			
Address: 133 24th Ave NW, Suite 188; Norman, OK 73069			
Email: will@preaamerica.com			
Telephone number: 405-945-1951			
Date of facility visit: May 15, 2015			
Facility Information			
Facility name: Center Point, Inc.; Osage County; also known as the Men's Work Release Facility			
Facility physical address: 1755 West 53rd Street North; Tulsa, OK 74126			
Facility mailing address: *(if different from above)*			
Facility telephone number: 405-605-2491			
The facility is:	☐ Federal	☐ State	☐ County
	☐ Military	☐ Municipal	☐ Private for profit
	■ Private not for profit		
Facility type:	☐ Community treatment center ■ Halfway house ☐ Alcohol or drug rehabilitation center	☐ Community-based confinement facility ☐ Mental health facility	☐ Other
Name of facility's Chief Executive Officer: Sushma D. Taylor, Ph.D.			
Number of staff assigned to the facility in the last 12 months:			
Designed facility capacity: 75			
Current population of facility: 75			
Facility security levels/inmate custody levels: Minimum			
Age range of the population: Adults			
Name of PREA Compliance Manager: Patricia J. Trail		**Title:**	Vice President
Email address: ptrail@cpinc.org		**Telephone number:**	405-605-2491
Agency Information			
Name of agency: Center Point, Inc.			
Governing authority or parent agency: *(if applicable)* Center Point provides services to the Oklahoma DOC			
Physical address:			
Mailing address: *(if different from above)* for Center Point, Inc., California Corp. Office: 135 Paul Drive; San Rafael, CA 94903			
Telephone number: 415-492-4444			
Agency Chief Executive Officer			
Name: Sushma D. Taylor, Ph.D.		**Title:**	CEO
Email address: staylor@cpinc.org		**Telephone number:**	415-492-4444
Agency-Wide PREA Coordinator			
Name: Patricia J. Trail		**Title:**	Vice President
Email address: ptrail@cpinc.org		**Telephone number:**	405-605-2491

AUDIT FINDINGS

NARRATIVE

On December 8, 2014, a contract was signed for PREAmerica LLC's Will Weir to conduct the PREA Audit of the Center Point, Inc., facility in Osage County near Tulsa. Notices went up by March 31, 2015 announcing the date of the audit and providing information about confidentiality as well as contact information for the auditor.

The auditor received the Pre Audit Questionnaire on flash drive March 25, 2015. The flash drive also contained the supportive documentation associated with the Questionnaire, including policy, forms, and documentation. During the next few weeks the PREA coordinator and the auditor exchanged a few emails and phone calls regarding details of the audit and the information provided. In addition, the auditor conducted PREA audits of Center Point's Oklahoma City facility and the their Tulsa Women's program. Also, the worker has visited with Elaine Thompson, the Sexual Assault Program Manager of the Domestic Violence Intervention Services (DVIS) regarding the Memorandum of Understanding (MOU).

Auditor Will Weir conducted the on-site audit on May 15, 2015. Arriving at 9 AM, the auditor had randomly selected inmates and staff from lists provided by Program Director Glenda Garrison and PREA Coordinator (and Center Point Vice President in charge of Oklahoma's Operations) Patricia Trail. Operation Supervisor Travis Cottrell was also present and a meeting was held welcoming the auditor to the facility. At that time the auditor was given a tour of the facility including part of the grounds (despite the rain), the 3 buildings where residents live, the administration building, and the multipurpose building with gym, kitchen, and visitation areas, with special attention given to places where PREA signs and notices are posted and locations where policy is made available to residents and staff.

Immediately after the tour, the interviews began and continued the rest of the day. The auditor was able to interview all 10 of the randomly selected residents. In addition to interviewing Mr. Cottrell, Ms. Trail, and Ms. Garrison, the auditor interviewed 7 other staff, randomly selected from the remaining list of 13. The selection included staff from all shifts. Since many staff have multiple roles, most staff interviewed are considered specialized staff by PREA standards.

Between interviews, the auditor, with the assistance of Ms. Trail, reviewed logs, records, and files that could not be included in the Pre Audit Questionnaire flash drive because they needed to be viewed on site, regarding the residents and staff. Around 5 PM the auditor again met with Ms. Trail, Ms. Garrison, and Mr. Cottrell for the exit conference. The auditor expressed appreciation for the years of hard work that went into getting the facility ready for the audit, and for helping the on-site audit flow smoothly. Also, the auditor congratulated them on having such a stable, dependable, and experienced workforce. Several of the employees have managed other programs and are leaders in the community outside of their vocational commitments at the facility, allowing them to enrich the resident's lives with their wealth of experiences and well honed problem solving skills.

Also of significance to the auditor was the focus, perseverance, and determination shown by the residents who were interviewed, many of whom have spent many years waiting to be allowed to come into a work program such as this, so close to family and/or other meaningful support systems on the outside. For some, their discharge dates are coming up soon. The residents knew the interviews were confidential and several felt free to mention the general problems of the correctional and justice systems, such as inordinately long sentences that don't seem to match the crime, and the general lack of assessable rehabilitation services in most prisons. Most were very straightforward and earnest, if not eloquent, in telling the auditor they have put crime behind them, and are moving forward with their lives not being distracted, or busted back down by rule violations, or inmate relationships. They say their fellow residents at Center Point cooperate with staff, with relatively few rule violations and disagreements, because being at this facility is so much better than being at the more restrictive facilities, and they feel the staff are assessable, sincerely trying to help them stick to their plans, not undermining them, and they appreciate being given more trust, and responsibilities, in addition to being held accountable in a work activity routine they will need when released.

DESCRIPTION OF FACILITY CHARACTERISTICS

Center Point residents at the Osage Work Release Program are housed in two dormitory units and one multi-person housing unit that are situated to the East, West, and North of the main administrative building at the entrance to the complex. The dormitories and the multi-person housing unit have private bathrooms which allows residents a private area to shower, perform bodily functions and change clothing. The multipurpose building with the kitchen, cafeteria/gym, and visitation areas is a short walk to the West side of the complex. There are also outdoor visitation and recreational by the cafeteria and between the cafeteria and the housing units. Parking is by the administration building and the multipurpose building.

SUMMARY OF AUDIT FINDINGS

Center Point's Osage County Work Release facility is located at 1755 West 53rd Street North in Tulsa, OK, and was audited on May 15, 2015 by DOJ Certified PREA Auditor Will Weir of PREAmerica, LLC. According to the information available to the auditor, the facility was found to be compliant with all standards, and exceeded standards in one area. The findings in each specific area are explained in pages 5 - 24 of this report.

Number of standards exceeded: 1

Number of standards met: 28

Number of standards not met: 0

Number of standards not applicable: 0

Standard 115.211 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.

As indicated in the Pre-Audit Questionnaire, and verified during interviews at the facility, the facility has a written policy mandating zero tolerance. The policy outlines how it will implement the agency's approach to preventing, detecting, and responding to sexual abuse and sexual harassment. The policy includes definitions of prohibited behaviors regarding sexual abuse and sexual harassment. The policy includes sanctions for those found to have participated in prohibited behaviors. The policy includes a description of agency strategies and responses to reduce and prevent sexual abuse and sexual harassment of residents. The agency employs or designates an upper-level, agency-wide PREA coordinator who has sufficient time and authority to develop, implement, and oversee agency efforts to comply with the PREA standards in all of its community confinement facilities. PREA Coordinator Patricia Trail is Vice President of the company in charge of Oklahoma's operations. She has a trained back up PREA Coordinator for in the event of her absence. These policies, and the organizational chart were provided to auditor in a flash drive. During the onsite audit, the auditor verified these policies to be in place and available to staff and residents. Signs are posted around the facility. All staff and residents interviewed indicated an understanding of the zero tolerance policy.

Standard 115.212 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.

The agency does not contract out for the confinement of its residents.

Standard 115.213 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.

Center Point Osage has developed and documented a staffing plan that provides for adequate levels of staffing to protect residents against sexual abuse. Since August 20, 2012 the average daily number of residents has been 73. The average daily number of residents on which the staffing plan was predicated was 75. The agency has not deviated from the staffing plan. At least once every year the facility reviews the staffing plan to see whether adjustments are needed in (1) the staffing plan, (2) prevailing staffing patterns, (3) the deployment of video monitoring systems and other monitoring technologies, or (4) the allocation of facility/agency resources to commit to the staffing plan to ensure compliance with the staffing plan. The staffing plan was provided to the auditor, as well as policy that guides the plan. The onsite audit indicates the staffing plan is being followed. There is a log book ready to document deviations of the staffing plan in the event they occur. No staff or inmate interviews indicated any incidents of staffing plan deviations, or times when the facility was not adequately staffed. There is documentation of the staffing plan being reviewed. Also, documentation has been provided describing the 9 camera surveillance system that has been ordered for the facility.

Standard 115.215 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.

The facility does not conduct cross-gender strip or cross-gender visual body cavity searches, or even cross-gender pat downs of residents. The facility does not house female residents. The facility has implemented policies and procedures that enable residents to shower, perform bodily functions, and change clothing without non-medical staff of the opposite gender viewing their breasts, buttocks, or genitalia, except in exigent circumstances or when such viewing is incidental to routine cell checks. Policies and procedures require staff of the opposite gender to announce their presence when entering a resident housing unit. In addition, policy requires staff of either sex to announce themselves before entering inmate bathrooms. The facility has a policy prohibiting staff from searching or physically examining a transgender or intersex resident for the sole purpose of determining the resident's genital status. None of these searches have occurred. The onsite audit indicates these policies have been followed for more than 12 months without exception, as verified by inmate and staff interviews. Ms. Trail and and Mr. Cottrell made shower curtains that are clear on the top and bottom, but are not clear in the middle, so room checks can be conducted appropriately in the event someone is showering at the time of the room check. Logs are in place, alongside the other logs, for staff to use in the event of an exigent circumstance when cross gender searching has to be performed, but nobody interviewed believes it will happen, since there is adequate male staff to perform searches at all times. All searches are documented except routine pat downs conducted when a resident returns to the facility without suspicion. In addition, exceeding standards, the facility has a relationship with the Osage County Sheriff's Department, as well as the Nowata County Jail, so that help will be available for most exigent circumstances in the form of law enforcement response to the facility, and/or for a resident to be immediately transported off site and housed at the Nowata County Jail until transferred back to DOC custody.

Standard 115.216 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.

The agency has established procedures to provide disabled residents, and residents with limited English proficiency, equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment. Policy prohibits use of resident interpreters, resident readers, or other types of resident assistants except in limited circumstances where an extended delay in obtaining an effective interpreter could compromise the resident's safety, the performance of first-response duties under §115.264, or the investigation of the resident's allegations. The agency or facility documents the limited circumstances in individual cases where resident interpreters, readers, or other types of resident assistants are used. In the past 12 months, there have been no instances where resident interpreters, readers, or other types of resident assistants have been used, and it was not the case that an extended delay in obtaining another interpreter compromised the resident's safety, the performance of first-response duties under § 115.264, or the investigation of the resident's allegations. The onsite audit interviews confirmed that all residents can participate fully, with no exceptions found. All staff interviewed agreed that residents would not be used as interpreters and that appropriate interpretors can be readily located. Spanish interpretors are on staff and other interpretors are available through the Department of Corrections, DVIS, and other services that can be utilized when a need is identified. Case managers and counselors interviewed are also committed to making sure all residents have a support system identified, including any assistance needed, from the day of their admission to Center Point.

Standard 115.217 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.

Center Point Osage policy prohibits hiring or promoting anyone who may have contact with residents and prohibits enlisting the services of any contractor who may have contact with residents who: has engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility, or other institution; has been convicted of engaging or attempting to engage in sexual activity in the community facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse; or has been civilly or administratively adjudicated to have engaged in any of these activities. Any incidents of sexual harassment must be considered in determining whether to hire or promote anyone, or to enlist the services of any contractor, who may have contact with residents. Policy also requires that before it hires any new employees who may have contact with residents, it conducts criminal background record checks, and consistent with federal, state, and local law, makes its best efforts to contact all prior institutional employers for information on substantiated allegations of sexual abuse or any resignation during a pending investigation of an allegation of sexual abuse. In the past 12 months there have been no persons hired who may have contact with residents who have not had criminal background record checks. Agency policy requires that a criminal background record check be completed. In the past 12 months, there have been 5 contracts for services where criminal background record checks were conducted. Criminal background record checks are conducted at least every five years. Material omissions regarding such misconduct, or the provision of materially false information is grounds for termination. The auditor reviewed binders containing current employee background checks as well as employee statements about their prior work history and that they had never been administratively adjudicated of a violation, etc. No volunteers come to the facility other than DOC badged volunteers, with appropriate training and background checks. Contractor information is documented.

Standard 115.218 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.

There have been no new facilities added to the Center Point/Osage complex, and no substantial expansions or modifications made since August 20, 2012. The facility has not yet installed a video monitoring system, but one is currently on order. Interviews indicate that the meetings held up to this point regarding the selection, placement, monitoring, and design of this system has considered PREA and the safety on inmates.

Standard 115.221 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 new Center Point/Osage Staff Identification Badge contains the first responder protocol on the back, including the requirement to protect evidence and refer residents alleged victims of sexual assault for forensic medical examinations by offering the service to alleged victims, and then following through as appropriate to assure victims get services they accept. Oklahoma Department of Corrections (DOC), along with local law enforcement, and any other agency with jurisdiction, is responsible for conducting criminal and administrative investigations. Center Point Osage is not responsible for conducting administrative or criminal sexual abuse investigations (including resident-on-resident sexual abuse or staff sexual misconduct). Policy places accused staff on administrative leave pending the outcome of DOC's investigation. Center Point Osage conducts an administrative review as per personnel policies, and utilizes the outcome of DOC's investigation. The onsite audit interviews indicate that the staff understand that DOC will do the investigations and Center Point requests DOC follow PREA protocol for forensic medical examinations, as DOC policy prescribes. Center Point policy spells out the PREA standards for investigations, and security staff have reviewed this protocol and will assist the initial process of protecting the evidence and in referring the victim to advocacy and medical exams (SANE's/SAFE's) in a way that can be understood and utilized by the victim at no cost. Center Point has an MOU with the DVIS Sexual Assault Program and provides services, including exams, at no charge to the victim.

Standard 115.222 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.

Center Point/Osage ensures that an administrative or criminal investigation is completed for all allegations of sexual abuse and sexual harassment (including resident-on-resident sexual abuse or staff sexual misconduct). During the past 12 months, there have been no allegations of sexual abuse and sexual harassment that were received, and no investigations performed. The agency has a policy that requires that allegations of sexual abuse or sexual harassment be referred for investigation to an agency with the legal authority to conduct criminal investigations, unless the allegation does not involve potentially criminal behavior. The agency's policy regarding the referral of allegations of sexual abuse or sexual harassment for criminal investigation is published on the agency website and made publicly available. The agency documents all referrals of allegations of sexual abuse or sexual harassment for criminal investigation. The onsite audit staff interviews indicate there is an understanding that all allegations will be referred to DOC immediately for administrative and criminal investigation, even if the victim recants or changes the story. Center Point/Osage will review all information and findings. The policy is publicly available, and is also the DOC policy, which is published on the DOC website.
Section 1 (G) of the Center Point Procedure's Manuel states, "For the purposes of this standard, a qualified agency staff member, Glenda Garrison, or a qualified community-based staff member shall be an individual who has been screened for appropriateness to serve in this role and has received education concerning sexual assault and forensic examination issues in general."

Standard 115.231 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.

Center Point/Osage trains all employees (or sends them to DOC training) who may have contact with residents on the following matters: (1) Agency's zero-tolerance policy for sexual abuse and sexual harassment; (2) How to fulfill their responsibilities under agency sexual abuse and sexual harassment prevention, detection, reporting, and response policies and procedures; (3) The right of residents to be free from sexual abuse and sexual harassment; (4) The right of residents and employees to be free from retaliation for reporting sexual abuse and sexual harassment; (5) The dynamics of sexual abuse and sexual harassment in confinement; (6) The common reactions of sexual abuse and sexual harassment victims; (7) How to detect and respond to signs of threatened and actual sexual abuse; (8) How to avoid inappropriate relationships with residents; (9) How to communicate effectively and professionally with residents, including lesbian, gay, bisexual, transgender, intersex, or gender-nonconforming residents; and (10) How to comply with relevant laws related to mandatory reporting of sexual abuse to outside authorities. Training is tailored to the gender of the residents at the facility. Employees who are reassigned from facilities housing the opposite gender are given additional training. There are 13 staff currently employed by the facility, who may have contact with residents, who were trained or retrained on the PREA requirements enumerated above. Between trainings the agency provides all employees with information about current policies regarding sexual abuse and harassment every 90 days. Policies are at the Administration/Control areas at all times. The agency documents that employees understand the training they have received through employee signature or electronic verification. The auditor reviewed the PREA training logs, which are maintained at Administration.

Standard 115.232 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.

All volunteers and contractors who have contact with Center Point/Osage residents have been trained on their responsibilities under the agency's policies and procedures regarding sexual abuse/harassment prevention, detection, and response. DOC volunteer training curriculum was provided to the auditor. The number of volunteers and individual contractors who have contact with residents who have been trained in agency policies and procedures regarding sexual abuse/harassment prevention, detection, and response is 14. The level and type of training provided to volunteers and contractors is based on the services they provide and level of contact they have with residents. All volunteers and contractors who have contact with residents have been notified of the agency's zero-tolerance policy regarding sexual abuse and sexual harassment and informed how to report such incidents. The agency maintains documentation confirming that volunteers and contractors who have contact with residents understand the training they have received. The auditor reviewed the records during the onsite audit. According to interviews with the Vice President, Program Director, Operation Supervisor, and counselors, most of resident's activities are in the community, consistent with their work release status. Volunteers and contractors lead meetings, take residents to church, and assist with Tulsa Reentry and employment programs, and with other limited community activities.

Standard 115.233 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.

Center Point/Osage residents receive information at time of intake about the zero-tolerance policy, how to report incidents or suspicions of sexual abuse or harassment, their rights to be free from sexual abuse and sexual harassment and to be free from retaliation for reporting such incidents, and regarding agency policies and procedures for responding to such incidents. Resident PREA education is available in formats accessible to all residents, including those who are: Limited English proficient, Deaf, Visually impaired, Otherwise disabled, and Limited in their reading skills. The agency maintains documentation of resident participation in PREA education sessions. The agency ensures that key information about the agency's PREA policies is continuously and readily available or visible through posters, resident handbooks, or other written formats. During the onsite audit, the auditor observed the notices and posters, examined the training logs and materials, and interviewed 10 randomly selected inmates. All inmates reported multiple PREA trainings and full understanding of all questions asked of them. They know they can get help reporting and that they can be anonymous. They know they should not be retaliated against and do not believe they would be retaliated against at Center Point. Also, the staff interviews indicated that the residents have been educated about PREA and know they can report and that victims of sexual assault and harassment can get help.

Standard 115.234 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.

Center Point/Osage does not perform its own investigations, but recognizes this standard in training and policies. It reviews all information and investigations. Center Point policy was reviewed during the investigation and it includes the PREA standards for this section in reference to the agency (DOC) that is to complete investigations. Also, DOC policy includes the requirements of this section.

Standard 115.235 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.

Center Point/Osage has a policy related to medical and mental health practitioners who work regularly with its residents. Although Center Point staff meet with their residents for guidance/mentoring, case management, and planning purposes, Director Garrison states that all ongoing mental health care for residents occurs off site at Family and Child Services by qualified professionals. The MOU with DVIS indicates that trained staff from DVIS Sexual Assault Program would have access to residents; then, after DVIS services are completed, in house services, or other outside referrals would be made if continued counseling is needed. However, policy and the contract with DOC addresses DOC's responsibility for medical and mental health treatment for all offenders. Center Point's Policy and Procedures Manuel Section 1(A) states, "Per contract, all medical and mental health services are the responsibility of the Oklahoma Department of Corrections."

Standard 115.241 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.

Center Point/Osage has a policy that requires screening (within 72 hours of admission or transfer to another facility) for risk of sexual abuse victimization or sexual abusiveness toward other residents. The updated screening tool utilizing all the PREA standards has been used since March 1. 10 inmates have been screened using this objective screening risk assessment instrument so far. The other inmates currently at the facility were admitted before March and screening information was captured during the "biopsychsocial" screening, which included most of the information, but not all, in the updated screening tool. Policy requires the facility reassess each resident's risk of victimization or abusiveness within a set time period, not to exceed 30 days after the resident's arrival at the facility, based upon any additional, relevant information received by the facility since the intake screening. The policy requires that a resident's risk level be reassessed when warranted due to a referral, request, incident of sexual abuse, or receipt of additional information that bears on the resident's risk of sexual victimization or abusiveness. Policy prohibits disciplining residents for refusing to answer (or for not disclosing complete information related to) the questions regarding whether or not the resident has a mental, physical, or developmental disability; whether or not the resident is or is perceived to be gay, lesbian, bisexual, transgender, intersex, or gender non-conforming; whether or not the resident has previously experienced sexual victimization; and, the resident's own perception of vulnerability. During the audit, all inmate and staff interviews indicate these screenings are conducted and the information is used appropriately to protect inmates, but kept confidential among administrative employees to protect privacy. There is always at least one administrator on call or on duty.

Standard 115.242 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.

Information from the risk screening required by § 115.241 is used to inform housing, bed, work, education, and program assignments with the goal of keeping separate those residents at high risk of being sexually victimized from those at high risk of being sexually abusive. Individualized determinations are made about how to ensure the safety of each resident. Center Point/Osage makes housing and program assignments for transgender or intersex residents in the facility on a case-by-case basis. All staff indicate an understanding that some residents are at higher risk of sexual abuse or abusiveness than others, although anyone can be a victim. Staff indicate an ability to be respectful of cultural diversity, as well as being sensitive to the needs of LGBTI residents even though they have no current residents who identify openly as LGBTI. Counselors and staff are experienced with working with inmates who have other risk factors, such as having learning disabilities and communication difficulties. Any sensitive information obtained during the screening process is restricted to Administrative staff and counselors.

Standard 115.251 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 agency has established procedures allowing for multiple internal ways for residents to report privately to agency officials about sexual abuse or sexual harassment; retaliation by other residents or staff for reporting sexual abuse and sexual harassment; and staff neglect or violation of responsibilities that may have contributed to such incidents. The agency provides at least one way for residents to report abuse or harassment to a public or private entity or office that is not part of the agency. The agency has a policy mandating that staff accept reports of sexual abuse and sexual harassment made verbally, in writing, anonymously, and from third parties. Staff are required to document verbal reports within 24 hours. The agency has established procedures for staff to privately report sexual abuse and sexual harassment of residents verbally and in writing. Staff are informed of these procedures. All inmates interviewed know they can report and all staff interviewed say they can take reports and know how to instruct and assist inmates to make reports. They are given the following information through handouts and postings: DVIS (Domestic Violence Intervention Services, Inc. Sexual Abuse Crisis Line 918-743-5763; PREA Reporting Line: 1-855-871-4139; ODOC Office of Inspector General: 405-425-2571; Send an email to: preareport@doc.state.ok.us. Report verbally or in writing to the Center Point PREA Coordinator, Patricia Trail, at 405-501-4976.

Standard 115.252 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.

Center Point/Osage has an administrative procedure for dealing with resident grievances regarding sexual abuse. A resident is allowed to submit a grievance regarding an allegation of sexual abuse at any time, regardless of when the incident is alleged to have occurred. Residents are not required to use an informal grievance process, or otherwise to attempt to resolve with staff, an alleged incident of sexual abuse. A resident may submit a grievance alleging sexual abuse without submitting it to the staff member who is the subject of the complaint, and it will not be referred to the staff member who is the subject of the complaint. A decision on the merits of any grievance or portion of a grievance alleging sexual abuse must be made within 90 days. In the past 12 months, no grievances have been filed that alleged sexual abuse. The agency always notifies a resident in writing when the agency files for an extension, including notice of the date by which a decision will be made. Agency policy and procedure permits third parties, including fellow residents, staff members, family members, attorneys, and outside advocates, to assist residents in filing requests for administrative remedies relating to allegations of sexual abuse, and file such requests on behalf of residents. Policy requires that if a resident declines to have third-party assistance in filing a grievance alleging sexual abuse, the agency documents the resident's decision to decline. Center Point/Osage has a policy and established procedures for filing an emergency grievance alleging that a resident is subject to a substantial risk of imminent sexual abuse. Policy for emergency grievances alleging substantial risk of imminent sexual abuse requires an initial response within 48 hours. Policy for emergency grievances alleging substantial risk of imminent sexual abuse requires that a final agency decision be issued within five days. Policy limits the ability to discipline a resident for filing a grievance alleging sexual abuse to occasions where the agency demonstrates that the resident filed the grievance in bad faith. Statements made during the audit interviews are consistent with policy being followed.

Standard 115.253 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.

Center Point/Osage provides residents with access to outside victim advocates for emotional support services related to sexual abuse by having a Memorandum of Understanding (MOU) with Domestic Violence Intervention Services, Inc., and providing access to the DVIS Crisis Line. Center Point/Osage enables reasonable communication between residents and DVIS, and such organizations, in as confidential a manner as possible. The facility informs residents, prior to giving them access to outside support services, of the extent to which such communications will be monitored. Residents interviewed at Center Point/Osage indicate no problems being able to participate in such communication freely, without being monitored. The facility informs residents, prior to giving them access to outside support services, of the mandatory reporting rules governing privacy, confidentiality, and/or privilege that apply to disclosures of sexual abuse made to outside victim advocates, including any limits to confidentiality under relevant federal, state, or local law. Auditor Weir reviewed the MOU and verified it with DVIS Director Elaine Thompson. Director Thompson states services are in place, but, to her knowledge, her staff have received no information that indicate any problems or concerns regarding Center Point.

Standard 115.254 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 agency and facility provides a method to receive third-party reports of resident sexual abuse or sexual harassment. Center Point and the Oklahoma Department of Corrections publicly distribute information on how to report resident sexual abuse or sexual harassment on behalf of residents/inmates. The auditor verified that staff and inmates are instructed about third party reporting, and the information is available publicly and on the agency's website. Residents indicated they know about third party reporting and know how to do it.

Standard 115.261 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.

Center Point/Osage requires all staff to report immediately and according to agency policy any knowledge, suspicion, or information they receive regarding an incident of sexual abuse or sexual harassment that occurred in a facility, whether or not it is part of the agency. Center Point also requires all staff to report immediately any retaliation against residents or staff who reported such an incident. All staff are to report immediately and according to agency policy any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation. Apart from reporting to designated supervisors or officials and designated state or local services agencies, agency policy prohibits staff from revealing any information related to a sexual abuse report to anyone other than to the extent necessary to make treatment, investigation, and other security and management decisions. All staff interviewed indicate they will report immediately, and all inmates interviewed indicate they believe staff will report. Residents, as well as staff, state they have not observed any sexual abuse or harassment at Center Point.

Standard 115.262 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.

Policy and established procedure at Center Point/Osage requires that when the facility learns that a resident is subject to a substantial risk of imminent sexual abuse, it takes immediate action to protect the resident (i.e., it takes some action to assess and implement appropriate protective measures without unreasonable delay). In the past 12 months, there were no residents determined to be at substantial risk of imminent sexual abuse. Interviews conducted during the onsite audit indicated that both staff and residents believe Center Point staff will take appropriate and effective immediate steps to protect a resident. No interview indicated there has been a specific need for this kind of protective measure to be used at Center Point in the past 12 months.

Standard 115.263 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 auditor confirmed that the agency has a policy requiring that, upon receiving an allegation that a resident was sexually abused while confined at another facility, the head of the facility must notify the head of the facility or appropriate office of the agency or facility where sexual abuse is alleged to have occurred. During the past 12 months, the facility has not received any allegations that a resident was abused while confined at another facility. Agency policy requires the facility head to provide such notification as soon as possible, but no later than 72 hours after receiving the allegation. The facility documents that it has provided such notification within 72 hours of receiving the allegation. Facility policy requires that allegations received from other facilities and agencies are investigated in accordance with the PREA standards. Information received during the audit indicates that in the past 12 months, there have been no allegations of sexual abuse the facility received from other facilities. A log book has been designated in Administration area with the other log books to record these reports, but does not yet have any reports listed. Interviews with Ms. Trail and Ms. Garrison indicate they understand and will comply with this standard.

Standard 115.264 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 agency has a first responder policy for allegations of sexual abuse. Policy and Procedure Manuel regarding health care states: "Per a directive from the District Supervisor of the Oklahoma Department of Corrections, Center Point will respond to a report of sexual misconduct in the following manner: 1. Separate the victim and perpetrator and isolate the victim; 2. Preserve evidence and crime scene. This includes preventing access to the crime scene itself, and ensuring the victim and alleged suspect (if known), do not change clothing, shower, brush teeth, eat, drink, urinate, defecate etc.; 3. Contact the PREA Coordinator, Patricia Trail (405)501-4976; 4. Lock down the facility; 5. Contact the DOC Duty Officer; 6. Contact the DVIS Crisis Hotline and follow their direction to transport the victim to a hospital where the S.A.N.E. is currently located; 7. In case of an emergency, Center Point, Inc. staff will transport the victim to the nearest local hospital and/or call for an ambulance; 8. Remain with the victim until the DOC arrives and assumes custody; 9. In the event the suspect is known, Center Point will arrange transfer of the suspect to the host facility for holding."
Agency policy requires that if the first staff responder is not a security staff member, that responder shall be required to (1) Request that the alleged victim not take any actions that could destroy physical evidence; and/or (2) Notify security staff. Interviews indicate that all security staff, counselors, and case managers have been trained on first responder duties, and some can even recite these duties from memory, and have the steps printed on the backs of their badges as well. No staff or resident indicates there have been any known incidents of sexual abuse in the past 12 months, so first responder services have not been required.

Standard 115.265 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 facility has developed a written institutional plan, which was reviewed during the audit, to coordinate actions taken in response to an incident of sexual abuse among staff first responders, medical and mental health practitioners, investigators, and facility leadership. This is reinforced in the MOU with Domestic Violence Intervention Services (DVIS).

Standard 115.266 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.

The agency, facility, or any other governmental entity responsible for collective bargaining on the agency's behalf has not entered into or renewed any collective bargaining agreement or other agreement since August 20, 2012. This was verified during the onsite audit. The facility has the ability and authority to protect residents from contact with abusers.

Standard 115.267 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 has a policy to protect all residents and staff who report sexual abuse or sexual harassment or cooperate with sexual abuse or sexual harassment investigations from retaliation by other residents or staff. The agency designates staff member(s) with monitoring for possible retaliation. The agency monitors the conduct or treatment of residents or staff who reported sexual abuse and of residents who were reported to have suffered sexual abuse to see if there are any changes that may suggest possible retaliation by residents or staff. The agency monitors the conduct or treatment for at least 90 days. The agency acts promptly to remedy any such retaliation. The agency continues such monitoring beyond 90 days if the initial monitoring indicates a continuing need. There have been no known incidents of retaliation in the past 12 months. Center Point/Osage has designated Patricia Trail, Glenda Garrison, and Travis Cottrell with monitoring retaliation. All of these administrators have been interviewed by the PREA auditor. They demonstrated an excellent grasp of the duties of the position and displayed a strong commitment to making sure the facility is free from retaliation, and that any incidents are discovered and handled appropriately and by PREA standards and policy.

Standard 115.271 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 agency/facility has a policy related to criminal and administrative agency investigations. Substantiated allegations of conduct that appear to be criminal are referred for prosecution. Since there have been no allegations, there have been no substantiated allegations of conduct that appear to be criminal that were referred for prosecution since August 20, 2012. The agency retains all written reports pertaining to the administrative or criminal investigation of alleged sexual abuse or sexual harassment for as long as the alleged abuser is incarcerated or employed by the agency, plus five years. The audit indicates allegations will be turned over to DOC immediately for investigation by qualified investigators following industry standards in collecting evidence and in reviewing all pertinent information. When the evidence supports prosecution, DOC will not compel interviews without first consulting with prosecutors. The credibility of a victim, witness, or suspect shall be assessed on an individual basis, not being determined by the person's status as resident or staff. Polygraph examinations will not be used as a condition of proceeding with an investigation. Investigations will be fully documented. Substantiated allegations of criminal conduct will be referred for prosecution. DOC and Center Point policy also states that the departure of a victim or abuser from the control of the institution, or from employment, does not provide a basis for terminating an investigation.

Standard 115.272 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 agency imposes a standard of a preponderance of evidence or a lower standard of proof when determining whether allegations of sexual abuse or sexual harassment can be substantiated.

Standard 115.273 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.

As verified by a review of policy and during interviews conducted at the facility, Center Point, Inc., has a policy requiring that any resident who makes an allegation that he suffered sexual abuse in the facility is informed, verbally or in writing, as to whether the allegation has been determined to be substantiated, unsubstantiated, or unfounded following an investigation. There were no allegations and no criminal and/or administrative investigations of alleged resident sexual abuse that were completed in the past 12 months. If an outside entity conducts such investigations, as would happen at Center Point Osage, the agency requests the relevant information from the investigative entity in order to inform the resident of the outcome of the investigation. Following a resident's allegation that a staff member has committed sexual abuse against the resident, the facility subsequently informs the resident (unless the facility has determined that the allegation is unfounded) whenever the staff member is no longer posted within the resident's unit; the staff member is no longer employed at the facility; the agency learns that the staff member has been indicted on a charge related to sexual abuse within the facility; or the agency learns that the staff member has been convicted on a charge related to sexual abuse within the facility. Following a resident's allegation that he has been sexually abused by another resident in the facility, the agency subsequently informs the alleged victim whenever: the agency learns that the alleged abuser has been indicted on a charge related to sexual abuse within the facility; or the agency learns that the alleged abuser has been convicted on a charge related to sexual abuse within the facility. The agency has a policy that all notifications to residents described under this standard are documented.

Standard 115.276 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.

Center Point staff are subject to disciplinary sanctions up to and including termination for violating agency sexual abuse or sexual harassment policies. In the past 12 months, there have been no staff from the facility who have allegedly violated agency sexual abuse or sexual harassment policies, so the auditor had no terminations, resignations, or disciplinary actions to review. The disciplinary sanctions for violations of agency policies relating to sexual abuse or sexual harassment (other than actually engaging in sexual abuse) are commensurate with the nature and circumstances of the acts committed, the staff member's disciplinary history, and the sanctions imposed for comparable offenses by other staff with similar histories. All terminations for violations of agency sexual abuse or sexual harassment policies, or resignations by staff who would have been terminated if not for their resignation, are reported to law enforcement agencies (unless the activity was clearly not criminal) and to any relevant licensing bodies, but this has not happened in the past 12 months since there have been no reports or allegations.

Standard 115.277 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.

Center Point policy requires that any contractor or volunteer who engages in sexual abuse be reported to law enforcement agencies (unless the activity was clearly not criminal) and to relevant licensing bodies. Agency policy requires that any contractor or volunteer who engages in sexual abuse be prohibited from contact with residents. In the past 12 months, there have been no contractors or volunteers alleged to have engaged in sexual abuse or harassment of residents, so none have been reported to law enforcement agencies and relevant licensing bodies. The facility takes appropriate remedial measures and considers whether to prohibit further contact with residents in the case of any other violation of agency sexual abuse or sexual harassment policies by a contractor or volunteer. Ms. Trail states that any sexual abuse or harassment will cause a volunteer or contractor to be banned from contact with residents.

Standard 115.278 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.

Residents at Center Point/Osage are subject to disciplinary sanctions only pursuant to a formal disciplinary process following an administrative finding, or a criminal finding of guilt, that a resident engaged in resident-on-resident sexual abuse. According to the Pre Audit Questionnaire and interviews conducted at the site, there have been no such findings in the past year. The facility offers some therapy, counseling, or other interventions designed to address and correct the underlying reasons or motivations for abuse, but focuses more on getting residents employed and ready to discharge back to the community. The facility refers the offender back to DOC for consideration of whether to require the offending resident to participate in such interventions as a condition of access to programming or other benefits. The agency disciplines residents for sexual conduct with staff only upon finding that the staff member did not consent to such contact. The agency prohibits disciplinary action for a report of sexual abuse made in good faith based upon a reasonable belief that the alleged conduct occurred, even if an investigation does not establish evidence sufficient to substantiate the allegation. The agency prohibits all sexual activity between residents but deems such activity to constitute sexual abuse only if it determines that the activity is coerced.

Standard 115.282 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.

According to policy, interviews with administrative staff, and the agreement with DVIS: Resident victims of sexual abuse receive timely, unimpeded access to emergency medical treatment and crisis intervention services. The nature and scope of such services are determined by medical and mental health practitioners according to their professional judgment. Medical and mental health staff document the timeliness of emergency medical treatment and crisis intervention services that were provided; the appropriate response by non-health staff in the event health staff are not present at the time the incident is reported; and the provision of appropriate and timely information and services concerning contraception and sexually transmitted infection prophylaxis. Resident victims of sexual abuse while incarcerated are offered timely information about and timely access to emergency contraception and sexually transmitted infections prophylaxis, in accordance with professionally accepted standards of care, where medically appropriate. Treatment services are provided to every victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident.

Standard 115.283 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.

Center Point, Inc., and/or the Oklahoma Department of Corrections, according to contractual agreement, offers medical and mental health evaluation and, as appropriate, treatment to all residents who have been victimized by sexual abuse in any prison, jail, lockup, or juvenile facility. Since this is an all male facility, the requirement to offer female victims pregnancy tests does not apply. Resident victims of sexual abuse while incarcerated are offered tests for sexually transmitted infections as medically appropriate. The facility attempts to conduct a mental health evaluation of all known resident-on-resident abusers within 60 days of learning of such abuse history and offers treatment when deemed appropriate by mental health practitioners.

Standard 115.286 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 facility conducts a sexual abuse incident review at the conclusion of every criminal or administrative sexual abuse investigation, unless the allegation has been determined to be unfounded. In the past 12 months, there have been no criminal and/or administrative investigations of alleged sexual abuse completed at the facility. The facility ordinarily conducts a sexual abuse incident review within 30 days of the conclusion of the criminal or administrative sexual abuse investigation. The sexual abuse incident review team includes upper-level management officials and allows for input from line supervisors, investigators, and medical or mental health practitioners who report their findings and and any recommendations for improvement to the facility head. The facility implements the recommendations for improvement or documents its reasons for not doing so. Interviews with Ms. Trail and other administrative staff indicate all administrative staff as well as the assigned counselor(s) of the residents involved, will be on the sexual incident review team, along with others who may be appropriate according to the nature of the allegations. The team will consider whether policies or practices need to be changed; whether the incident or allegation was motivated by race, ethnicity, LGBTI status or perceived status, or gang affiliation or other group dynamics at the facility; whether physical barriers in the area where the abuse allegedly occurred might enable abuse; and whether monitoring technology should be augmented or changed.

Standard 115.287 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.

Center Point, Inc., and the Oklahoma Department of Corrections collects accurate, uniform data for every allegation of sexual abuse at facilities under its direct control using a standardized instrument and set of definitions. The standardized instrument includes, at a minimum, the data necessary to answer all questions from the most recent version of the Survey of Sexual Violence (SSV) conducted by the Department of Justice. They aggregate the incident-based sexual abuse data at least annually and maintain, review, and collect data as needed from all available incident-based documents, including reports, investigation files, and sexual abuse incident reviews. DOJ did not ask Center Point, Inc., for the previous year's data, but it is available upon request. Center Point data is available on their website: http://www.cpinc.org/index.php?option=com_content&view=article&id=37:annual-reports&catid=8:news&Itemid=149 and: http://www.cpinc.org/images/pdfs/Center%20Point%20PREA%20Annual%20Report.pdf
The DOC annual report can be found at http://www.ok.gov/doc/Organization/Inspector_General/PREA.html

Standard 115.288 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.

Center Point, Inc., and the Oklahoma Department of Corrections reviews data collected and aggregated pursuant to §115.287 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, response policies, and training, including: identifying problem areas; taking corrective action on an ongoing basis; and preparing an annual report of its findings from its data review and any corrective actions for each facility, as well as the agency as a whole. The annual report includes a comparison of the current year's data and corrective actions with those from prior years. The annual report provides an assessment of the agency's progress in addressing sexual abuse. The agency makes its annual report readily available to the public at least annually through its website, once approved by the agency head. When the agency redacts material from an annual report for publication, the redactions are limited to specific materials where publication would present a clear and specific threat to the safety and security of the facility. The agency indicates the nature of material redacted.

Standard 115.289 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.

Center Point, Inc., securely retains incident-based and aggregate data. Policy requires, and the auditor's interview with Center Point's Vice President who is in charge of the agency's Oklahoma operations, Patricia Trail, verified, that aggregated sexual abuse data from facilities under its direct control is made readily available to the public at least annually through its website and also to the Oklahoma Department of Corrections. Before making aggregated sexual abuse data publicly available, the agency removes all personal identifiers. The agency maintains sexual abuse data collected pursuant to §115.287 for at least 10 years after the date of initial collection, unless federal, state, or local law requires otherwise. This report, with no allegations or investigations listed for the past year, was reviewed by the auditor.

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 resident or staff member, except where the names of administrative personnel are specifically requested in the report template.

D. Will Weir — 06/03/2015

Auditor Signature — Date