

Prison Rape Elimination Act (PREA) Audit Report Community Confinement Facilities

Interim Final

Date of Interim Audit Report: April 15, 2021

Date of Final Audit Report: August 2, 2021

Auditor Information

Name: K. E. Arnold	Email: kenarnold220@gmail.com
Company Name: KEA Correctional Consulting LLC	
Mailing Address: P.O. Box 1872	City, State, Zip: Castle Rock, CO 80104
Telephone: 484-999-4167	Date of Facility Visit: March 1, 2, 2021

Agency Information

Name of Agency: CoreCivic			
Governing Authority or Parent Agency (If Applicable):			
Physical Address: 5501 Virginia Way Suite 110		City, State, Zip: Brentwood, Tennessee 37027	
Mailing Address: SAA		City, State, Zip: SAA	
The Agency Is:	<input type="checkbox"/> Military	<input checked="" type="checkbox"/> Private for Profit	<input type="checkbox"/> Private not for Profit
<input type="checkbox"/> Municipal	<input type="checkbox"/> County	<input type="checkbox"/> State	<input type="checkbox"/> Federal
Agency Website with PREA Information: https://www.corecivic.com/the-prison-rape-elimination-act-of-2003-prea			

Agency Chief Executive Officer

Name: Damon Hininger, President and Chief Executive Officer	
Email: Damon.Hininger@corecivic.com	Telephone: 615-263-3000

Agency-Wide PREA Coordinator

Name: Eric S. Pierson, Senior Director, PREA Compliance and Programs	
Email: eric.pierson@corecivic.com	Telephone: 615-263-6915

PREA Coordinator Reports to: S. Conry, Vice President, Operations Administration	Number of Compliance Managers who report to the PREA Coordinator: 65 (indirect)
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Facility Information

Name of Facility: Oklahoma Reentry Opportunity Center

Physical Address: 40 S. May Ave.	City, State, Zip: Oklahoma City, OK 73103
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Mailing Address (if different from above): SAA	City, State, Zip: SAA
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The Facility Is:	<input type="checkbox"/> Military	<input checked="" type="checkbox"/> Private for Profit	<input type="checkbox"/> Private not for Profit
<input type="checkbox"/> Municipal	<input type="checkbox"/> County	<input type="checkbox"/> State	<input type="checkbox"/> Federal

Facility Website with PREA Information: <https://www.corecivic.com/the-prison-rape-elimination-act-of-2003-prea>

Has the facility been accredited within the past 3 years? Yes No

If the facility has been accredited within the past 3 years, select the accrediting organization(s) – select all that apply (N/A if the facility has not been accredited within the past 3 years):

ACA
 NCCHC
 CALEA
 Other (please name or describe):
 N/A

If the facility has completed any internal or external audits other than those that resulted in accreditation, please describe:

Facility Director

Name: Christe Sweat

Email: christe.Sweat@corecivic.com	Telephone: 405-232-8233
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Facility PREA Compliance Manager

Name: P. Renee Watkins

Email: renee.Watkins@corecivic.com	Telephone: 405-232-8233
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Facility Health Service Administrator N/A

Name:

Email:	Telephone:
Facility Characteristics	
Designated Facility Capacity:	300
Current Population of Facility:	85
Average daily population for the past 12 months:	74
Has the facility been over capacity at any point in the past 12 months?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Which population(s) does the facility hold?	<input type="checkbox"/> Females <input type="checkbox"/> Males <input checked="" type="checkbox"/> Both Females and Males
Age range of population:	18-70
Average length of stay or time under supervision	3months - 2 years.
Facility security levels/resident custody levels	Minimum, Community - Halfway House
Number of residents admitted to facility during the past 12 months	141
Number of residents admitted to facility during the past 12 months whose length of stay in the facility was for 72 hours or more:	141
Number of residents admitted to facility during the past 12 months whose length of stay in the facility was for 30 days or more:	141
Does the audited facility hold residents for one or more other agencies (e.g. a State correctional agency, U.S. Marshals Service, Bureau of Prisons, U.S. Immigration and Customs Enforcement)?	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Select all other agencies for which the audited facility holds residents: Select all that apply (N/A if the audited facility does not hold residents for any other agency or agencies):	<input checked="" type="checkbox"/> Federal Bureau of Prisons <input type="checkbox"/> U.S. Marshals Service <input type="checkbox"/> U.S. Immigration and Customs Enforcement <input type="checkbox"/> Bureau of Indian Affairs <input type="checkbox"/> U.S. Military branch <input checked="" type="checkbox"/> State or Territorial correctional agency <input type="checkbox"/> County correctional or detention agency <input type="checkbox"/> Judicial district correctional or detention facility <input type="checkbox"/> City or municipal correctional or detention facility (e.g. police lockup or city jail) <input type="checkbox"/> Private corrections or detention provider <input type="checkbox"/> Other - please name or describe: <input type="checkbox"/> N/A
Number of staff currently employed by the facility who may have contact with residents:	42
Number of staff hired by the facility during the past 12 months who may have contact with residents:	5

<p>Number of contracts in the past 12 months for services with contractors who may have contact with residents:</p>	<p>0</p>
<p>Number of individual contractors who have contact with residents, currently authorized to enter the facility:</p>	<p>0</p>
<p>Number of volunteers who have contact with residents, currently authorized to enter the facility:</p>	<p>0- The auditor notes that statewide COVID-19 restrictions have resulted in the lack of volunteers at OROC. However, records reflect that 12 volunteers are currently approved by ODOC for entry into OROC.</p>

Physical Plant	
<p>Number of buildings:</p> <p>Auditors should count all buildings that are part of the facility, whether residents are formally allowed to enter them or not. In situations where temporary structures have been erected (e.g., tents) the auditor should use their discretion to determine whether to include the structure in the overall count of buildings. As a general rule, if a temporary structure is regularly or routinely used to hold or house residents, or if the temporary structure is used to house or support operational functions for more than a short period of time (e.g., an emergency situation), it should be included in the overall count of buildings.</p>	5
<p>Number of resident housing units:</p> <p>Enter 0 if the facility does not have discrete housing units. DOJ PREA Working Group FAQ on the definition of a housing unit: How is a "housing unit" defined for the purposes of the PREA Standards? The question has been raised in particular as it relates to facilities that have adjacent or interconnected units. The most common concept of a housing unit is architectural. The generally agreed-upon definition is a space that is enclosed by physical barriers accessed through one or more doors of various types, including commercial-grade swing doors, steel sliding doors, interlocking sally port doors, etc. In addition to the primary entrance and exit, additional doors are often included to meet life safety codes. The unit contains sleeping space, sanitary facilities (including toilets, lavatories, and showers), and a dayroom or leisure space in differing configurations. Many facilities are designed with modules or pods clustered around a control room. This multiple-pod design provides the facility with certain staff efficiencies and economies of scale. At the same time, the design affords the flexibility to separately house residents of differing security levels, or who are grouped by some other operational or service scheme. Generally, the control room is enclosed by security glass, and in some cases, this allows residents to see into neighboring pods. However, observation from one unit to another is usually limited by angled site lines. In some cases, the facility has prevented this entirely by installing one-way glass. Both the architectural design and functional use of these multiple pods indicate that they are managed as distinct housing units.</p>	12
Number of single resident cells, rooms, or other enclosures:	0
Number of multiple occupancy cells, rooms, or other enclosures:	9
Number of open bay/dorm housing units:	10
Does the facility have a video monitoring system, electronic surveillance system, or other monitoring technology (e.g. cameras, etc.)?	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Has the facility installed or updated a video monitoring system, electronic surveillance system, or other monitoring technology in the past 12 months?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Medical and Mental Health Services and Forensic Medical Exams	
Are medical services provided on-site?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No

Are mental health services provided on-site?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Where are sexual assault forensic medical exams provided? Select all that apply.	<input type="checkbox"/> On-site <input checked="" type="checkbox"/> Local hospital/clinic <input type="checkbox"/> Rape Crisis Center <input type="checkbox"/> Other (please name or describe: Click or tap here to enter text.)
Investigations	
Criminal Investigations	
Number of investigators employed by the agency and/or facility who are responsible for conducting CRIMINAL investigations into allegations of sexual abuse or sexual harassment:	0
When the facility received allegations of sexual abuse or sexual harassment (whether staff-on-resident or resident-on-resident), CRIMINAL INVESTIGATIONS are conducted by: Select all that apply.	<input type="checkbox"/> Facility investigators <input checked="" type="checkbox"/> Agency investigators <input checked="" type="checkbox"/> An external investigative entity
Select all external entities responsible for CRIMINAL INVESTIGATIONS : Select all that apply (N/A if no external entities are responsible for criminal investigations)	<input checked="" type="checkbox"/> Local police department <input type="checkbox"/> Local sheriff's department <input type="checkbox"/> State police <input type="checkbox"/> A U.S. Department of Justice component <input checked="" type="checkbox"/> Other (ODOC OIG) <input type="checkbox"/> N/A
Administrative Investigations	
Number of investigators employed by the agency and/or facility who are responsible for conducting ADMINISTRATIVE investigations into allegations of sexual abuse or sexual harassment?	3
When the facility receives allegations of sexual abuse or sexual harassment (whether staff-on-resident or resident-on-resident), ADMINISTRATIVE INVESTIGATIONS are conducted by: Select all that apply	<input checked="" type="checkbox"/> Facility investigators <input type="checkbox"/> Agency investigators <input type="checkbox"/> An external investigative entity
Select all external entities responsible for ADMINISTRATIVE INVESTIGATIONS : Select all that apply (N/A if no external entities are responsible for administrative investigations)	<input type="checkbox"/> Local police department <input type="checkbox"/> Local sheriff's department <input type="checkbox"/> State police <input type="checkbox"/> A U.S. Department of Justice component <input type="checkbox"/> Other (please name or describe: NA

Audit Findings

The Prison Rape Elimination Act (PREA) on-site audit of the Oklahoma Reentry Opportunity Center (OROC) in Oklahoma City, OK was conducted March 1 and 2, 2021, by K. E. Arnold from Castle Rock, CO, a United States Department of Justice Certified PREA Auditor for both juvenile and adult facilities. Pre-audit preparation included review of all materials and self reports uploaded to a secure electronic program.

As a point of reference, OROC was formerly known as Carver Transitional Center (CTC) with a mission of housing male Oklahoma Department of Corrections (ODOC) residents. The male ODOC population was removed from CTC on May 29, 2020. Prior to August 13, 2020, the facility was renamed to OROC with a mission change of housing female ODOC residents. Female ODOC residents began arriving on August 13, 2020. Prior to February 9, 2021, the OROC mission was expanded by new contract to house both male and female Federal Bureau of Prisons (FBOP) residents, in addition to the aforementioned ODOC residents. FBOP residents began arriving on February 9, 2021.

The documentation review included, but was not limited to, agency and facility policies, staff training slides, completed forms regarding both staff and resident training, Memorandums Of Understanding (MOUs), organizational chart(s), Core Civic (CC) PREA brochure (tri-fold), ODOC PREA brochure, resident education materials, photographs of PREA related materials (e.g. posters, etc.), executed Human Resource (HR) documents associated with relevant PREA standard(s), staff training certifications, and Victimization/Aggressor screenings. This review prompted several questions and informational needs that were addressed with the OROC PREA Compliance Manager (PCM). The majority of informational needs were addressed pursuant to this process.

Following conclusion of the on-site audit, the auditor spoke with the Director of Nursing at YWCA Oklahoma City. As mentioned in various locations throughout this report, YWCA Oklahoma City provides victim advocacy services to OROC residents if warranted and/or requested, pursuant to the conditions specified in the narrative for 115.21(d). When questioned as to the frequency of interaction with residents from OROC and/or staff requests regarding sexual abuse allegations on behalf of alleged OROC resident victims of sexual abuse, the interviewee responded the same equates to very infrequent. OROC is not widely known for resident sexual abuse interventions.

The auditor met with the Director, assistant director (ad), CC Senior Director PREA Compliance and Programs, PCM, case manager supervisor and operations supervisor (os) at 7:45AM on Monday, March 1, 2021. The auditor provided an overview of the audit process and advised all attendees the same would be facilitated in the least disruptive manner possible. Additionally, the auditor advised attendees of the tentative schedule(s) for the conduct of the audit. Between 8:15AM and 9:45AM, the auditor toured the entire facility with the Director, CC Senior Director PREA Compliance and Programs, and PCM.

It is noted the rated capacity of OROC is 300 residents and the institutional count on March 1, 2021 was 85 residents.

During the on-site audit, the auditor was staged in an office near the PCM's Office for document reviews and facilitation of confidential interviews with staff/residents. The auditor randomly selected (from a resident roster provided by the OROC PCM) and interviewed 17 residents on-site pursuant to the Random Resident Interview Questionnaire. At least one resident (representative of the total sample of resident interviewees) was interviewed from each living area throughout the facility. The auditor notes zero letters were received from either residents or staff prior to the conduct of the on-site audit.

None of the 17 random resident interviewees were also interviewed pursuant to specialty interviewee questionnaires. Accordingly, all 17 interviewees are counted as random resident interviewees only.

As the result of the aforementioned mission changes, the PCM asserts zero residents who allege(d) they have either been sexually abused at OROC were confined at OROC at the time of the on-site audit. Additionally, the PCM asserts zero residents with low hearing/vision/blindness or deafness/physical disabilities/mental health/cognitive concerns/ and Limited English Proficient (LEP) residents were confined at OROC during the on-site audit. Likewise, the PCM reported zero transgender/intersex residents, zero residents who reported sexual abuse during previous confinement, and zero residents who self identified as gay,/bisexual were confined at OROC during the on-site audit and accordingly, those specialty interviews could not be conducted. Of note, pursuant to staff/resident interviews and on-site observations, the auditor found no contradictory evidence with respect to potential specialty questionnaire interviewees.

It is noted the 17 random resident interviewees were generally questioned regarding their knowledge of a variety of PREA protections and their knowledge of reporting mechanisms available to residents for reporting sexual abuse and sexual harassment. Overall, random interviewees presented reasonable knowledge of PREA policies and practices. Of note, the auditor inquired as to the basis for their knowledge and several interviewees assert they had received training by OROC staff, as well as, staff at other facilities. Of note, one reporting issue pertaining to FBOP residents is noted in the narrative for 115.251.

Of note, all 17 interviewees assert they feel sexually safe at OROC.

Twelve random staff selected by the auditor from a staff roster provided by the PCM, were interviewed. The Random Sample of Staff Interview Questionnaire was administered to this sample group of interviewees. Interviewees were questioned regarding PREA training and overall knowledge of the agency's zero tolerance policy, reporting mechanisms available to residents and staff, the response protocols when a resident alleges sexual abuse, and First Responder duties.

The following specialty staff questionnaires were utilized during this review:

Agency Head
Director
CC PREA Coordinator (1), OROC PCM (1)
Designated Staff Charged with Monitoring Retaliation (1)
Incident Review Team (1)
Human Resources (1)
Investigator [one facility administrative sexual abuse investigator, one ODOC Office of the Inspector General (OIG) investigator, and one Oklahoma City Police Department (OCPD) investigator]
SAFE/SANE Staff- (1)
Intake (1)
Staff Who Perform Screening for Risk of Victimization and Abusiveness (1)
Security and Non-Security Staff Who Have Acted as First Responders (one security and one non-security)
Non-medical Staff Involved in Cross-Gender Strip or Visual Searches (1)
Volunteers (3) who have contact with residents

The auditor notes the PCM was also interviewed pursuant to the Incident Review Team questionnaire.

The Contract Administrator interview was not conducted as OROC does not employ staff in that capacity.

It is noted CC is the umbrella company for OROC.

The auditor reviewed 10 Staff Training records, 10 resident files, 10 staff HR files, seven PREA investigative files, and other records reflected throughout the following narrative prior to the audit, during the audit, and subsequent to completion of the same. The auditor randomly selected all file reviews, with the exception of investigative files.

On March 1, 2021 the auditor was processed into the facility at the facility Front Entrance/Control Center. Standard security processing was employed.

During the facility tour, the auditor noted an Ethics Liaison poster (staff private reporting mechanism) was posted in Staff Assembly Area. PREA Audit Notices were prevalent throughout the facility, inclusive of the housing units, pods, program areas, etc.

During the facility tour, the auditor observed, among other features, the facility configuration, location of cameras, staff supervision of residents, unit layout (inclusive of shower/toilet areas), placement of PREA posters and informational resources, security monitoring, and resident programming.

Throughout the tour, the auditor observed numerous PREA posters and informational documents hung on housing unit bulletin boards, in program areas, and in staff offices/gathering places. Clearly, residents have access to continual education regarding PREA processes.

The auditor noted ample camera surveillance and mirrors in all areas, inclusive of programs and operations areas. Resident and staff appears to be easily tracked throughout the facility. It is also noted cameras are positioned in key areas outside buildings and recreation areas.

The auditor observed camera monitoring, particularly focusing on camera placements and the degree of resident exposure in their cells and shower areas. Monitors provided the auditor several different views of housing unit/program/operational area cameras and he found no evidence of resident exposure in violation of PREA standards and expectations. There are no cameras in housing units and toilet/shower areas. Physical staff supervision is addressed in the narrative for 115.13.

During the tour, the auditor did note properly shielded (shower curtains) shower areas. In one ODOC Unit shower area, multiple shower heads are positioned in a single shower room. Shower curtain partitions are constructed, completely surrounding each shower head. Additionally, toilet areas are properly shielded.

Of note, there are windows in each dormitory. Staff offices likewise have windows in the door. The OROC campus consists of five buildings and has a capacity of 300 male and female (primarily female) residents, 30 residents per barracks-style dorm. There are 10 dormitories. Additionally, FBOP residents are housed in multiple occupancy rooms in modular buildings.

The auditor notes FBOP residents are housed in the two barracks style dormitories. Male residents are housed in one area while female residents are housed in another area. The two areas are separated by security fencing barriers.

A bathroom/shower area is located in each multiple occupancy room in the above areas. As with all other resident showers/toilet areas, showers and toilets are properly shielded.

The dining area/Day Room/programs room for FBOP residents was absent any PREA-related documentation. Additionally, the Emergency Grievance Box was unlocked.

During the facility tour, the auditor noted a sign on every resident room door reading, "Opposite Gender Must Announce Upon Entry". Additionally, the same notice is affixed to dormitory entrance doors.

Facility Characteristics

As previously mentioned, OROC was formerly known as CTC, a community confinement facility operated via contract with ODOC. CoreCivic acquired CTC in October, 2015 and prior to that, the facility was operated by Avalon Correctional Services. The initial PREA audit certification was received in 2015 when the facility was under Avalon Correctional Services operations.

OROC operates pursuant to contracts with ODOC and the FBOP and daily security/programmatic and PREA operations are focused on ODOC/CC policies, procedures, and practices. ODOC and supplemental CC policies are exclusively applied to ODOC residents while CC policies are applicable to FBOP residents. Reentry eligible convicted and committed ODOC/FBOP residents are housed at OROC.

Expanded reentry programming at OROC focuses heavily on the needs of residents who have transitioned to OROC since August, 2020, preparing them to move forward in their lives and work. Facilitation of change for the whole resident is the goal.

Offerings include the personalized coaching program "Go Further", which assists residents who are still incarcerated, prepare for reentry and later connect with the resources they need following release. "Go Further" helps residents obtain housing, employment, and other necessities, as well as, helping with goal setting and follow-through.

OROC's holistic approach also means offering career training and apprenticeship opportunities, as well as, assisting residents in cultivation of life skills and mental strength, essential to successful reentry. For many residents, incarceration has affected the relationships they once had with their children and other family members and as such, part of the programming is designed to help them reconnect with their loved ones, ultimately becoming better prepared to take on the responsibilities of home life.

The CC Mission Statement reads as follows.

We help government better the public good through:

Core Civic Safety - We operate safe, secure facilities that provide high quality services and effective re-entry programs that enhance public safety.

Core Civic Community - We deliver proven and innovative practices in settings that help people obtain employment, successfully reintegrate into society, and keep communities safe.

Core Civic Properties - We offer innovative and flexible real estate solutions that provide value to government and the people they serve.

Summary of Audit Findings

The summary should include the number and list of standards exceeded, number of standards met, and number and list of standards not met.

Auditor Note: *No standard should be found to be “Not Applicable” or “NA”. A compliance determination must be made for each standard.*

Standards Exceeded

Number of Standards Exceeded: 2
List of Standards Exceeded: 115.231, 115.288

Standards Met

Number of Standards Met: 39

Standards Not Met

Number of Standards Not Met: 0
List of Standards Not Met:

PREVENTION PLANNING

Standard 115.211: Zero tolerance of sexual abuse and sexual harassment; PREA coordinator

All Yes/No Questions Must Be Answered by The Auditor to Complete the Report

115.211 (a)

- Does the agency have a written policy mandating zero tolerance toward all forms of sexual abuse and sexual harassment? Yes No
- Does the written policy outline the agency's approach to preventing, detecting, and responding to sexual abuse and sexual harassment? Yes No

115.211 (b)

- Has the agency employed or designated an agency-wide PREA Coordinator? Yes No
- Is the PREA Coordinator position in the upper-level of the agency hierarchy? Yes No
- Does the PREA Coordinator have sufficient time and authority to develop, implement, and oversee agency efforts to comply with the PREA standards in all of its facilities? Yes No

Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

Pursuant to the Pre-Audit Questionnaire (PAQ), the Director self reports the agency has a written policy mandating zero tolerance toward all forms of sexual abuse and sexual harassment in facilities it operates directly or under contract. The Director further self reports the facility has a written policy outlining how it will implement the agency's approach to preventing, detecting, and responding to sexual abuse and sexual harassment. The facility also has a written policy which includes definitions of prohibited behaviors regarding sexual abuse and sexual harassment and the policy includes sanctions for those found to have participated in prohibited behaviors. Finally, the policy includes a description of agency strategies and responses to reduce and prevent sexual abuse and sexual harassment of residents.

The Zero Tolerance policy is clearly articulated in Core Civic (CC) Policy 14-2 entitled Sexual Abuse Prevention and Response, pages 1-30, and ODOC OP-030601 entitled Facility Operations Prison Rape Elimination Act, pages 2 and 5. Additionally, all other requirements articulated in this provision are likewise addressed throughout the previously referenced CC policy. The CC policy is comprehensive, incorporating both standards and implementation language.

In view of the above, the auditor finds OROC to be substantially compliant with 115.211(a).

Pursuant to the PAQ, the Director self reports the agency employs or designates an upper-level, agency-wide PREA Coordinator (CCPC) 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. The Director

reports the CCPC is in the agency's organizational structure and the auditor verified the same pursuant to review of the CC Organizational Chart.

The auditor notes the Part-time ACA Coordinator (ACA/PREA Compliance Manager) serves as the PREA Compliance Manager (PCM) at OROC and she does have sufficient time and authority to develop, implement, and oversee facility efforts to comply with the PREA standards at OROC. She is likewise included in the facility organizational chart hierarchy, directly reporting to the assistant director (ad) who reports directly to the Director. The PCM has continuous access to the facility executive staff, enabling communication relative to PREA matters.

The CCPC reports to the CC Vice President of Core Services. In turn, the Vice President of Core Services reports to the Executive Vice President and Chief Corrections Officer. The PCM's reporting status is reflected in the preceding sentence.

Pursuant to interview with the CCPC, the auditor learned he does feel he has sufficient time to manage all of his PREA related responsibilities. Each facility has a PREA Compliance Manager (PCM), numbering in excess of sixty.

As Senior Director, he oversees the Director who facilitates reviews of all PREA investigations. The Director tracks any follow-up regarding reviewed PREA investigations. The Director is now working on an enhanced PREA training program for implementation at the facilities.

The CCPC's primary focus is audit preparation. Specifically, he reviews each PAQ for sufficiency and comprehensiveness prior to forwarding the same to PREA auditors. The CC Quality Assurance Department (QA) currently facilitates mock audits of each facility. The CCPC reviews each mock audit report and coordinates corrective action with Wardens and facility PCMs. He posts common audit deficiencies on a shared website so stakeholders can assume a proactive approach, as opposed to, reactive in terms of PREA-related matters. Additionally, the CCPC coordinates all corrective action following each PREA audit.

Finally, the CCPC reviews each facility PREA Staffing Plan and signs the same. Assistance with relevant MOU development is also a primary responsibility, with approval being conferred by the CC Legal Department.

The PCM asserts she likewise feels she has sufficient time to facilitate her PREA responsibilities. She currently occupies a hybrid position wherein policy review, follow-up regarding policy compliance, and weekly facility tours ensure performance based compliance, are required. She is heavily involved with American Correctional Association (ACA) standards compliance, facilitating operations inspections on a routine basis. During such Management by Wandering Around (MBWA) inspections, she is able to assess PREA education (both staff and resident) endeavors and any unique compliance issues requiring corrective action.

She assesses operational "actual practice" against the standards during rounds, many times questioning staff regarding PREA operational issues. Subsequent to identification of an issue(s), she develops potential solutions and alerts executive staff of the same. If Chief Executive Officer (Director) approval is required, she discusses the same with her. Additionally, the PCM is actively involved in policy development which provides the latitude to address issues, if appropriate.

The PCM asserts she has been actively involved in development of PREA operations with respect to the FBOP contract.

In view of the above, the auditor finds OROC substantially compliant with 115.211.

Standard 115.212: Contracting with other entities for the confinement of residents

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.212 (a)

- If this agency is public and it contracts for the confinement of its residents with private agencies or other entities including other government agencies, has the agency included the entity's obligation to comply with the PREA standards in any new contract or contract renewal signed on or after August 20, 2012? (N/A if the agency does not contract with private agencies or other entities for the confinement of residents.) Yes No NA

115.212 (b)

- Does any new contract or contract renewal signed on or after August 20, 2012 provide for agency contract monitoring to ensure that the contractor is complying with the PREA standards? (N/A if the agency does not contract with private agencies or other entities for the confinement of residents.) Yes No NA

115.212 (c)

- If the agency has entered into a contract with an entity that fails to comply with the PREA standards, did the agency do so only in emergency circumstances after making all reasonable attempts to find a PREA compliant private agency or other entity to confine residents? (N/A if the agency has not entered into a contract with an entity that fails to comply with the PREA standards.) Yes No NA
- In such a case, does the agency document its unsuccessful attempts to find an entity in compliance with the standards? (N/A if the agency has not entered into a contract with an entity that fails to comply with the PREA standards.) Yes No NA

Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

Pursuant to the PAQ, the Director self reports CC and OROC do not contract with other facilities or companies to house residents designated for confinement at OROC. The auditor's research and informal interview with the CCPC and Director validate the same.

Given the lack of evidence substantiating non-compliance with 115.212, the auditor finds OROC substantially compliant with the same.

Standard 115.213: Supervision and monitoring

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.213 (a)

- Does the facility have a documented staffing plan that provides for adequate levels of staffing and, where applicable, video monitoring, to protect residents against sexual abuse?
- Yes No In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: The physical layout of each facility?
 Yes No

- In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: The composition of the resident population? X Yes No
- In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: The prevalence of substantiated and unsubstantiated incidents of sexual abuse? X Yes No
- In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: Any other relevant factors? X Yes No

115.213 (b)

- In circumstances where the staffing plan is not complied with, does the facility document and justify all deviations from the plan? (N/A if no deviations from staffing plan.)
X Yes No NA

115.213 (c)

- In the past 12 months, has the facility assessed, determined, and documented whether adjustments are needed to the staffing plan established pursuant to paragraph (a) of this section? X Yes No
- In the past 12 months, has the facility assessed, determined, and documented whether adjustments are needed to prevailing staffing patterns? X Yes No
- In the past 12 months, has the facility assessed, determined, and documented whether adjustments are needed to the facility's deployment of video monitoring systems and other monitoring technologies? X Yes No
- In the past 12 months, has the facility assessed, determined, and documented whether adjustments are needed to the resources the facility has available to commit to ensure adequate staffing levels? X Yes No

Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- X **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

Pursuant to the PAQ, the Director self reports the agency develops and documents a staffing plan that provides for adequate levels of staffing, and where applicable, video monitoring to protect residents against sexual abuse. The Director self reports the average daily number of residents since the last PREA audit is 65 and the average daily number of residents on which the staffing plan is predicated is 65.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response in Community Corrections, page 7, section D(1)(a-d) addresses 115.213(a). Additionally, CC APS 030601 entitled Oklahoma Prison Rape Elimination Act, page 4, section entitled Staffing D(1 and 2) addresses 115.213(a).

The auditor's review of Annual PREA Staffing Plans dated December 5, 2018, December 19, 2019, and June 8, 2020 reveals substantial compliance with 115.213(a). All requisite 115.213(a) and (c) criteria were reviewed by proper authorities.

Pursuant to the Director, the facility does have a staffing plan. Adequate staffing levels and video monitoring to protect residents against sexual abuse are considered in the plan. Five monitors plus one supervisor are assigned to the 1st Shift, four monitors plus one supervisor are assigned to 2nd Shift, and three monitors plus one supervisor are assigned to 3rd Shift. At least one staff member is assigned to the security office at all times. The staffing plan is documented and maintained electronically in the Director's Office, ad, PCM, operations supervisor (os), and human resources (hr) offices.

When assessing adequate staffing levels and the need for video monitoring, the staffing plan considers the following:

a. Mirrors have been installed in the D Unit housing units to assist with surveillance. Blind spots factor heavily into the staffing plan. The Director asserts the size of the population and facility design factors are considerations. The CC Managing Director periodically visits the facility, assessing staffing and electronic needs based on contract and population. The PCM can recommend to the Director additional positions/electronics based on observations and the Director makes such recommendations to the Managing Director, if appropriate. As OROC is a large facility with a rated capacity of 300 residents, population trends are tracked weekly to determine increased staffing needs, especially with the new contract.

b. While Security Threat Group (STG) members may be housed at OROC, no PREA concerns are noted. Generally, residents are focused on the emerging program offerings and re-entry into society. Resident mental health issues are a minimal concern at OROC. There are no concerns with the LGBTI population.

The Director notes that the FBOP contract requires one male and one female staff on site at all times.

c. The Director asserts since the mission change to female residents in late 2020, there has been no sexual abuse/harassment allegations. There were some allegations during the last year when the facility was designated as a male facility. Both male and female FBOP residents are housed at the facility pursuant to the new contract.

While substantiated and unsubstantiated incidents of sexual abuse are considered in terms of staffing plan development, frequency of the same is minimal. Close attention is devoted to recommendations subsequent to incident reviews to determine strategies to enhance resident sexual safety at OROC.

d. The Director and the PCM assert the gender specific PREA training provided to staff is invaluable.

In regard to daily checks for compliance with the staffing plan, shift supervisors are the primary monitors, ensuring compliance with the PREA staffing plan, as well as, each individual contract. The os also reviews daily compliance with the staffing plan, reporting discrepancies to the Director.

An established protocol is used to fill vacancies. During non-regular business hours, the administrative duty officer (ado) effects staffing decisions to ensure no vacant security posts. The os and ado monitor shift staffing.

The ado, inclusive of the Director as noted to have recently occurred, may fill in and overtime may be utilized to cover vacancy(ies), dependent upon the circumstances. OROC is always compliant with the contract and staffing plan.

The auditor notes the PCM's assertions regarding the same subject-matter parallel those of the Director. Accordingly, her statement regarding staffing plan considerations is reflected in the preceding paragraph(s).

Pursuant to the PAQ, the Director self reports in circumstances where the staffing plan is not complied with, the facility documents and justifies all deviations from the plan. According to the Director's self report in the PAQ, there were no instances of deviation from the staffing plan during the last year.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response in Community Corrections, page 7, section D(5) addresses 115.213(b). CC APS 303601 entitled Oklahoma Prison Rape and Elimination Act, page 4, section entitled Staffing, D(3) also addresses 115.213(b).

The Director asserts all instances of non-compliance with the PREA Staffing Plan would be documented. Specifically, the deviation would be documented in a 5-1 packet as a reportable incident and forwarded to the CCPC, among other executives, within seven days of occurrence.

The Director self reports there were no instances of deviation from the staffing plan during the last 12 months. The auditor's observation of staffing during the facility tour and during non-regular business hours reveals substantial compliance with 115.213. Staffing, as described in the narrative for 115.213(a), was found to be implemented and sufficient.

The auditor did note camera surveillance, in addition to the aforementioned mirrors, is sufficient to augment staffing, thereby serving to facilitate resident sexual safety. Camera placements are addressed in the first few pages of this report.

Pursuant to the PAQ, the Director self reports at least once every year, the facility reviews the staffing plan to see whether adjustments are needed to:

The staffing plan;
Prevailing staffing patterns;
The deployment of video monitoring systems and other monitoring technologies; and
The allocation of facility/agency resources to commit to the staffing plan to ensure compliance with the same.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response in Community Corrections, page 7, section D(2) addresses 115.213(c). CC APS 030601 entitled Oklahoma Prison Rape Elimination Act, pages 4 and 5, section D(5)(a and b) also addresses 115.213(c).

According to the OROC PCM, the facility staffing plan is reviewed at least once each year. While she is new in the position, she will be reviewing and signing the staffing plan going forward.

The auditor notes, as reflected in the narrative for 115.213(a), all requisite reviewing authorities and signatures are present in each staffing plan, inclusive of past PCMs.

In view of the above, the auditor finds OROC substantially compliant with 115.213.

Standard 115.215: Limits to cross-gender viewing and searches

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.215 (a)

- Does the facility always refrain from conducting any cross-gender strip or cross-gender visual body cavity searches, except in exigent circumstances or by medical practitioners?
X Yes No

115.215 (b)

- Does the facility always refrain from conducting cross-gender pat-down searches of female residents, except in exigent circumstances? (N/A if the facility does not have female residents.)
X Yes No NA

- Does the facility always refrain from restricting female residents' access to regularly available programming or other outside opportunities in order to comply with this provision? (N/A if the facility does not have female residents.) X Yes No NA

115.215 (c)

- Does the facility document all cross-gender strip searches and cross-gender visual body cavity searches? X Yes No
- Does the facility document all cross-gender pat-down searches of female residents? (N/A if the facility does not have female residents). X Yes No NA

115.215 (d)

- Does the facility have policies that enable residents to shower, perform bodily functions, and change clothing without nonmedical staff of the opposite gender viewing their breasts, buttocks, or genitalia, except in exigent circumstances or when such viewing is incidental to routine cell checks? X Yes No
- Does the facility have procedures that enables residents to shower, perform bodily functions, and change clothing without nonmedical staff of the opposite gender viewing their breasts, buttocks, or genitalia, except in exigent circumstances or when such viewing is incidental to routine cell checks? X Yes No
- Does the facility require staff of the opposite gender to announce their presence when entering an area where residents are likely to be showering, performing bodily functions, or changing clothing? X Yes No

115.215 (e)

- Does the facility always refrain from searching or physically examining transgender or intersex residents for the sole purpose of determining the resident's genital status? X Yes No
- If a resident's genital status is unknown, does the facility determine genital status during conversations with the resident, by reviewing medical records, or, if necessary, by learning that information as part of a broader medical examination conducted in private by a medical practitioner? X Yes No

115.215 (f)

- Does the facility/agency train security staff in how to conduct cross-gender pat down searches in a professional and respectful manner, and in the least intrusive manner possible, consistent with security needs? X Yes No
- Does the facility/agency train security staff in how to conduct searches of transgender and intersex residents in a professional and respectful manner, and in the least intrusive manner possible, consistent with security needs? X Yes No

Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- X **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)

□ **Does Not Meet Standard** (*Requires Corrective Action*)

Pursuant to the PAQ, the Director self reports cross-gender strip searches or cross-gender visual body cavity searches of the anal or genital opening are not conducted at OROC. However, as reflected in the policy narrative cited below, the same can be conducted in exigent circumstances. The Director further self reports zero strip or cross-gender visual body cavity searches of residents were conducted at OROC during the last 12 months.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 12, section J(3) addresses 115.215(a). Such searches can be completed in exigent circumstances. Exigent circumstances are defined in this policy provision, as well as, the specifics of provision requirements. CC Policy 9-5 entitled Searches of Inmates/Residents and Various Locations, page 3, section C(5) addresses 115.215(a). As previously mentioned, OROC is a private contract facility engaged in a business relationship with ODOC. Accordingly, compliance with ODOC policy, as well as CC policy, is requisite to the agreement.

In addition to the above, ODOC OP-040110 entitled Search and Seizure Standards, pages 7 and 8. section III(A)(1)(a) addresses 115.215(a).

The non-medical staff (who may be involved in cross-gender strip or visual searches) interviewee asserts when a transgender male requests search by male staff, the same is allowable. Likewise, a transgender female FBOP resident may be subject to search by a female staff member, if requested. Additionally, if staff observe secreting of narcotics in a body cavity, the same exigent circumstance warrants a cross-gender strip search of the resident.

The auditor has found no evidence of cross-gender strip or visual searches conducted by non-medical staff, at OROC during the last 12 months.

Pursuant to the PAQ, the Director self reports the facility does not permit cross-gender pat-down searches of female residents, absent exigent circumstances. The Director further self reports the facility does not restrict female resident's access to regularly available programming or other outside opportunities in order to comply with this provision. In the last 12 months, zero female resident pat-down searches were conducted by male staff.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 12, section I(J)(1), (2), (5), and (6) addresses 115.215(a). Exigent circumstances are defined in this policy provision, as well as, the specifics of provision requirements.

In addition to the above, ODOC OP-040110 entitled Search and Seizure Standards, pages 7 and 8. section III(A)(1)(a) addresses 115.215(b).

All 12 random staff interviewees assert the facility does not restrict resident access to outside programming or outside opportunities in the event female staff are not available to facilitate pat-down searches of female residents. Many interviewees assert female staff are always on shift.

All 15 female random resident interviewees assert the facility does not restrict resident access to outside programming or outside opportunities in the event female staff are not available to facilitate pat-down searches of female residents. Many interviewees assert female staff are always on shift.

The auditor has not discovered any incident wherein such programming or opportunities were canceled based on the circumstances cited in the provision.

Pursuant to the PAQ, the Director self reports facility policy requires all cross-gender strip searches and cross-gender visual body cavity searches are documented. The Director further self reports facility policy also requires that all cross-gender pat-down searches of female residents are documented.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, pages 12 and 13, section I(J)(5) addresses 115.215(c). Exigent circumstances are defined in this policy provision, as well as, the specifics of provision requirements. In addition to the above, ODOC OP-040110 entitled Search and Seizure Standards, page 8. section III(A)(1)(d) addresses 115.215(c).

The auditor finds no evidence of the conduct of cross-gender strip searches/visual body cavity searches/ or cross-gender pat searches of female residents at OROC during the audit period.

Pursuant to the PAQ, the Director self reports 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 (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.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 13, section I(J)(7)(a-e) addresses 115.215(d). ODOC OP-030601 entitled Facility Operations Prison Rape Elimination Act, page 6, section C(1-5) also addresses 115.215(d).

All 17 random resident interviewees assert male and female staff announce their presence, by gender, when entering opposite gender housing areas, when entering a resident room, or a resident bathroom. All interviewees also assert they are never naked or in full view of female staff (not including medical staff such as doctors, nurses) when toileting, showering, or changing clothing.

All 12 random staff interviewees assert male and female staff announce their presence, by gender, when entering cross-gender housing and shower/toilet areas. Similarly, all interviewees self report residents are able to dress, shower, and toilet without being viewed by staff of the opposite gender.

During the facility tour, the auditor noted a sign on every resident room door reading, "Opposite Gender Must Announce Upon Entry". Additionally, the same notice is affixed to dormitory entrance doors. The auditor noted no instances either during the facility tour or throughout the duration of the audit wherein male or female staff failed to announce their presence (by gender) whenever they entered a housing area where opposite gender residents were housed.

Pursuant to the PAQ, the Director self reports 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. According to the Director, no such searches were facilitated during the last 12 months.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 13, section I(J)(10)(a) addresses 115.215(e). ODOC OP-040110 entitled Search and Seizure Standards, page 8. section III(A)(1)(c) also addresses 115.215(e).

All 12 random staff interviewees assert the facility prohibits staff from searching or physically examining a transgender or intersex resident for the sole purpose of determining the resident's genital status and that they are aware of the relevant policy.

The PCM advises zero transgender/intersex residents were housed at OROC at the time of the on-site audit. Accordingly, such interview(s) were not facilitated.

Pursuant to the PAQ, the Director self reports 100% of all security staff have received training on conducting cross-gender pat-down searches and searches of transgender/intersex residents in a professional and respectful manner, consistent with security needs.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 5, section C(4) and page 14, section I(J)(10)(g) addresses 115.215(f). ODOC OP-040110 entitled Search and Seizure Standards, page 8. section III(A)(1)(b) also addresses 115.215(f).

The auditor's review of the training module regarding the conduct of cross-gender pat down searches and searches of transgender/intersex residents in a professional and respectful manner (module entitled "Searches") reveals substantial compliance with 115.215(f). Cross-gender pat-down searches and searches of transgender/intersex residents in a professional and respectful manner training is facilitated in the PREA Overview session during Pre-Service and annual In-Service training.

The auditor also reviewed a Power Point Presentation entitled Supervising Female Residents PREA: What You Need to Know and finds the same to be commensurate with 115.215(f).

In addition to the above, the auditor's review of a Training Searches document dated February 2, 2021 reveals 39 staff completed the on-line Searches class. The auditor's review of another Orientation form bearing the same date reveals requisite training was provided to one employee completing Orientation training.

The auditor's review of three Training/Activity Attendance Rosters (bearing the date, participant's printed name, and signature) dated April 30, 2020, August 7, 2020, and October 5, 2020 reveals five staff completed requisite training during Orientation. A Transcript Status Roster reveals 34 OROC staff completed the PREA Overview course during 2019.

Clearly, requisite training is provided during both pre-service and in-service training.

The auditor's on-site review of 10 random staff training files reveals requisite training was provided in two cases (Pre-Service) and all applicable cases (eight annual In-Service). At least two years of requisite In-Service training were reviewed with respect to applicable cases.

All 12 random staff interviewees assert the agency does train staff how to conduct cross-gender pat down searches of female residents and professional and respectful searches of transgender/intersex residents. All interviewees also self report they received the requisite training either during Pre-Service, In-Service training, or both. The training is provided in a video/power point/discussion format and in some cases, a demonstration however, COVID 19 restrictions have inhibited demonstration training during 2020.

In view of the above, the auditor finds OROC substantially compliant with 115.215.

Standard 115.216: Residents with disabilities and residents who are limited English proficient

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.216 (a)

- Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Residents who are deaf or hard of hearing? Yes No
- Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Residents who are blind or have low vision? Yes No
- Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Residents who have intellectual disabilities? Yes No
- Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect,

and respond to sexual abuse and sexual harassment, including: Residents who have psychiatric disabilities? Yes No

- Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Residents who have speech disabilities? Yes No
- Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Other? (if "other," please explain in overall determination notes.) Yes No
- Do such steps include, when necessary, ensuring effective communication with residents who are deaf or hard of hearing? Yes No
- Do such steps include, when necessary, providing access to interpreters who can interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary? Yes No
- Does the agency ensure that written materials are provided in formats or through methods that ensure effective communication with residents with disabilities including residents who: Have intellectual disabilities? Yes No
- Does the agency ensure that written materials are provided in formats or through methods that ensure effective communication with residents with disabilities including residents who: Have limited reading skills? Yes No
- Does the agency ensure that written materials are provided in formats or through methods that ensure effective communication with residents with disabilities including residents who: Are blind or have low vision? Yes No

115.216 (b)

- Does the agency take reasonable steps to ensure meaningful access to all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment to residents who are limited English proficient? Yes No
- Do these steps include providing interpreters who can interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary? Yes No

115.216 (c)

- Does the agency always refrain from relying on resident interpreters, resident readers, or other types of resident assistants except in limited circumstances where an extended delay in obtaining an effective interpreter could compromise the resident's safety, the performance of first-response duties under §115.264, or the investigation of the resident's allegations? Yes No

Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

Does Not Meet Standard (*Requires Corrective Action*)

Pursuant to the PAQ, the Director asserts the agency 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/harassment.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 11, section H(6)(a) and (b) addresses 115.216(a). ODOC OP-030601 entitled Oklahoma Prison Rape Elimination Act, page 14, section VI also addresses 115.216(a-c). Of note, the above ODOC citation clearly stipulates if literacy problems, intellectual disabilities/disabilities (visual/ hearing impairments) exist, the resident will be assisted in understanding the material. All resident education will be provided by staff. Approved community or facility volunteers may also be utilized.

The PCM asserts staff read materials to residents with low vision or those who are blind, if needed. Similarly, staff explain materials to those resident(s) who are blind or low vision. A TTY phone is available for resident use at OROC.

The PCM further asserts there are no additional contracts, other than LanguageLine, relative to communication services for disabled residents within the meaning of 115.216(a). Staff are advised to read or interpret meaning to ensure the resident is able to comprehend the materials required. Senior staff are advised to ensure understanding. Residents with disabilities may be received, at times, if they are able to complete work release employment.

Generally speaking, the Director advises that residents must be able to complete program requirements regarding work and other programming. Accordingly, it is unlikely that residents who are acutely cognitively impaired or physically disabled would be housed at OROC. As reflected in the narrative for 115.216(b) below, there are provisions to assist residents who are Limited English Proficient (LEP).

According to the Agency Head interviewee, the agency has established procedures to provide residents with disabilities and residents who are LEP 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. Specifically, LanguageLine is used, when necessary, to communicate with LEP residents. Generally speaking, staff translators can also be used. TTY units are available in every facility and Braille is available in some facilities.

According to the PCM, zero residents with disabilities [within the definition of 115.216(a)] or who are LEP were housed at OROC during the on-site audit. The auditor's observations during the facility tour and interview process validated the PCM's assertion. Accordingly, such interviews could not be facilitated.

Throughout the facility tour, the auditor notes relevant standards-related information is posted at eyesight levels conducive with reading for any residents confined to wheelchairs, etc. Relevant information is available on posters, brochures or tri-folds, and placards posted on walls or bulletin boards. Such information appears to be written in formats conducive with resident comprehension.

Pursuant to the PAQ, the Director self reports 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.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 11, section H(7) addresses 115.216(a). ODOC OP-030601 entitled Oklahoma Prison Rape Elimination Act, page 14, section VI also addresses 115.216(b).

The auditor's review of the LanguageLine Solutions contract and instructions reveals substantial compliance with 115.216(b). Finally, the auditor's review of the PREA: Prevent, Detect, Respond brochure reveals the same is presented in both English and Spanish.

Pursuant to the PAQ, the Director self reports 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, or the investigation of the resident's allegations. The Director further self reports the facility does not document the limited circumstances in individual cases where resident interpreters, readers, or other types of resident assistants are used as such scenarios are disallowed pursuant to company practice. Upon further inquiry, the auditor learned such incidents would be documented if facilitated in accordance with the parameters of 115.216(c). Finally, in the last 12 months, there were no instances wherein resident interpreters, readers, or other types of resident assistants have been used and it was not the case that an extended delay in obtaining another interpreter could compromise the resident's safety, the performance of first response duties, or the investigation of the resident's allegations.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 11, section H(8) addresses 115.216(a). ODOC OP-030601 entitled Oklahoma Prison Rape Elimination Act, page 14, section VI also addresses 115.216(c).

Ten of 12 random staff interviewees were aware of at least one condition under which a resident translator, interpreter, reader, or assistant can be used to assist with translation in the event a disabled or LEP resident attempts to report sexual abuse. The auditor notes interviewees quickly identified the condition(s) following dissection of a scenario. All 12 interviewees self report no such instances of using translators pursuant to the circumstances articulated in 115.216(c) have presented during the last 12 months.

Of note, one interviewee asserts the use of resident translators, etc. pursuant to 115.216(c) is disallowed at OROC.

In view of the above, the auditor finds OROC substantially compliant with 115.216.

Standard 115.217: Hiring and promotion decisions

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.217 (a)

- Does the agency prohibit the hiring or promotion of anyone who may have contact with residents who: Has engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility, or other institution (as defined in 42 U.S.C. 1997)? X Yes No
- Does the agency prohibit the hiring or promotion of anyone who may have contact with residents who: Has been convicted of engaging or attempting to engage in sexual activity in the community facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse? X Yes No
- Does the agency prohibit the hiring or promotion of anyone who may have contact with residents who: Has been civilly or administratively adjudicated to have engaged in the activity described in the question immediately above? X Yes No
- Does the agency prohibit the enlistment of services of any contractor who may have contact with residents who: Has engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility, or other institution (as defined in 42 U.S.C. 1997)? X Yes No

- Does the agency prohibit the enlistment of services of any contractor who may have contact with residents who: Has been convicted of engaging or attempting to engage in sexual activity in the community facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse? X Yes No
- Does the agency prohibit the enlistment of services of any contractor who may have contact with residents who: Has been civilly or administratively adjudicated to have engaged in the activity described in the question immediately above? X Yes No

115.217 (b)

- Does the agency consider any incidents of sexual harassment in determining whether to hire or promote anyone who may have contact with residents? X Yes No
- Does the agency consider any incidents of sexual harassment in determining whether to enlist the services of any contractor, who may have contact with residents? X Yes No

115.217 (c)

- Before hiring new employees who may have contact with residents, does the agency: Perform a criminal background records check? X Yes No
- Before hiring new employees who may have contact with residents, does the agency, consistent with Federal State, and local law: Make its best efforts to contact all prior institutional employers for information on substantiated allegations of sexual abuse or any resignation during a pending investigation of an allegation of sexual abuse? X Yes No

115.217 (d)

- Does the agency perform a criminal background records check before enlisting the services of any contractor who may have contact with residents? X Yes No

115.217 (e)

- Does the agency either conduct criminal background records checks at least every five years of current employees and contractors who may have contact with residents or have in place a system for otherwise capturing such information for current employees? X Yes No

115.217 (f)

- Does the agency ask all applicants and employees who may have contact with residents directly about previous misconduct described in paragraph (a) of this section in written applications or interviews for hiring or promotions? X Yes No
- Does the agency ask all applicants and employees who may have contact with residents directly about previous misconduct described in paragraph (a) of this section in any interviews or written self-evaluations conducted as part of reviews of current employees? X Yes No
- Does the agency impose upon employees a continuing affirmative duty to disclose any such misconduct? X Yes No

115.217 (g)

- Does the agency consider material omissions regarding such misconduct, or the provision of materially false information, grounds for termination? X Yes No

115.217 (h)

- Does the agency provide information on substantiated allegations of sexual abuse or sexual harassment involving a former employee upon receiving a request from an institutional employer for whom such employee has applied to work? (N/A if providing information on substantiated allegations of sexual abuse or sexual harassment involving a former employee is prohibited by law.) Yes No NA

Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

Pursuant to the PAQ, the Director self reports agency 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 the activity described in the above paragraph.

Of note, the Director self reports zero contractors provide services at OROC.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 4, section B(1)(a-c) addresses 115.217(a). ODOC OP-110235 entitled Hiring and Promotional Procedures, page 29, section XI(C)(1-3) and CC APS OP-030601 entitled Oklahoma PREA, page 2, section III(B)(1)(a-c) also address 115.217(a) in totality.

The auditor's review of a completed 14-2H CC document relative to one staff member applicant reveals applicant certification of the absence of the three 115.217(a) issues, as well as, sexual harassment 115.217(b) from her history. Additionally, one document issued by ODOC validates the applicant is appropriate for hire following review of a fingerprint check.

It is noted the auditor's on-site random review of three Human Resources (HR) files regarding staff promoted during the last 18 months reveals they completed the 14-2H CC in a timely manner and prior to the promotion date. Additionally, criminal background record checks reveal non-existence of 115.217(a) and (b) issues with respect to the promotions.

The auditor's on-site random review of four HR files for staff hired at OROC during the last 18 months reveals the requisite 14-2H CC form [captures the three questions plus the 115.217(b) question] was completed by the applicants either prior to the date of hire or on the date of hire. Two additional random staff file reviews pertained to employees who were hired outside the last 18 month time frame and they completed requisite documents for at least two years.

Finally, the auditor's review of four additional random staff HR files relative to staff who were hired either during the last audit period or prior to the same reveals the 14-2H CC has been completed for at least two years. Accordingly, the same is consistent with CC policy.

The auditor notes timely criminal record background record checks also substantiate the lack of 115.217(a) issues in the staff member's history. Additionally, pursuant to inquiry with prior institutional employers, one random file reveals non-existence of both 115.217(a) and (b) findings.

The auditor finds compliance with 115.217(a) and (b) is demonstrated.

Pursuant to the PAQ, the Director self reports 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.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 4, section B(2) addresses 115.217(b). ODOC OP-110235 entitled Hiring and Promotional Procedures, page 15, section 4(f); ODOC OP-110210 entitled Background Investigations, page 2, section II(A)(3); and CC APS OP-030601 entitled Oklahoma PREA, page 2, section III(B) also address 115.217(b) in totality.

As articulated in the narrative for 115.217(a), the Form 14-2H CC contains a separate question as to whether a substantiated allegation of sexual harassment has been made against the individual. Additionally, the Form 3-20-2B entitled PREA Questionnaire for Prior Institutional Employers reflects the same question. Previous institutional employers are requested to complete the same however, there is no obligation. There is an expectation of response regarding PREA issues.

As criminal background record checks do not address sexual harassment, the latter form is the only document available to validate the 14-2H CC.

The auditor's review of one Form 3-20-2B reveals OROC is substantially compliant with 115.217(b).

The HR interviewee asserts the facility does consider prior incidents of sexual harassment when determining whether to hire or to promote anyone, or to enlist the services of any contractor, who may have contact with residents. New hires/promotion applicants complete the 14-2H CC. The interviewee also notes that the sexual harassment question is noted on the employment application, as well as, the internal promotion application (Note: the auditor validated the same pursuant to review of both applications). They complete the document at pre-hire and again following hire.

Prior Institutional Employer Checks validate any incidence of sexual harassment when the receiving party completes the mailed form. The sexual harassment question is reflected on the same.

ODOC staff complete criminal background record checks and sexual harassment might not be part of their check. The interviewee also notes ODOC approves all new hires.

Pursuant to the PAQ, the Director self reports agency policy requires 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. The Director further self reports 42 applicants were hired during the last 12 months who may have contact with residents and zero have had criminal background record checks. Pursuant to follow-up, the auditor learned that seven applicable staff have been hired within the last 12 months and criminal background record checks were completed in each case prior to the entry on duty date. The auditor validated the same pursuant to review of a spread sheet.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 5, section B(7) addresses 115.217(c). ODOC OP-110210 entitled Background Investigations, page 9, section G(f); and CC APS OP-030601 entitled Oklahoma PREA, page 3, section B(III)(a)(i-iii) also address 115.217(c) in totality.

As reflected in the narrative for 115.217(c), the auditor reviewed four random staff HR files and determined that timely criminal background record checks were completed in three cases (completed prior to the date of hire). However, with respect to the remaining criminal background record check (completed approximately 1

and 1/2 months following the entry on duty date), ODOC had assumed full control of the process at the time the investigation was completed. In view of the above, the auditor finds no deviation from this provision of 115.217(c).

During the on-site audit, the auditor reviewed one random HR file wherein the applicant listed prior correctional experience. Pursuant to the auditor's review of the application, the applicant listed two prior institutional employers however, the 3-20-2B Form was forwarded to only one of the institutional employers. Clearly, one 3-20-B form was properly completed as reflected above while one form was not submitted as reflected in the latter scenario. The auditor does not find the latter incident indicative of program failure and accordingly, there is no finding. The auditor did, however, admonish the interviewee that both standard and CC policy require the 3-20-B form is forwarded to all prior institutional employers.

The HR interviewee asserts the facility performs criminal background record checks or considers pertinent civil or administrative adjudications for all newly hired employees who may have contact with residents. The practice, as described by the HR interviewee, is clearly articulated in the narrative for 115.217(a).

A criminal background record check is not completed when current employees apply for promotion. The initial and 5-year criminal background record checks are considered in the promotion selection decision. Additionally, an internal vetting system is utilized to address any 115.217 questions or issues. Finally, all current employees complete a 14-2H CC form on an annual basis.

As previously mentioned, zero contractors are used at OROC however, criminal background record checks would be conducted regarding each contractor prior to selection, ensuring non-existence of 115.217(a) and (b) issues.

Pursuant to the PAQ, the Director self reports agency policy requires a criminal background record check is completed before enlisting the services of any contractor who may have contact with residents. The Director further self reports there were zero contracts for services where a criminal background record check was conducted during the last 12 months. As previously indicated in the narrative for 115.217, there are no contractors at OROC.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 5, section B(7) addresses 115.217(d). ODOC OP-110210 entitled Background Investigations, page 2, section II(A)(3) and CC APS OP-030601 entitled Oklahoma PREA, page 3, section III(B)(3)(b) also address 115.217(d) in totality.

Pursuant to the PAQ, the Director self reports agency policy requires that either criminal background record checks are conducted at least every five years for current employees and contractors who may have contact with residents or a system is in place for otherwise capturing such information for current employees.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 5, section B(7) addresses 115.217(e). ODOC OP-110210 entitled Background Investigations, page 4, section II(B)(7) and CC APS OP-030601 entitled Oklahoma PREA, page 3, section III(B)(3)(c) also address 115.217(e) in totality.

The auditor's review of a spreadsheet utilized by HR staff reveals the same captures the five-year re-investigation updates.

The HR interviewee asserts CC tracks 5-year re-investigation needs. Generally, the same is tracked via spread sheet and the HR interviewee reviews the same three times per month to ensure re-investigation dates are not missed.

Five-year criminal background record re-investigations are triggered when the HR interviewee forwards the Background Authorization and fingerprint card to ODOC.

The auditor's on-site review of four random staff five-year re-investigations reveals substantial compliance with 115.217(e).

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 4, sections B(4) and (5) addresses 115.217(f). CC APS OP-030601 entitled Oklahoma PREA, page 2, section III(B)(2)(a-c) also addresses 115.217(f) in totality.

The auditor is aware, as reflected in previous paragraphs, that the equivalent of the Form 14-2H CC is completed annually by all staff as required by the above policy. Additionally, the document is completed as a staff applicant and prior to hire. Finally, the same is completed by staff who are promoted.

According to the HR interviewee, the facility asks all applicants and employees who may have contact with residents about previous misconduct described in 115.217(a) as an applicant (asked in the application and separate from the application), at the interview, and following hire. Additionally, staff are asked the same questions on an annual basis and during the promotion phase. The 14-2H CC is completed annually as of calendar year 2018, to encompass the performance evaluation process and affirmative duty to report. Of note, the affirmative duty to report caveat is also reflected on the 14-2H CC.

The auditor finds the intent of the standard has been accomplished in this regard.

Pursuant to the PAQ, the Director self reports agency policy states material omissions regarding such misconduct, or the provision of materially false information, shall be grounds for termination of employment.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 5, section B(6) and CC APS OP-030601 entitled Oklahoma PREA, page 2, section III(B)(1)(Note) address 115.217(g) in totality.

The auditor's review of the Form 14-2H CC reflects a caveat about material omissions regarding such misconduct or the provision of materially false information, being grounds for termination. This document is signed and dated by the employee on an annual basis.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 5, section B(9); ODOC OP-110210 entitled Background Investigations, page 9, section G(f); and CC APS OP-030601 entitled Oklahoma PREA, page 3, section III(B)(3)(d) address 115.217(h) in totality.

According to the Director, during the last 12 months, no requests for information were received from an institutional employer, to whom a CC or ex-CC employee has applied to work, relative to substantiated allegations of sexual abuse or sexual harassment.

The HR interviewee asserts when a former employee applies for work at another institution, upon request from that institution, the facility provides information regarding substantiated allegations of sexual abuse/sexual harassment involving the former employee, unless prohibited by law.

In view of the above, the auditor finds OROC substantially compliant with 115.217.

Standard 115.218: Upgrades to facilities and technologies

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.218 (a)

- If the agency designed or acquired any new facility or planned any substantial expansion or modification of existing facilities, did the agency consider the effect of the design, acquisition, expansion, or modification upon the agency's ability to protect residents from sexual abuse? (N/A if agency/facility has not acquired a new facility or made a substantial expansion to existing facilities since August 20, 2012, or since the last PREA audit, whichever is later.)
- Yes No NA

115.218 (b)

- If the agency installed or updated a video monitoring system, electronic surveillance system, or other monitoring technology, did the agency consider how such technology may enhance the agency's ability to protect residents from sexual abuse? (N/A if agency/facility has not installed or updated a video monitoring system, electronic surveillance system, or other monitoring technology since August 20, 2012, or since the last PREA audit, whichever is later.)
Yes No NA

Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

Pursuant to the PAQ, the Director self reports the facility has not acquired a new facility or made a substantial expansion or modification to existing facilities since the date of the last PREA audit. The Director confirmed this statement during her interview.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, pages 7 and 8, section E(1) and (2) and CC APS OP-030601 entitled Oklahoma PREA, page 18, section R(1) address 115.218(a) in totality.

According to the Agency Head interviewee, when designing, acquiring, or planning substantial modifications to facilities, CC commences the process through land purchase(s) and then subsequent construction. A design team facilitates most of the preparation and standards compliance work. Architects are well versed in PREA. Lines of sight are assessed to enhance resident sexual and personal safety and camera surveillance needs to address blind spots. The same protocol is utilized with regard to expansion and renovations. Requests for changes must be approved by the design team which is part of the Real Estate Group.

Pursuant to the PAQ, the Director self reports the facility has not installed or updated a video monitoring system, electronic surveillance system, or other monitoring technology since the last PREA audit. She confirmed the same statement during her interview.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 8, section E(3) and CC APS OP-030601 entitled Oklahoma PREA, page 18, section R(2) address 115.218(b) in totality.

Given the fact the auditor finds no deviation from either standard/CC policy/or ODOC policy, the auditor finds OROC substantially compliant with 115.218.

RESPONSIVE PLANNING

Standard 115.221: Evidence protocol and forensic medical examinations

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.221 (a)

- If the agency is responsible for investigating allegations of sexual abuse, does the agency follow a uniform evidence protocol that maximizes the potential for obtaining usable physical evidence for administrative proceedings and criminal prosecutions? (N/A if the agency/facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations.)
X Yes No NA

115.221 (b)

- Is this protocol developmentally appropriate for youth where applicable? (N/A if the agency/facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations.) X Yes No NA
- Is this protocol, as appropriate, adapted from or otherwise based on the most recent edition of the U.S. Department of Justice's Office on Violence Against Women publication, "A National Protocol for Sexual Assault Medical Forensic Examinations, Adults/Adolescents," or similarly comprehensive and authoritative protocols developed after 2011? (N/A if the agency/facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations.) X Yes No NA

115.221 (c)

- Does the agency offer all residents who experience sexual abuse access to forensic medical examinations, whether on-site or at an outside facility, without financial cost, where evidentiarily or medically appropriate? X Yes No
- Are such examinations performed by Sexual Assault Forensic Examiners (SAFEs) or Sexual Assault Nurse Examiners (SANEs) where possible? X Yes No
- If SAFEs or SANEs cannot be made available, is the examination performed by other qualified medical practitioners (they must have been specifically trained to conduct sexual assault forensic exams)? X Yes No
- Has the agency documented its efforts to provide SAFEs or SANEs? X Yes No

115.221 (d)

- Does the agency attempt to make available to the victim a victim advocate from a rape crisis center? X Yes No
- If a rape crisis center is not available to provide victim advocate services, does the agency make available to provide these services a qualified staff member from a community-based organization, or a qualified agency staff member? (N/A if agency *always* makes a victim advocate from a rape crisis center available to victims.) X Yes No NA
- Has the agency documented its efforts to secure services from rape crisis centers? X Yes No

115.221 (e)

- As requested by the victim, does the victim advocate, qualified agency staff member, or qualified community-based organization staff member accompany and support the victim through the forensic medical examination process and investigatory interviews? X Yes No
- As requested by the victim, does this person provide emotional support, crisis intervention, information, and referrals? X Yes No

115.221 (f)

- If the agency itself is not responsible for investigating allegations of sexual abuse, has the agency requested that the investigating agency follow the requirements of paragraphs (a)

through (e) of this section? (N/A if the agency/facility is responsible for conducting criminal AND administrative sexual abuse investigations.) X Yes No NA

115.221 (g)

- Auditor is not required to audit this provision.

115.221 (h)

- If the agency uses a qualified agency staff member or a qualified community-based staff member for the purposes of this section, has the individual been screened for appropriateness to serve in this role and received education concerning sexual assault and forensic examination issues in general? (N/A if agency *always* makes a victim advocate from a rape crisis center available to victims.) X Yes No NA

Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- X **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

Pursuant to the PAQ, the Director self reports the facility is responsible for conducting administrative sexual abuse investigations (including resident-on-resident sexual abuse or staff sexual misconduct). The Director further self reports the Oklahoma Department of Corrections Office of the Inspector General (ODOC OIG) facilitates criminal investigations relative to ODOC residents. With respect to Federal Bureau of Prisons (FBOP) residents, Oklahoma City Police Department (OCPD) investigators assume primary criminal investigative authority and responsibility. When conducting administrative sexual abuse investigations, the agency investigators follow a uniform evidence protocol. This caveat is also articulated in the Memorandum of Understanding (MOU) between OCPD and CC.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 23, section O(4)(a) and ODOC OP 040117 entitled Investigation, pages 2-4, sections II and III address 115.221(a).

All 12 random staff interviewees assert they know and understand the agency's protocol for obtaining usable physical evidence if a resident alleges sexual abuse. The responses regarding first responder duties essentially encompass evidence preservation. As previously indicated, ODOC OIG and OCPD conduct criminal investigations and they are responsible for physical evidence collection while all staff are responsible to secure the crime scene and guard against destruction of physical evidence by the victim and perpetrator.

Seven of the 12 random staff interviewees were able to correctly identify all four tasks as cited at 115.264(a). The majority of confusion centers on telling or ensuring both the victim and perpetrator do not destroy physical evidence, as opposed to, requesting that the victim and ensuring the perpetrator do not destroy physical evidence.

As policy is clearly scripted in accordance with 115.264(a) and each interviewee was in possession of a CC First Responder card, there is no basis for a non-compliance finding. However, additional training of all staff, accentuating the nuances (request the victim not destroy physical evidence vs. ensure the perpetrator does not destroy physical evidence), is recommended. The auditor notes all OROC staff receive the same first responder training.

Six of 12 random staff interviewees assert one of the three trained facility investigators facilitate administrative sexual abuse/harassment investigations and 10 interviewees properly identified one of the two agencies responsible for facilitation of criminal investigations.

Pursuant to the PAQ, the Director self reports no youth are housed at OROC and accordingly, that component of 115.221(b) is not applicable. The Director further self reports the protocol was adapted from or is otherwise based on the most recent edition of the DOJ's Office on Violence Against Women publication, "A National Protocol for Sexual Assault Medical Forensic Examinations, Adults/Adolescents", or similarly comprehensive and authoritative protocols developed after 2011.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 23, section O(1) and O(4)(b) addresses 115.221(b).

The auditor's review of the MOU between OCPD and CC reveals substantial compliance with 115.221(b).

Pursuant to the PAQ, the Director self reports the facility offers to all residents who experience sexual abuse access to forensic medical examinations. Forensic medical examinations are offered without financial cost to the victim. Where possible, examinations are conducted by SAFE/SANE Nurse Examiners.

When SAFE/SANE Nurses are unavailable, a qualified medical practitioner performs forensic medical examinations. The auditor's review of a YWCA Oklahoma City Domestic Violence, Sexual Assault and Stalking Services brochure reveals SAFE/SANE services are provided through their organization. The PCM asserts SANE examinations are facilitated at a hospital determined by ODOC. ODOC maintains MOUs, etc. with those hospitals. According to the Director, zero forensic medical examinations have been conducted during the last 12 months.

During the course of facilitation of the SANE interview, the auditor learned that SANEs are generally dispatched by YWCA Oklahoma City, as previously referenced. Accordingly, the auditor interviewed a SANE representing that organization.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 23, section O(4)(c) and ODOC OP-030601 entitled PREA, page 24, section 1(a)(1) address 115.221(c). The latter policy stipulates that if within 120 hours of the incident, OIG will determine if the need for a sexual assault medical forensic examination exists. If so, resident clothing will be tagged as evidence at the hospital or examination site.

The PCM asserts ODOC OIG investigators determine the location at which the SANE examination will be conducted. ODOC is engaged in agreements, some verbal and some written, with hospitals used for this purpose. They coordinate and pay for medical services.

The SANE interviewee asserts she is one of 12-14 on-call state trained SANE nurses who facilitate forensic examinations for ODOC and FBOP inmates/residents, as well as, members of the community. Generally, such services are provided for victims within a one to two hour radius of the hospital(s). The training is patterned after the International SANE Nurses training. The interviewee reports that zero forensic examinations have been missed by her group within the last 10 years.

If, for some reason, a SANE nurse is not immediately available, the forensic examination would ordinarily be delayed a few hours. As a last resort, however, she would "walk" the ER physician and/or an ER nurse through the process.

Pregnancy tests (urine test only) are provided in conjunction with the forensic examination. Information regarding pregnancy-related services, as well as, infection prophylaxis treatment are also provided.

Pursuant to the PAQ, the Director self reports the facility attempts to make a victim advocate from a rape crisis center available to the victim, either in person or by other means, and these efforts are doc-

umented. The Director further self reports the facility provides victim advocate services pursuant to an MOU between CC and the YWCA Oklahoma City dated August 17, 2017 and reviewed annually thereafter.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 23, section O(4)(d) addresses 115.221(d).

According to the PCM, victim advocacy services are available to OROC residents pursuant to an MOU with the YWCA Oklahoma City. YWCA Oklahoma City information is posted within the facility.

Pursuant to the auditor's review, he has determined zero sexual abuse incidents have been reported since September, 2020. The seven prior investigations revolve around incidents involving male residents when the facility was known as CTC. Zero incidents have been realized since the mission change to ODOC female residents and FBOP male/female residents.

In view of the above, interview(s) with residents who reported a sexual abuse could not be conducted.

Pursuant to the PAQ, the Director self reports if requested by the victim, a victim advocate accompanies and supports the victim through the forensic medical examination process and investigatory interviews and provides emotional support, crisis intervention, information, and referrals.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 24, section O(4)(e) and ODOC OP-030601 entitled PREA, page 21, section B(8) address 115.221(e).

Pursuant to the auditor's review of the MOU between CC and YWCA Oklahoma City, there is a blanket statement which reads as follows:

YWCA shall provide residents with confidential emotional support services related to sexual abuse, when referred by CoreCivic.

The auditor finds the above language to be representative of compliance with 115.221(e).

The PCM asserts, if requested by the victim, a victim advocate is accessed through YWCA Oklahoma City to accompany the victim and provide emotional support, crisis intervention, information, and referrals during the forensic medical examination process and investigatory interviews. This is generally addressed in the YWCA Oklahoma City MOU.

As reflected throughout this narrative, the OROC investigator facilitates administrative sexual abuse/harassment investigations. Accordingly, the auditor finds 115.221(f) to be non-applicable to OROC.

In view of the above, the auditor finds OROC substantially compliant with 115.221.

Standard 115.222: Policies to ensure referrals of allegations for investigations

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.222 (a)

- Does the agency ensure an administrative or criminal investigation is completed for all allegations of sexual abuse? X Yes No
- Does the agency ensure an administrative or criminal investigation is completed for all allegations of sexual harassment? X Yes No

115.222 (b)

- Does the agency have a policy and practice in place to ensure that allegations of sexual abuse or sexual harassment are referred for investigation to an agency with the legal authority to conduct criminal investigations, unless the allegation does not involve potentially criminal behavior? X Yes No
- Has the agency published such policy on its website or, if it does not have one, made the policy available through other means? X Yes No
- Does the agency document all such referrals? X Yes No

115.222 (c)

- If a separate entity is responsible for conducting criminal investigations, does the policy describe the responsibilities of both the agency and the investigating entity? (N/A if the agency/facility is responsible for conducting criminal investigations. See 115.221(a).) X Yes No NA

115.222 (d)

- Auditor is not required to audit this provision.

115.222 (e)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- X **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

Pursuant to the PAQ, the Director self reports the agency ensures an administrative or criminal investigation is completed for all allegations of sexual abuse and sexual harassment (including resident-on-resident sexual abuse and staff sexual misconduct). In the last 12 months, zero allegations of sexual abuse/harassment were received.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 22, section N(1) addresses 115.222(a). Additionally, ODOC OP 040117 entitled Investigation, pages 2 and 3, section II (A) generally addresses 115.222(a) to the extent that allegations are investigated promptly, thoroughly, and objectively. Of course, these two policies generally address the conduct of criminal investigations by ODOC Office of Inspector General (OIG) investigators. Finally, ODOC OP-030601 entitled Oklahoma PREA, pages 23-26 addresses 115.222(a), from completion of the administrative investigation perspective.

According to the Agency Head interviewee, an administrative or criminal investigation is completed for all allegations of sexual abuse or sexual harassment. Administrative investigations are completed by a sexual abuse/harassment trained investigator and whenever the Inspector General (IG) arm of the partner is tasked with facilitation of criminal investigations, they are generally PREA trained pursuant to the contract.

In regard to the protocol relative to administrative/criminal sexual abuse or sexual harassment investigations, the Agency Head interviewee asserts the allegation triggers the rest of the investigative process. Medical examination and allegations the victim incurred physical harm may trigger a forensic examination as ordered by medical professionals. The allegation is generally reported to the Director, ad, os, and PCM. Notifications to the facility investigator and/or criminal investigating agency would ensue.

The Agency Head interviewee continued, stating first responders ensure the victim and perpetrator are separated and perpetrator, if known, is isolated. The victim would likewise remain under staff's physical supervision. Generally, physical evidence is collected by the criminal investigator in a criminal matter. If criminal, the criminal investigator determines interview status and whether the facility investigator assists. CC investigative staff would assist the criminal investigator in any way needed, inclusive of research and preservation of camera footage, resident/staff file reviews, review of reports submitted by staff, review of resident statements (if applicable), and coordination of investigative activities. Additionally, CC officials would support prosecution efforts of both staff and residents.

The administrative investigation is generally completed by the facility investigator. He/she employs essentially the same protocol however, he/she does interview witnesses and assesses victim, perpetrator, witness credibility. Finally, the investigator writes an investigative report.

Pursuant to the PAQ, the Director self reports the agency has a policy that requires allegations of sexual abuse or sexual harassment be referred for investigation to an agency with the legal authority to conduct criminal investigations, including the agency if it conducts its own investigations, unless the allegation does not involve potentially criminal behavior. The Director further self reports agency policy regarding the referral of allegations of sexual abuse or sexual harassment for criminal investigation is published on the agency website. The agency documents all referrals of allegations of sexual abuse or sexual harassment for criminal investigation.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 17, section M(9) and page 23, section O(1) address 115.222(b). Additionally, ODOC OP-040117 entitled Investigations, pages 2 and 3, section II(A) also addresses 115.222(b).

The investigative staff interviewee asserts agency policy requires allegations of sexual abuse/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. As previously indicated, allegations (criminal in nature) involving ODOC residents are referred to the ODOC OIG and allegations involving FBOP female and male residents are referred to the OCPD.

Pursuant to the auditor's review of all seven Carver Transitional Center (CTC) investigations, all seven (one sexual harassment and six sexual abuse) were referred to the ODOC OIG and they made the determination regarding investigation by their office or CTC investigator(s). Of note, one case involving alleged staff voyeurism was not determined to be a PREA matter by ODOC OIG however, CTC investigator(s) retained the same as a sexual abuse allegation. Additionally, in another matter, ODOC OIG ultimately investigated the case as a criminal matter and referred the same for criminal charges.

The auditor's review of the CC and OROC websites reveals the appropriate policy regarding criminal referrals and the investigative responsibilities for administrative and criminal investigative entities is posted on the same.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 23, section O(2) and (3) addresses 115.222(c). ODOC policies regarding criminal investigations are clearly articulated throughout this report.

In view of the above, the auditor finds OROC substantially compliant with 115.222.

TRAINING AND EDUCATION

Standard 115.231: Employee training

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.231 (a)

- Does the agency train all employees who may have contact with residents on: Its zero-tolerance policy for sexual abuse and sexual harassment? X Yes No
- Does the agency train all employees who may have contact with residents on: How to fulfill their responsibilities under agency sexual abuse and sexual harassment prevention, detection, reporting, and response policies and procedures? X Yes No
- Does the agency train all employees who may have contact with residents on: Residents' right to be free from sexual abuse and sexual harassment X Yes No
- Does the agency train all employees who may have contact with residents on: The right of residents and employees to be free from retaliation for reporting sexual abuse and sexual harassment? X Yes No
- Does the agency train all employees who may have contact with residents on: The dynamics of sexual abuse and sexual harassment in confinement? X Yes No
- Does the agency train all employees who may have contact with residents on: The common reactions of sexual abuse and sexual harassment victims? X Yes No
- Does the agency train all employees who may have contact with residents on: How to detect and respond to signs of threatened and actual sexual abuse? X Yes No
- Does the agency train all employees who may have contact with residents on: How to avoid inappropriate relationships with residents? X Yes No
- Does the agency train all employees who may have contact with residents on: How to communicate effectively and professionally with residents, including lesbian, gay, bisexual, transgender, intersex, or gender nonconforming residents? X Yes No
- Does the agency train all employees who may have contact with residents on: How to comply with relevant laws related to mandatory reporting of sexual abuse to outside authorities? X Yes No

115.231 (b)

- Is such training tailored to the gender of the residents at the employee's facility? X Yes No
- Have employees received additional training if reassigned from a facility that houses only male residents to a facility that houses only female residents, or vice versa? X Yes No

115.231 (c)

- Have all current employees who may have contact with residents received such training? X Yes No

- Does the agency provide each employee with refresher training every two years to ensure that all employees know the agency's current sexual abuse and sexual harassment policies and procedures? Yes No
- In years in which an employee does not receive refresher training, does the agency provide refresher information on current sexual abuse and sexual harassment policies? Yes No

115.231 (d)

- Does the agency document, through employee signature or electronic verification, that employees understand the training they have received? Yes No

Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

Pursuant to the PAQ, the Director self reports the agency trains all employees who may have contact with residents on:

- 1) Its 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) Resident's rights 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, and intersex, or gender non-conforming residents; and
- 10) How to comply with relevant laws related to mandatory reporting of sexual abuse to outside authorities.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 5, section C(2)(a-j) and ODOC OP-030601 entitled PREA, pages 11 and 12, section V(A-C)(1-7) address the PREA topic training requirements as articulated in 115.231(a).

The auditor's review of the PREA Overview Curriculum, student workbook, and accompanying training slides reveals substantial compliance with 115.231(a). The PREA Teach back Topics document suggests significant interactive learning between facilitator and students and content appears to be comprehensive.

The auditor's review of PAQ Pre-Service and In-Service CORECIVIC PREA POLICY ACKNOWLEDGMENT AND/OR TRAINING ACKNOWLEDGMENT forms reveals four staff members were provided In-Service PREA Overview training during 2020. These documents include the "I understand the subject-matter presented" caveat and are signed/dated by the employee participant.

The auditor's review of two Oklahoma PREA Staff Training Acknowledgments likewise substantiates compliance with 115.231. The staff member's signature and date likewise attest to receipt of the requisite training and understanding of the same.

In addition to the above, a Training Activity Enrollment/Attendance Roster reflects 36 staff completed Gender Responsive and Trauma Informed Care In-Service training classes conducted on August 12, 13, 18, and 19, 2020.

The auditor's review of 10 random resident training files reveals three staff hires within the last 12 months received pre-service PREA training on their entry-on-duty date or during the first week following their entry-on-duty date. Seven files reflect affected staff members received at least two PREA Annual Refresher Training (ART- In-Service) trainings. One additional employee completed one ART training as she was hired in 2020.

All 12 random staff interviewees self report they received training regarding the afore-mentioned 10 PREA topics either during Pre-Service, ART, or preparation training regarding the FBOP contract in January, 2021.

Pursuant to the PAQ, the Director self reports training is tailored to the male and female gender of the residents housed at the facility.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 5, section C(1) and ODOC OP-030601 entitled PREA, page 12, section V(D) address 115.231(b).

The auditor's review of the afore-mentioned training curriculum reveals the same is commensurate with 115.231(b).

The PCM asserts the majority of staff, as well as the new administrator and ad, were reassigned from a previously closed male facility. Special training was given to all staff for the transition to female residents.

Pursuant to the PAQ, the Director self reports 42 staff, who may have contact with residents, were trained or retrained in PREA requirements. This equates to 100% of the staff complement. If there are any policy updates in regard to PREA matters, staff would be trained on the policy during staff meetings. Employees who may have contact with residents receive PREA training on an annual basis.

Given the fact 115.231(c) requires refresher training every two years to ensure all employees know the agency's current sexual abuse/harassment policies and procedures and the fact OROC facilitates PREA ART, the auditor finds OROC exceeds standard requirements with respect to this provision.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 5, section C(2) and ODOC OP-030601 entitled PREA, page 12, section V(C)(2) address 115.231(c).

The PCM asserts new or amended PREA policies and changes are forwarded to all staff via email and the new policy changes are reviewed during "All Staff Meetings" facilitated by the quality assurance manager. All policies are also accessible to staff on the CoreCivic web site.

Pursuant to the PAQ, the Director self reports the agency documents that employees, who may have contact with residents, understand the training they received through employee signature or electronic verification.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 5, section C(3) and ODOC OP-030601 entitled PREA, page 13, section V(E)(2) address 115.231(d).

The auditor's on-site review of staff training files, as reflected in the narrative for 115.231(a), reveals staff signed and dated the requisite Core Civic PREA Policy Acknowledgment and/or Training Acknowledgment forms, the aforementioned requisite ODOC Acknowledgment, and CC training rosters acknowledging their understanding of the subject-matter presented for 2018, 2019, and/or 2020. Accordingly, the auditor finds OROC substantially compliant with 115.231(d).

In view of the above, the auditor finds OROC exceeds standard expectations with respect to 115.231.

Standard 115.232: Volunteer and contractor training

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.232 (a)

- Has the agency ensured that all volunteers and contractors who have contact with residents have been trained on their responsibilities under the agency's sexual abuse and sexual harassment prevention, detection, and response policies and procedures? X Yes No

115.232 (b)

- Have all volunteers and contractors who have contact with residents been notified of the agency's zero-tolerance policy regarding sexual abuse and sexual harassment and informed how to report such incidents (the level and type of training provided to volunteers and contractors shall be based on the services they provide and level of contact they have with residents)? X Yes No

115.232 (c)

- Does the agency maintain documentation confirming that volunteers and contractors understand the training they have received? X Yes No

Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- X **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

Pursuant to the PAQ, the Director self reports all volunteers and contractors who have contact with residents are trained on their responsibilities under the agency's policies and procedures regarding sexual abuse/harassment prevention, detection, and response. The Director further self reports zero contractor(s) and volunteer(s) provide services at OROC. The auditor notes only ODOC residents were housed at OROC until February 8, 2021. In light of COVID 19 restrictions, the ODOC had suspended all resident visitation, inclusive of volunteers, in March, 2020 and the same is still ongoing as of the date of the on-site audit.

No contractors are utilized at OROC. Some contract repair services, in the absence of resident contact and with staff supervision, are provided and such contractors review and sign a PREA information form prior to entry into the facility.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 6, section C(8) and ODOC OP-030601 entitled PREA, pages 11 and 12, section V(B)(1-7) address 115.232(a). Additionally, ODOC OP-090211 entitled Volunteer Services, pages 10 and 11, section F(1)(a) and (c) addresses 115.232(a).

The auditor's review of the CC Volunteer Orientation video reveals substantial compliance with 115.232. The same provides sufficient information and background enabling all contractors/volunteers to fulfill their PREA responsibilities.

In view of the aforementioned COVID-19 restrictions, the PCM self reports volunteer access at OROC was suspended, at least until February, 2021. Accordingly, the auditor was provided a volunteer list (dated March, 2020), apparently pertinent to CTC.

The auditor has made contact with three volunteers (CTC) and left messages regarding return calls for two other volunteers. Additionally, the auditor also made contact with another volunteer listed on the foremen-

tioned ODOC volunteer list and she advised she has never provided volunteer services at either CTC or OROC.

In view of the above, the auditor's narrative regarding volunteer interviews captures his conversations with three individuals. This is relevant throughout the 115.232 narrative.

The volunteer interviewees assert they have been trained relative to their responsibilities regarding sexual abuse and sexual harassment, prevention, detection, and response per agency policy and procedure. Two interviewees assert their initial initial training was facilitated by ODOC staff at a local church in Oklahoma City prior to contact with residents. The training included a Power Point Presentation, as well as, a video and lecture. They completed this training in 2019 and within the last eight months, one of the two interviewees completed an on-line training provided by ODOC staff. The third interviewee asserts, in addition to the above, that he receives such PREA training on a bi-annual basis, the last session provided on or about February, 2019. COVID-19 adversely impacted relevant training, as well as, entry into facilities.

The interviewees further advise they have been notified of the agency's zero-tolerance policy on sexual abuse and sexual harassment, as well as, informed about how to report such incidents.

The PCM asserts ODOC approves volunteers, completes requisite criminal background record checks, and facilitates requisite training. ODOC has not allowed volunteers access to the facility during the COVID-19 pandemic.

The auditor's review of four signed and dated volunteer (one 2019 and three 2020) Oklahoma PREA Volunteer/Contractor Training Acknowledgment forms reveals the volunteers completed requisite training and understand the same.

Pursuant to the PAQ, the Director self reports 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. The Director further self reports 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.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 6, section C(8)(b)(1) and (2) and ODOC OP-030601 entitled PREA, page 12, section V(C)(3) address 115.232(b).

Pursuant to the PAQ, the Director self reports the agency maintains documentation confirming that volunteers/contractors understand the training they have received.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 7, section C(8)(d) and ODOC OP-030601 entitled PREA, page 13, section V(E)(2) address 115.232(c).

In view of the above, the auditor finds OROC substantially compliant with 115.232.

Standard 115.233: Resident education

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.233 (a)

- During intake, do residents receive information explaining: The agency's zero-tolerance policy regarding sexual abuse and sexual harassment? X Yes No
- During intake, do residents receive information explaining: How to report incidents or suspicions of sexual abuse or sexual harassment? X Yes No

- During intake, do residents receive information explaining: Their rights to be free from sexual abuse and sexual harassment? X Yes No
- During intake, do residents receive information explaining: Their rights to be free from retaliation for reporting such incidents? X Yes No
- During intake, do residents receive information regarding agency policies and procedures for responding to such incidents? X Yes No

115.233 (b)

- Does the agency provide refresher information whenever a resident is transferred to a different facility? X Yes No

115.233 (c)

- Does the agency provide resident education in formats accessible to all residents, including those who: Are limited English proficient? X Yes No
- Does the agency provide resident education in formats accessible to all residents, including those who: Are deaf? X Yes No
- Does the agency provide resident education in formats accessible to all residents, including those who: Are visually impaired? X Yes No
- Does the agency provide resident education in formats accessible to all residents, including those who: Are otherwise disabled? X Yes No
- Does the agency provide resident education in formats accessible to all residents, including those who: Have limited reading skills? X Yes No

115.233 (d)

- Does the agency maintain documentation of resident participation in these education sessions? X Yes No

115.233 (e)

- In addition to providing such education, does the agency ensure that key information is continuously and readily available or visible to residents through posters, resident handbooks, or other written formats? X Yes No

Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- X **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

Pursuant to the PAQ, the Director self reports residents receive information at the 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 Director self reports 141 residents were provided requisite information at intake during the last 12 months. The Director further self reports 100% of residents admitted during the last 12 months were provided this information at intake.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 10, section H(1)(a-e) and ODOC OP-030601 entitled PREA, page 14, section VI(A)(1) address 115.233(a).

The intake staff interviewee self reports she provides residents with information about the CC and OROC zero-tolerance policy and how to report incidents or suspicions of sexual abuse or sexual harassment at intake. The interviewee asserts she provides the CC and ODOC tri-fold brochures, as well as, the OROC Handbook to incoming residents. The PREA video is displayed following the intake process.

Within a few days of intake, a follow-up orientation is provided to new arrivals and the PCM or case managers provide this orientation. The interviewee also asserts PREA documentation is posted throughout the facility.

Thirteen of 17 random resident interviewees self report they received information about the facility's rules against sexual abuse/harassment during intake or within 24 hours of intake. Similarly, the majority of these 13 random resident interviewees assert they were told about the following within a couple days of arrival at OROC:

- a. Their right not to be sexually abused or sexually harassed;
- b. How to report sexual abuse or sexual harassment;
- c. Their right not to be punished for reporting sexual abuse or sexual harassment; and
- d. Their right not to be retaliated against for reporting sexual abuse or sexual harassment.

Interviewees confirmed the materials provided to them were consistent with staff assertions as reflected above.

The auditor's review of the CoreCivic PREA- Prevent, Detect, and Respond brochure reveals verbiage regarding the resident's right to be free from sexual abuse/harassment and retaliation for reporting the same. The pamphlet is presented in both English and Spanish. Additionally, strategies to avoid sexual abuse/sexual harassment are addressed in this document.

The auditor's review of the Oklahoma PREA Zero Tolerance Acknowledgments for Inmates document reveals the resident received and understands relevant brochures and information at intake, as validated by the resident's date and signature on the form. Additionally, another CC form reflects the resident viewed the PREA video, etc. This document serves as evidence the resident completed Orientation. The resident signs this pre-dated document, attesting to receipt of the identified training.

The auditor's review of the OROC Resident Handbook, CC PREA: Prevent. Detect. Respond. tri-fold brochure and the ODOC Inmate's Guide to Sexual Misconduct brochure confirms the zero tolerance policy of OROC regarding sexual abuse and sexual harassment and the various options for reporting incidents or suspicions of sexual abuse or sexual harassment. The PREA Intake Pamphlets document memorializes resident receipt of the same pursuant to signature and date.

During pre-audit preparations, the auditor determined residents view the PREA video (English and Spanish) and receive the OROC Resident Handbook/ODOC Inmate's Guide to Sexual Misconduct (available in English and Spanish) and the aforementioned CC tri-fold pamphlet. Each resident signs and dates a CC document entitled PREA Intake Pamphlets signifying receipt of the aforementioned ODOC tri-fold pamphlet. Additionally, they sign and date an ODOC document entitled Oklahoma PREA Zero Tolerance Acknowledgment for Inmates. Both documents reflect the "I understand the subject-matter" caveat and the latter document is available in Spanish. With respect to the FBOP residents, they do not receive the aforementioned ODOC tri-fold pamphlet however, they do receive an OROC Resident Handbook applicable to them and the aforementioned CC tri-fold.

The auditor's on-site review of 10 random resident files (pertaining to residents received at OROC during this audit cycle) reveals substantial compliance with both 115.33(a) and (b). Specifically, requisite materials were received in a timely manner and the resident(s) properly acknowledged receipt of training. All resident PREA education was completed within 24 hours of arrival at OROC.

The auditor's review of eight Oklahoma PREA Zero Tolerance Acknowledgment for Inmate forms and PREA Intake Pamphlet forms reveals substantial compliance with 115.233(a).

Pursuant to the PAQ, the Director self reports the facility provides residents who are transferred from a different community confinement facility with refresher information as referenced above. The Director further self reports one resident was transferred to OROC from a different community confinement facility within the last 12 months and she has received refresher training. The auditor validated the same pursuant to review of the aforementioned Oklahoma PREA Act Zero Tolerance Acknowledgment for Inmate forms and PREA Intake Pamphlet forms.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 11, section H(5) and ODOC OP-030601 entitled PREA, page 14, section VI(A)(4) address 115.233(b).

The intake staff interviewee asserts that within 72 hours of intake, a follow-up PREA orientation is provided to new arrivals and the PCM or case managers provide this orientation. The interviewee also asserts PREA documentation is posted throughout the facility.

All 17 random resident interviewees reported being transferred to OROC from state correctional facilities, county jail(s), or private re-entry facilities.

The PCM asserts all 141 residents received at OROC within the last year came from state correctional facilities, county jail(s), or private re-entry facilities. All residents were provided ODOC PREA education and/or FBOP PREA education, whichever is applicable. Any and all residents received at OROC received PREA education.

The auditor's review of seven of 10 random resident files correspond with random resident interviewees. All seven files reveal the resident received timely and comprehensive PREA education pursuant to 115.233(a) and (b).

Pursuant to the PAQ, the Director self reports resident PREA education is available in accessible formats for all residents including those who are LEP, deaf, visually impaired, otherwise disabled, as well as, to residents who have limited reading skills.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 10, section H(2) and ODOC OP-030601 entitled PREA, page 14, section VI(A)(4)(a) and (b) address 115.233(c). Additionally, ODOC OP-030601 entitled PREA, page 15, section B(1-7) addresses 115.233(c).

Resident education formats and accessibility of the same to the resident population are addressed in the narrative for 115.216 above.

Pursuant to the PAQ, the Director self reports the agency maintains documentation of resident participation in PREA education sessions.

Substantiating documentation is referenced in the narrative for 115.233(a) above. Multiple documents discussed in the narrative for 115.233(a) substantiate compliance with this provision. Executed documents, as discussed above, are applicable to eight residents, in addition to the on-site random resident file reviews.

Pursuant to the PAQ, the Director self reports the agency ensures key information about the agency's PREA policies is continuously and readily available or visible through posters, resident handbooks, or other written formats.

The auditor's review of numerous documents referenced throughout the narrative for 115.233 reveals substantial compliance with 115.233(e).

Throughout the facility tour, the auditor observed plentiful PREA posters, pamphlets (inclusive of the Oklahoma City YWCA information referenced in the narrative for 115.221) posted on bulletin boards and relevant telephone numbers etched on placards affixed to the wall near the D Unit telephone banks. Additionally, residents retain the OROC Resident Handbook and CC/ODOC tri-fold pamphlets in their possession. FBOP residents retain the OROC Resident Handbook and the aforementioned CC PREA tri-fold in their possession.

In view of the above, the auditor finds OROC substantially compliant with 115.233.

Standard 115.234: Specialized training: Investigations

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.234 (a)

- In addition to the general training provided to all employees pursuant to §115.231, does the agency ensure that, to the extent the agency itself conducts sexual abuse investigations, its investigators receive training in conducting such investigations in confinement settings? (N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.221(a).)
 Yes No NA

115.234 (b)

- Does this specialized training include: Techniques for interviewing sexual abuse victims? (N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.221(a).) Yes No NA
- Does this specialized training include: Proper use of Miranda and Garrity warnings? (N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.221(a).) Yes No NA
- Does this specialized training include: Sexual abuse evidence collection in confinement settings? (N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.221(a).) Yes No NA
- Does this specialized training include: The criteria and evidence required to substantiate a case for administrative action or prosecution referral? (N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.221(a).)
 Yes No NA

115.234 (c)

- Does the agency maintain documentation that agency investigators have completed the required specialized training in conducting sexual abuse investigations? (N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.221(a).)
 Yes No NA

115.234 (d)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

Pursuant to the PAQ, the Director asserts agency policy requires that investigators are trained in conducting sexual abuse investigations in confinement settings.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 6, section C(5) and ODOC OP-030601 entitled PREA, page 13, section F(1) address 115.234(a). Additionally, ODOC OP-040117 entitled Investigations, page 3, section II(A)(3) addresses 115.234(a).

The auditor's review of OROC investigator certificates for the three hour RELIAS training course entitled PREA: Investigation Protocols reveals three current administrative sexual abuse/harassment investigators plus the previous PCM completed the same. The auditor's review of the RELIAS training plan reveals substantial compliance with 115.234(a) and (b).

During the course of the on-site audit, the auditor determined that one additional staff member completed another RELIAS sexual abuse/harassment investigation course entitled PREA Investigations: What Happens After An Allegation.

Pursuant to a memorandum dated July 28, 2020, there are 12 trained sexual abuse investigators on board at ODOC OIG. Any of these investigators may complete an investigation at OROC. Additionally, pursuant to the previously mentioned MOU with OCPD, sexual abuse training provided to investigators is deemed to be sufficient.

The auditor notes CC policy requires more than one trained investigator at OROC. The auditor's review of two RELIAS certificates reveals two administrative sexual abuse/harassment investigators completed the aforementioned training programs and have been on-site throughout the audit period. Clearly, OROC demonstrates compliance with 115.234(a).

According to the investigative staff interviewee, she completed a 1.5 hour on-line Relias sexual abuse/harassment investigative training regarding the conduct of sexual abuse investigations in a confinement setting.

This course included topics such as interviewing techniques relative to victims and perpetrators in a confinement setting, execution of Miranda and Garrity warnings, evidence collection in sexual abuse cases, and the evidence standard necessary to substantiate a case for administrative action or prosecution referral.

The ODOC OIG interviewee asserts he completed the National Institute of Corrections (NIC) course regarding the same subject-matter. The course consisted of a three hour on-line format. He completed the course in September or October, 2018.

The OCPD interviewee asserts he received extensive sexual abuse training through OCPD. Intensive classroom in-service training and shadowing a seasoned investigator for three months and developing investigations under his/her guidance and monitoring constituted the bulk of this training.

He attended specific classes presented by subject-matter experts regarding interviewing techniques. Much of specialty training was scenario based. Additionally, representatives from the District Attorneys Office provided evidentiary and statutory training. All four topics, as described above, were covered, at one point or another, during these training sessions.

Of note, the Crime Scene Investigation (CSI) Unit is primarily responsible for collection of evidence at the scene, dependent upon the circumstances. The interviewee may also collect physical and direct evidence as he is so trained.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 6, section C(5)(a) addresses 115.234(b). The ODOC policy citations referenced in the narrative for 115.234(a) are also applicable to 115.234(b).

Pursuant to the PAQ, the Director self reports the agency maintains documentation showing investigators have completed the required training. As previously indicated, the Director also self reports the agency maintains documentation showing one current investigator has completed the required training.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 6, section C(5)(b) and ODOC OP-030601 entitled PREA, page 13, section F(2) address 115.234(c).

Documentation substantiating completion of requisite training is addressed in the narrative for 115.234(a).

In view of the above, the auditor finds OROC substantially compliant with 115.234.

Standard 115.235: Specialized training: Medical and mental health care

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.235 (a)

- Does the agency ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in: How to detect and assess signs of sexual abuse and sexual harassment? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners who work regularly in its facilities.)
 Yes No NA
- Does the agency ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in: How to preserve physical evidence of sexual abuse? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners who work regularly in its facilities.) Yes No NA
- Does the agency ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in: How to respond effectively and professionally to victims of sexual abuse and sexual harassment? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners who work regularly in its facilities.) Yes No NA
- Does the agency ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in: How and to whom to report allegations or suspicions of sexual abuse and sexual harassment? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners who work regularly in its facilities.)
 Yes No NA

115.235 (b)

- If medical staff employed by the agency conduct forensic examinations, do such medical staff receive appropriate training to conduct such examinations? (N/A if agency does not employ medical staff or the medical staff employed by the agency do not conduct forensic exams.)

Yes No NA

115.235 (c)

- Does the agency maintain documentation that medical and mental health practitioners have received the training referenced in this standard either from the agency or elsewhere? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners who work regularly in its facilities.) Yes No NA

115.235 (d)

- Do medical and mental health care practitioners employed by the agency also receive training mandated for employees by §115.231? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners employed by the agency.) Yes No NA
- Do medical and mental health care practitioners contracted by and volunteering for the agency also receive training mandated for contractors and volunteers by §115.232? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners contracted by or volunteering for the agency.) Yes No NA

Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

Pursuant to the PAQ, the Director self reports the agency has a policy related to the training of medical and mental health practitioners who work regularly in its facilities. However, no medical or mental health staff work at OROC. The Director further self reports that zero medical/mental health practitioners, who work regularly at the facility, received the training.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 6, section C(6)(a-e) addresses 115.235(a).

According to the PCM and pursuant to the auditor's observation and review of the OROC Organizational Chart, medical and mental health staff are not employed at OROC. Accordingly, such interviews could not be conducted. Of note, none of the provisions of 115.235 are applicable to OROC however, as the auditor finds no evidence of non-compliance, OROC is compliant with the standard.

Pursuant to the PAQ and in view of the above, the Director self reports facility medical staff do not conduct forensic examinations at OROC. Accordingly, the auditor finds 115.235(b) not applicable to OROC.

Pursuant to the PAQ and in view of the above, the Director self reports the agency does not maintain documentation showing that medical/mental health practitioners have completed the required training as medical/mental health care is provided in community facilities.

As mentioned throughout the narrative for this standard, no medical/mental health practitioners are employed at OROC. Accordingly, 115.235(d) is not applicable to OROC.

As there are no apparent deviations from standard, the auditor finds OROC substantially compliant with 115.235.

SCREENING FOR RISK OF SEXUAL VICTIMIZATION AND ABUSIVENESS

Standard 115.241: Screening for risk of victimization and abusiveness

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.241 (a)

- Are all residents assessed during an intake screening for their risk of being sexually abused by other residents or sexually abusive toward other residents? X Yes No
- Are all residents assessed upon transfer to another facility for their risk of being sexually abused by other residents or sexually abusive toward other residents? X Yes No

115.241 (b)

- Do intake screenings ordinarily take place within 72 hours of arrival at the facility?
X Yes No

115.241 (c)

- Are all PREA screening assessments conducted using an objective screening instrument?
X Yes No

115.241 (d)

- Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: Whether the resident has a mental, physical, or developmental disability? X Yes No
- Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: The age of the resident? X Yes No
- Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: The physical build of the resident? X Yes No
- Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: Whether the resident has previously been incarcerated?
X Yes No
- Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: Whether the resident's criminal history is exclusively nonviolent?
X Yes No
- Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: Whether the resident has prior convictions for sex offenses against an adult or child? X Yes No
- Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: Whether the resident is or is perceived to be gay, lesbian, bisexual, transgender, intersex, or gender nonconforming (the facility affirmatively asks the resident about his/her sexual orientation and gender identity AND makes a subjective determination based on

the screener's perception whether the resident is gender non-conforming or otherwise may be perceived to be LGBTI)? X Yes No

- Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: Whether the resident has previously experienced sexual victimization? X Yes No
- Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: The resident's own perception of vulnerability? X Yes No

115.241 (e)

- In assessing residents for risk of being sexually abusive, does the initial PREA risk screening consider, when known to the agency: prior acts of sexual abuse? X Yes No
- In assessing residents for risk of being sexually abusive, does the initial PREA risk screening consider, when known to the agency: prior convictions for violent offenses? X Yes No
- In assessing residents for risk of being sexually abusive, does the initial PREA risk screening consider, when known to the agency: history of prior institutional violence or sexual abuse? X Yes No

115.241 (f)

- Within a set time period not more than 30 days from the resident's arrival at the facility, does the facility reassess the resident's risk of victimization or abusiveness based upon any additional, relevant information received by the facility since the intake screening? X Yes No

115.241 (g)

- Does the facility reassess a resident's risk level when warranted due to a: Referral? X Yes No
- Does the facility reassess a resident's risk level when warranted due to a: Request? X Yes No
- Does the facility reassess a resident's risk level when warranted due to a: Incident of sexual abuse? X Yes No
- Does the facility reassess a resident's risk level when warranted due to a: Receipt of additional information that bears on the resident's risk of sexual victimization or abusiveness? X Yes No

115.241 (h)

- Is it the case that residents are not ever disciplined for refusing to answer, or for not disclosing complete information in response to, questions asked pursuant to paragraphs (d)(1), (d)(7), (d)(8), or (d)(9) of this section? X Yes No

115.241 (i)

- Has the agency implemented appropriate controls on the dissemination within the facility of responses to questions asked pursuant to this standard in order to ensure that sensitive information is not exploited to the resident's detriment by staff or other residents? X Yes No

Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

Pursuant to the PAQ, the Director self reports the agency has a policy that requires screening (upon admission to a facility or transfer to another facility) for risk of sexual abuse victimization or sexual abusiveness toward other residents.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 8, section G(1) and ODOC OP-030102 entitled Inmate Housing, pages 2 and 3, section II(A)(1) address 115.241(a). Additionally, CC APS 030601 entitled Oklahoma PREA, page 5, section III(F)(1) addresses 115.241(a).

The staff who performs screening for risk of victimization and abusiveness interviewee self reports she does screen residents upon admission to OROC or transfer from another facility for risk of sexual victimization or sexual abusiveness toward other residents. Additionally, she facilitates 30-day reassessments.

Sixteen of 17 random resident interviewees self report when they arrived at OROC, they were asked questions like whether they had been in jail or prison before, whether they have ever been sexually abused, whether they identify as being LGBTI, and whether they think they may be in danger of being sexually abused at the facility. Fifteen of the 17 interviewees self report they were asked these questions on the date of arrival or within 24 hours of arrival.

Pursuant to the PAQ, the Director self reports 115.241(a) screening shall ordinarily take place within 72 hours of arrival at the facility. The below policy requires that screening is conducted within 24 hours of arrival at OROC. The Director self reports during the last 12 months, 141 residents entering the facility (either through intake or transfer) whose length of stay in the facility was 72 hours or more, were screened for risk of sexual victimization or risk of sexually abusing other residents, within 72 hours of their entry into the facility. This equates to 100% of residents admitted to the facility during the last 12 months, for 72 hours or more.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, pages 8 and 9, section G(2) and ODOC OP-030102 entitled Inmate Housing, pages 2 and 3, section II(A)(1) address 115.241(b). It is noted the ODOC Cell Assessment Form (included in this policy and used as a PREA Assessment Tool at Reception Centers, as well as, OROC) clearly reflects the assessment must be completed within 72 hours of Intake.

According to the PCM, the ODOC Cell Assessment Form is used at OROC with respect to ODOC admissions. Housing assignments are effected subsequent to completion of the risk assessment tool.

Additionally, CC APS 030601 entitled Oklahoma PREA, page 5, section III(F)(1)(b) addresses 115.241(b).

The auditor's review of two initial assessments and 30-day reassessments, conducted during 2020 reveals substantial compliance with 115.241(b). CoreCivic policy requires completion of the initial assessment within 24 hours of arrival and the same was comprehensive/timely. The reassessment was likewise comprehensive and timely.

Pursuant to the 115.241(a) narrative, the auditor's on-site review of 10 random resident files reveals timely and comprehensive completion of initial victimization/aggressor screenings within 24 hours of arrival at the facility. Review of 30-day reassessments related to the same residents reveals one was untimely (within three days of the due date), three were completed in a timely manner, five were not yet due in view of the recency of arrival at OROC, and one was untimely in view of COVID 19 quarantine procedures.

Pursuant to the staff who performs screening for risk of victimization and abusiveness interviewee, she screens residents for risk of sexual victimization or risk of sexually abusing others upon arrival at OROC. Generally, the screening occurs within hours of arrival.

Pursuant to the PAQ, the Director self reports risk assessment is conducted using an objective screening instrument.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 9, section G(3) and ODOC OP-030102 entitled Inmate Housing, pages 1 and 3, sections Inmate Housing, II(A)(2), and II(B) address 115.241(c). The latter policy appears to primarily refer to PREA Assessment at an ODOC Reception Center. Another attachment is referenced in this policy (Self Report Form) and the same is considered in making initial placement housing at the Reception Center.

The auditor's review of the PREA Assessment Questionnaire information reveals the same is based on objective criteria.

The auditor's review of the Sexual Abuse Screening Tool reflects substantial compliance with 115.241(d). Specifically, the document reflects the following issues:

- 1) Whether the resident has a mental, physical, or developmental disability;
- 2) The age of the resident;
- 3) The physical build of the resident;
- 4) Whether the resident has previously been incarcerated;
- 5) Whether the resident's criminal history is exclusively nonviolent;
- 6) Whether the resident has prior convictions for sex offenses against an adult or child;
- 7) Whether the resident is or is perceived to be gay, lesbian, bisexual, transgender, intersex, or gender non-conforming;
- 8) Whether the resident has previously experienced sexual victimization; and
- 9) The resident's own perception of vulnerability.

The staff member who performs screening for risk of victimization and abusiveness interviewee self reports the following factors are considered in the sexual victimization/abusiveness screening;

History of sexual victimization in both confinement and community settings, history of incarceration, history of perpetration of sexual abuse in a confinement setting, mental/physical disabilities, resident self-identification or appearance of LGBTI status, and stature.

According to the interviewee who conducts such assessments, a monitor II (security staff) can complete the 115.241(a) screening. The same is conducted in an office (security screening room- has a one-way window wherein observation from the hallway is obscured). The door is closed and the screener reads the questions to the resident, probing and documents responses. The screening is completed in a one-on-one setting.

The auditor notes there are no windows in the case manager offices.

The auditor's review of the Sexual Abuse Screening Tool reveals substantial compliance with 115.241(e). Specifically, the same addresses prior acts of sexual violence, prior convictions for violent offenses, and history of prior institutional violence or sexual abuse.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 9, section G(5) addresses 115.241(e).

Pursuant to the PAQ, the Director self reports the policy requires the facility to 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 Director further self reports during the last 12 months (until the date on which the PAQ was completed), 141 residents entering the facility (either through intake or transfer) were reassessed for their risk of sexual

victimization or of being sexually abusive, within 30 days after their arrival at the facility based upon any additional relevant information received since intake. This represents 100% of residents entering the facility for more than 30 days.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 10, section G(12) and CC APS 030601 entitled Oklahoma PREA, page 6, section III(F)(2)(a) address 115.241(f). ODOC OP-030102 entitled Inmate Housing, page 7, section IV(A)(1)(f) also addresses 115.241(f).

According to the staff who performs screening for risk of victimization and abusiveness interviewee, re-assessments are conducted within 30 days of arrival at OROC by case managers. The target time frame for completion of reassessments is 27-30 days from the date of arrival at OROC. A weekly report is generated by case managers as a tool to monitor reassessment due dates and timeliness.

Six of 17 random resident interviewees report they were asked the questions reflected in the narrative for 115.241(a) above since arrival at OROC. The questions were allegedly asked within 30 days of arrival at the facility.

The auditor's on-site review of seven of 10 random resident files related to residents who assert they were not reassessed reveals one 30-day reassessment was untimely, two reassessments were completed in a timely and complete fashion, and four reassessments were not yet due as the result of the arrival date. Of the remaining three files, one reassessment was timely and complete, one was untimely but complete in view of the aforementioned COVID 19 restrictions, and one reassessment was not yet due.

Pursuant to the PAQ, the Director self reports policy requires 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.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 10, section G(13 and 14) and CC APS 030601 entitled Oklahoma PREA, page 6, section III(F)(2)(b) address 115.241(g). Additionally, ODOC OP-030102 entitled Inmate Housing, page 7, section IV(A)(1)(g) addresses 115.241(g).

According to the PCM, additional sexual abuse or sexual victimization information has not been received regarding residents (since August, 2020) which triggered a re-assessment within the parameters of 115.241(g). Pursuant to the auditor's review of 2019 investigations, he learned one investigation substantiated the resident's allegation of sexual abuse. The incident occurred in July, 2019, within the audit period and when the facility was known as CTC. According to the PCM, the resident was not reassessed following completion of the investigation.

The auditor notes this investigation is the only applicable audit period example he has located. With respect to one other example, the victim was not housed at the facility when the incident(s) occurred, nor was he housed at the facility following completion of the investigation(s). Accordingly, reassessment was not feasible.

Since 115.241(g) requires reassessment following an incident of sexual abuse, the auditor finds OROC non-compliant with 115.241(g). Accordingly, the auditor imposes a 180-day corrective action period, ending on September 22, 2021. To demonstrate compliance with 115.241(g), the PCM will provide training to all stakeholders regarding follow-up reassessments in response to substantiated allegations of sexual abuse. Stakeholders may be interpreted as the assistant director, case manager supervisor, and all case managers. The PCM will provide a copy of the lesson plan, as well as, documentation certifying stakeholders received the requisite training. The documentation will reflect stakeholder name(s), signature(s), and date of training.

One question to be addressed prior to this training is the procedure to be employed in this regard. Who is responsible for identification of resident(s) requiring reassessment pursuant to 115.241(g). For example, is the ad or the case manager supervisor responsible for identification of applicable cases? If so, the same must be incorporated into the lesson plan.

In addition to the above, the PCM will provide a copy of the investigation roster capturing sexual abuse investigations conducted between the dates of this Interim PREA Report and September 22, 2021. The auditor will review the same and identify any substantiated sexual abuse cases. The PCM will subsequently forward to the auditor the reassessment attributed to that investigation. He will subsequently review the same and determine the appropriateness of closure.

July 1, 2021 Update:

The OROC PCM has provided to the auditor a copy of the Training/Activity Attendance Roster bearing the names of nine staff stakeholders in terms of 115.241(g) reassessments. The auditor's review of the lesson plan applicable to procedures to be employed for both ODOC and FBOP reassessment scenarios reveals specific responsibilities are articulated throughout the same to ensure compliance with 115.241(g). Additionally, a highlighted CC Policy 14-2CC hand-out is included in the training packet. The same and the lesson plan are included for attendee reference.

September 1, 2021 Update:

As zero incidents of sexual abuse occurred at OROC between the date of the interim report and this date, the auditor agreed to facilitation of a mock scenario wherein 115.241(g) requirements were addressed. The auditor's review of the mock scenario reveals completion of requisite reassessments (both victim and perpetrator) in a timely and efficient manner pursuant to the scenario.

In view of the above, the auditor now finds OROC compliant with 115.241(g).

The staff responsible for risk screening interviewee relates the case managers reassess within 30 days of arrival. The case manager also facilitates reassessments, as needed, 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.

The interviewee asserts if a resident is abused and departs the facility for a forensic examination (resident is temporarily removed from the count sheet), a new screening is conducted. Investigator(s) may refer an adjudicated case of sexual abuse to the case manager supervisor or respective case manager.

Pursuant to the PAQ, the Director self reports the policy prohibits disciplining residents for refusing to answer (or for not disclosing complete information related to) 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 lesbian, gay, bisexual, transgender, intersex, or gender nonconforming;
Whether or not the resident has previously experienced sexual victimization; or
The resident's own perception of vulnerability.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 9, section G(7) and CC APS 030601 entitled Oklahoma PREA, page 6, section III(F)(3)(a-c) address 115.241(h). Additionally, ODOC OP-030102 entitled Inmate Housing, page 3, section II(A)(3) addresses 115.241(h).

According to the staff member who performs screening for risk of victimization and abusiveness interviewee, residents are not disciplined in any way for refusing to respond to (or for not disclosing complete information related to):

Whether or not the resident has a mental, physical, or developmental disability;
Whether or not the resident is or is perceived to be lesbian, gay, bisexual, transgender, intersex, or gender nonconforming;
Whether or not the resident has previously experienced sexual victimization; and
The resident's own perception of vulnerability.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 9, section G(10)(a-d) and CC APS 030601 entitled Oklahoma PREA, page 6, section III(F)(4) address 115.241(i).

According to the PCM, the agency has outlined who should have access to a resident's risk assessment within the facility in order to protect sensitive information from exploitation. Initial PREA Assessment information is available to the Director, assistant director, case manager supervisor, case managers, os, and all administrative duty officers (ADOs).

The staff member who performs screening for risk of sexual victimization and abusiveness asserts the Director, assistant director, investigator, PCM, and case manager supervisor have access to the 115.241(a) assessments and 115.241(f) and (g) reassessments.

In view of the above, the auditor finds OROC substantially compliant with 115.241.

Standard 115.242: Use of screening information

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.242 (a)

- Does the agency use information from the risk screening required by § 115.241, with the goal of keeping separate those residents at high risk of being sexually victimized from those at high risk of being sexually abusive, to inform: Housing Assignments? X Yes No
- Does the agency use information from the risk screening required by § 115.241, with the goal of keeping separate those residents at high risk of being sexually victimized from those at high risk of being sexually abusive, to inform: Bed assignments? X Yes No
- Does the agency use information from the risk screening required by § 115.241, with the goal of keeping separate those residents at high risk of being sexually victimized from those at high risk of being sexually abusive, to inform: Work Assignments? X Yes No
- Does the agency use information from the risk screening required by § 115.241, with the goal of keeping separate those residents at high risk of being sexually victimized from those at high risk of being sexually abusive, to inform: Education Assignments? X Yes No
- Does the agency use information from the risk screening required by § 115.241, with the goal of keeping separate those residents at high risk of being sexually victimized from those at high risk of being sexually abusive, to inform: Program Assignments? X Yes No

115.242 (b)

- Does the agency make individualized determinations about how to ensure the safety of each resident? X Yes No

115.242 (c)

- When deciding whether to assign a transgender or intersex resident to a facility for male or female residents, does the agency consider on a case-by-case basis whether a placement would ensure the resident's health and safety, and whether a placement would present management or security problems (NOTE: if an agency by policy or practice assigns residents to a male or female facility on the basis of anatomy alone, that agency is not in compliance with this standard)? X Yes No

- When making housing or other program assignments for transgender or intersex residents, does the agency consider on a case-by-case basis whether a placement would ensure the resident's health and safety, and whether a placement would present management or security problems? X Yes No

115.242 (d)

- Are each transgender or intersex resident's own views with respect to his or her own safety given serious consideration when making facility and housing placement decisions and programming assignments? X Yes No

115.242 (e)

- Are transgender and intersex residents given the opportunity to shower separately from other residents? X Yes No

115.242 (f)

- Unless placement is in a dedicated facility, unit, or wing established in connection with a consent decree, legal settlement, or legal judgment for the purpose of protecting lesbian, gay, bisexual, transgender, or intersex residents, does the agency always refrain from placing: lesbian, gay, and bisexual residents in dedicated facilities, units, or wings solely on the basis of such identification or status? (N/A if the agency has a dedicated facility, unit, or wing solely for the placement of LGBT or I residents pursuant to a consent decree, legal settlement, or legal judgement.) X Yes No NA
- Unless placement is in a dedicated facility, unit, or wing established in connection with a consent decree, legal settlement, or legal judgment for the purpose of protecting lesbian, gay, bisexual, transgender, or intersex residents, does the agency always refrain from placing: transgender residents in dedicated facilities, units, or wings solely on the basis of such identification or status? (N/A if the agency has a dedicated facility, unit, or wing solely for the placement of LGBT or I residents pursuant to a consent decree, legal settlement, or legal judgement.) X Yes No NA
- Unless placement is in a dedicated facility, unit, or wing established in connection with a consent decree, legal settlement, or legal judgment for the purpose of protecting lesbian, gay, bisexual, transgender, or intersex residents, does the agency always refrain from placing: intersex residents in dedicated facilities, units, or wings solely on the basis of such identification or status? (N/A if the agency has a dedicated facility, unit, or wing solely for the placement of LGBT or I residents pursuant to a consent decree, legal settlement, or legal judgement.) X Yes No NA

Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- X **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

Pursuant to the PAQ, the Director self reports the facility uses information from the risk screening 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.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 11, section I(1) and ODOC OP 030601 entitled Oklahoma PREA, pages 16 and 17, section VII(B)(1)(a-g) address 115.242(a-g).

According to the PCM, the agency uses information gleaned from the risk screening during intake to keep residents safe from being sexually victimized or sexually abusive. This information is used primarily with housing decisions as the facility is open in terms of structure, etc. Potential and known victims (PVs/KVs) are separated from potential and known abusers (PAs/KAs). Residents classified as Unrestricted (Us) may be placed with PVs/KVs or PAs/KAs. In regard to work assignments, victims and aggressors are not routinely assigned to the same worksite.

Each KV/PV and KA/PA is keyed into a grid reflecting the aforementioned designations. This alerts staff assigning room/bed placements to ensure the same are specific to resident sexual safety.

According to the staff who performs screening for risk of victimization and abusiveness interviewee, PVs/KVs are physically separated (housing only) from PAs/KAs in terms of housing. Residents may be placed in areas/rooms closer to surveillance and staff. Programming activities are supervised by staff and work assignments are generally off-site.

The electronic resident tracking system automatically assigns the above designations to specific bunks, generally spread throughout the facility. Upper level staff generally provide input with PV/KV and PA/KA placements while Us can be placed by the screeners.

The auditor's review of an OROC PREA Bed Assignments schematic (dated December 3, 2020) reveals consistency in terms of geographic separation (by room and area) of KVs/PVs and KAs/PAs. Additionally, the auditor's review of one initial victimization/abuser assessment (potential victim), compared against the above document, reveals the individual is housed pursuant to 115.242(a).

Pursuant to the PAQ, the Director self reports the facility makes individualized determinations about how to ensure the safety of each resident.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 11, section I(3) and ODOC OP 030601 entitled Oklahoma PREA, page 16, section VII(B)(1)(a) address 115.242(b).

Pursuant to the PAQ, the Director self reports the facility makes housing and program assignments for transgender or intersex residents in the facility on a case-by-case basis.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 12, section I(7)(b) and ODOC OP 140147 entitled Management of Gender Nonconforming Inmates, pages 1-3, sections I(A) through IV(A) address 115.242(c).

The PCM asserts all incoming residents are placed in a sexually safe situation based on screening results. There are no designated location(s) for transgender/intersex resident housing.

The agency does consider whether the placement will ensure the resident's health and safety. Similarly, the agency does consider whether the placement would present management or security concerns.

The PCM asserts zero transgender/intersex residents were housed at OROC during the on-site audit. Accordingly, such interview(s) could not be conducted.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 12, section I(7)(c) and ODOC OP 030601 entitled Oklahoma PREA, page 17, section VII(B)(1)(e) address 115.242(d).

The PCM asserts the transgender/intersex resident's own views with respect to his/her own safety are given serious consideration in placement and programming assignments. The staff member who conducts screening for risk of victimization and abusiveness interviewee confirms the PCM's statement in this regard.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 14, section J(10)(h)(i-iii) and ODOC OP 030601 entitled Oklahoma PREA, page 17, section VII(B)(1)(e) address 115.242(e).

According to the PCM, transgender and intersex residents are given the opportunity to shower separately from other residents. Procedurally, the resident requests the same, in writing, from the PCM or above. Showers may then approved to be conducted at a specific time (e.g. during count) and subsequent to staff clearing the shower area of other residents. With respect to FBOP residents, requested showers pursuant to 115.242(e) are handled in much the same manner with staff intensifying rounds during the established shower time.

Of note, the staff responsible for risk screening interviewee asserts transgender and intersex residents are given the opportunity to shower separately from other residents however, she was unaware of the mechanics of the process.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 12, section I(7)(d) and ODOC OP 030601 entitled Oklahoma PREA, page 17, section VII(B)(1)(h) address 115.242(f).

The PCM asserts the facility is not subject to a consent decree, legal settlement, or legal judgment requiring that it establish a dedicated facility, unit, or wing for LGBTI residents. The PCM further asserts the screening dictates room assignments. Bed and room assignments are made based on room/bed availability and screening results.

Monitoring the housing grid for both the ODOC and FBOP areas/rooms serves to preclude 115.242(f) deviations.

The auditor's cursory review of room/bed assignments reveals no deviation from standard.

In view of the above, the auditor finds OROC substantially compliant with 115.242.

REPORTING

Standard 115.251: Resident reporting

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.251 (a)

- Does the agency provide multiple internal ways for residents to privately report: Sexual abuse and sexual harassment? Yes No
- Does the agency provide multiple internal ways for residents to privately report: Retaliation by other residents or staff for reporting sexual abuse and sexual harassment? Yes No
- Does the agency provide multiple internal ways for residents to privately report: Staff neglect or violation of responsibilities that may have contributed to such incidents? Yes No

115.251 (b)

- Does the agency also provide at least one way for residents to report sexual abuse or sexual harassment to a public or private entity or office that is not part of the agency? Yes No
- Is that private entity or office able to receive and immediately forward resident reports of sexual abuse and sexual harassment to agency officials? Yes No
- Does that private entity or office allow the resident to remain anonymous upon request? Yes No

115.251 (c)

- Do staff members accept reports of sexual abuse and sexual harassment made verbally, in writing, anonymously, and from third parties? Yes No
- Do staff members promptly document any verbal reports of sexual abuse and sexual harassment? Yes No

115.251 (d)

- Does the agency provide a method for staff to privately report sexual abuse and sexual harassment of residents? Yes No

Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

Pursuant to the PAQ, the Director self reports 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.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 14, section K(1)(a and b)(i-iii) and ODOC OP-030601 entitled PREA, page 15, section B(5) address 115.51(a). Additionally, CC APS OP 030601 entitled Oklahoma PREA, page 8, section J(1)(a)(i-v) addresses 115.251(a).

The auditor's review of the Oklahoma PREA Zero Tolerance Acknowledgments for Inmates form (signed and dated by the resident), the ODOC Inmate's Guide to Sexual Misconduct tri-fold, and CoreCivic PREA- Prevent. Detect. Respond. pamphlet reveals multiple methods for private resident reporting of sexual abuse and sexual harassment incidents. The CoreCivic PREA- Prevent. Detect. Respond. tri-fold is available in Spanish.

The PCM asserts 1-855-871-4139 activates the ODOC PREA Hotline. The Hotline is toll free and the same is not monitored. Residents do not enter a pin number when making such calls.

The PCM further asserts the National Sexual Assault Telephone Hotline is the outside reporting source for FBOP residents. Such telephone calls are handled in the same manner as those received from a member of the general public. Staff can likewise contact OCPD to report sexual abuse/harassment of a resident.

FBOP residents have access to a single resident telephone however, they may also may have a cellular telephone in their possession. Accordingly, FBOP residents may use either option to report sexual abuse/harassment. The auditor notes the resident is able to report sexual abuse/harassment free of charge, the telephone is adequately secure, and the same is not monitored. Residents can also place telephone calls to family, friends, employers, etc. on this telephone.

A discussion regarding 115.251(b) non-compliance (as applied to the National Sexual Assault Telephone Hotline) ensues in the following narrative for 115.215(b).

All 12 random staff interviewees are able to cite at least two methods available to residents for reporting sexual abuse/harassment, retaliation by other residents/staff for reporting sexual abuse/harassment, or staff neglect/violation of responsibilities that may have contributed to an incident of sexual abuse/harassment. Methods of reporting include the Hotline (ODOC OIG Hotline), contact the National Sexual Assault Telephone Hotline to report, submission of letter, verbal report to staff, Ethics Hotline, submit an Emergency Grievance, and an anonymous report, and submission of a third party report.

All 17 random resident interviewees are able to cite at least two methods available to them to report. Options include talking to staff, dialing the Hotline (ODOC OIG for ODOC residents and the RAINN National Sexual Assault Telephone Hotline for FBOP residents), submit a kite to staff, submit a written report, contact OCPD, third-party, and report to family.

As previously addressed in the narrative for 115.233, posters (regarding procedures for reporting sexual abuse/harassment of residents) are available throughout the facility.

Pursuant to the PAQ, the Director self reports the agency provides at least one way for residents to report sexual abuse or sexual harassment to a public or private entity or office that is not part of the agency.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 15, section K(1)(c) and ODOC OP-030601 entitled PREA, page 15, section B(5) address 115.51(b). Additionally, CC APS OP 030601 entitled Oklahoma PREA, page 8, section J(1)(a)(i) addresses 115.251(b).

The auditor notes the Office of the Inspector General's three digit telephone number is listed on the Oklahoma PREA Zero Tolerance Acknowledgment for Inmates form. The same is signed and dated by the resident and the relevant 1-855 telephone number (as previously mentioned) is etched onto a placard mounted on the wall near the resident telephones. The auditor finds no issues related to the literal language of 115.251(b) as applied to the ODOC procedure.

With respect to FBOP residents, the auditor's review of the FBOP resident Handbook reveals those residents are instructed to contact the National Sexual Assault Telephone Hotline to facilitate 115.251(b) sexual abuse/harassment reports. Pursuant to the auditor's review of the RAINN National Sexual Assault Telephone Hotline and follow-up interviews with representatives from that agency and Just Detention International (JDI), the auditor has learned that resident reports of sexual abuse/harassment allegations would not be immediately forwarded to agency officials for follow-up in accordance with 115.251(b). Accordingly, the auditor finds OROC non-compliant with 115.251(a) and (b) as applied to FBOP residents.

In view of the above, the auditor is placing OROC in corrective action status for a 180-day period, concluding on or about September 22, 2021. To demonstrate compliance, the PCM must develop a procedure wherein all tenets of 115.251(b) are met. The auditor recommends that the PCM contact OCPD and engage in an MOU with that agency to fulfill all 115.251(b) requirements. OCPD is external to OROC, provides 24/7 coverage to the public, and should have the ability to forward the report to the Director or designee in such a manner as to protect resident anonymity should he/she desire. If this option is pursued and reduced to writing, the PCM will forward a copy of the MOU to the auditor for review. Of course, CC Corporate staff should be consulted with respect to development and implementation of this MOU.

Once the MOU process is complete, the PCM will provide the auditor with the revised Resident Handbook provision(s) and the revised FBOP PREA Zero Tolerance Acknowledgment for Inmates. Additionally, the PCM will provide the auditor with evidence validating that all staff stakeholders were provided relevant training regarding the nuances of the aforementioned revisions. Finally, the PCM will provide the auditor with a roster of residents received at OROC since completion of the amended documents and he will randomly select names for which the PCM will provide evidence of receipt of the amended documents. Additionally, the PCM will provide to the auditor any Orientation lesson plan changes surrounding the aforementioned revisions.

July 1, 2021 Update:

The auditor's review of the CC PREA Acknowledgement Zero Tolerance Acknowledgements for Offenders document reveals the telephone number for the National Sexual Assault Telephone Hotline has been deleted. The OROC PCM asserts the amended form is now provided to all FBOP residents and the same is posted on bulletin boards. Additionally, FBOP resident PREA posters, available on bulletin boards in each resident room and common areas, substantiates the PCM's assertion. The auditor's review of photographs of BOP resident room bulletin boards and common areas validates the above.

The auditor's review of the lesson plan relative to 115.251(b) training reveals substantial compliance. Attendees at this training are captured in the July 1, 2021 Update narrative for 115.241(g).

August 1, 2021 Update:

The auditor has been provided a copy of an email from OCPD regarding the amended MOU wherein they will facilitate 115.51(b) responsibilities. The email is dated August 19, 2021 and is authored by the Police Legal Advisor, OCPD. In the email, the author asserts that the document is in the review process and no issues have been discovered thus far.

While the revised MOU is a timely work in progress with OCPD, the auditor has reasonable assurance (based on the above) that the same will be signed. The auditor's review of the amended MOU reveals substantial compliance with 115.51(b). Once the same is signed, the PCM will provide a copy of the same to the auditor.

In view of the above, the auditor is reasonably assured FBOP residents are educated regarding established 115.251(b) reporting option available to them. The Resident Handbook has been updated and has been approved by appropriate FBOP officials.

Accordingly, the auditor now finds OROC substantially compliant with 115.251(b).

As previously addressed, the PCM asserts the ODOC OIG Hotline serves as one way for ODOC residents to report sexual abuse/harassment to a public or private entity or office that is not part of the agency. Operators are ODOC employees. The PCM asserts the Director or administrative duty officer (ADO) are quickly notified by ODOC OIG of the allegation within hours either by telephone or e-mail, excluding weekends and holidays. This service is offered pursuant to ODOC contract.

With respect to FBOP resident reporting pursuant to 115.251(b) requirements, the same is currently made to the RAINN National Sexual Abuse Telephone Hotline. A discussion regarding the same is provided above.

All 17 random resident interviewees assert they are allowed to make a report without having to give their name.

Pursuant to the PAQ, the Director self reports 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. The Director further self reports staff are required to document verbal reports. The time frame in which staff are required to document such verbal reports is "immediately".

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 15, section K(2)(b) and ODOC OP-030601 entitled PREA, page 19, section X(A)(3) address 115.51(c). Additionally, CC APS OP 030601 entitled Oklahoma PREA, page 9, section J(2) addresses 115.251(c).

All 12 random staff interviewees assert when a resident alleges sexual abuse, he/she can do so verbally, in writing, anonymously, and from third parties. Eleven of 12 interviewees assert they immediately document any verbal reports of sexual abuse/harassment received from residents.

All 17 random resident interviewees assert reports of sexual abuse/harassment can be made both in person and in writing. Furthermore, 12 of 17 interviewees assert a friend or relative can make the report for the resident without giving his/her name.

Pursuant to the PAQ, the Director self reports the agency has established procedures for staff to privately report sexual abuse and sexual harassment of residents. Pursuant to ODOC policy, staff may report resident sexual abuse/harassment via the OIG PREA Hotline. The auditor's review of the CC website reveals staff reporting information. The same can generally be accomplished through reporting to the Ethics and Compliance Hotline. Staff are alerted to reporting procedures pursuant to Pre-Service and In-Service training.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 16, section K(2)(f) and ODOC OP-030601 entitled PREA, page 19, section X(A)(3) address 115.251(d). Additionally, CC APS OP 030601 entitled Oklahoma PREA, page 9, section J(2)(d) addresses 115.251(d).

One staff-related poster was observed during the facility tour regarding The Ethics Line. The Ethics Line is specifically referenced in the above policy as a resource for private staff reporting in accordance with 115.251(d).

All 12 random staff interviewees are able to cite at least one method of privately reporting sexual abuse/harassment of residents. Methods cited are placement of a telephone call or e-mail to a supervisor/Director/ad/os, closed door meeting, report to Director/ad/PCM via their cell phone during non-regular business hours, Ethics Hotline, resident Hotlines, or submit a written report.

In view of the above, the auditor finds OROC substantially compliant with 115.251.

Standard 115.252: Exhaustion of administrative remedies

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.252 (a)

- Is the agency exempt from this standard? NOTE: The agency is exempt ONLY if it does not have administrative procedures to address resident grievances regarding sexual abuse. This does not mean the agency is exempt simply because a resident does not have to or is not ordinarily expected to submit a grievance to report sexual abuse. This means that as a matter of explicit policy, the agency does not have an administrative remedies process to address sexual abuse. X Yes No

115.252 (b)

- Does the agency permit residents to submit a grievance regarding an allegation of sexual abuse without any type of time limits? (The agency may apply otherwise-applicable time limits to any portion of a grievance that does not allege an incident of sexual abuse.) (N/A if agency is exempt from this standard.) X Yes No NA
- Does the agency always refrain from requiring a resident to use any informal grievance process, or to otherwise attempt to resolve with staff, an alleged incident of sexual abuse? (N/A if agency is exempt from this standard.) X Yes No NA

115.252 (c)

- Does the agency ensure that: A resident who alleges sexual abuse may submit a grievance without submitting it to a staff member who is the subject of the complaint? (N/A if agency is exempt from this standard.) X Yes No NA
- Does the agency ensure that: Such grievance is not referred to a staff member who is the subject of the complaint? (N/A if agency is exempt from this standard.) X Yes No NA

115.252 (d)

- Does the agency issue a final agency decision on the merits of any portion of a grievance alleging sexual abuse within 90 days of the initial filing of the grievance? (Computation of the 90-day time period does not include time consumed by residents in preparing any administrative appeal.) (N/A if agency is exempt from this standard.) X Yes No NA
- If the agency determines that the 90-day timeframe is insufficient to make an appropriate decision and claims an extension of time (the maximum allowable extension of time to respond is 70 days per 115.252(d)(3)) , does the agency notify the resident in writing of any such extension and provide a date by which a decision will be made? (N/A if agency is exempt from this standard.) X Yes No NA
- At any level of the administrative process, including the final level, if the resident does not receive a response within the time allotted for reply, including any properly noticed extension, may a resident consider the absence of a response to be a denial at that level? (N/A if agency is exempt from this standard.) X Yes No NA

115.252 (e)

- Are third parties, including fellow residents, staff members, family members, attorneys, and outside advocates, permitted to assist residents in filing requests for administrative remedies relating to allegations of sexual abuse? (N/A if agency is exempt from this standard.) X Yes No NA

- Are those third parties also permitted to file such requests on behalf of residents? (If a third-party files such a request on behalf of a resident, the facility may require as a condition of processing the request that the alleged victim agree to have the request filed on his or her behalf, and may also require the alleged victim to personally pursue any subsequent steps in the administrative remedy process.) (N/A if agency is exempt from this standard.) X Yes No NA
- If the resident declines to have the request processed on his or her behalf, does the agency document the resident's decision? (N/A if agency is exempt from this standard.) X Yes No NA

115.252 (f)

- Has the agency established procedures for the filing of an emergency grievance alleging that a resident is subject to a substantial risk of imminent sexual abuse? (N/A if agency is exempt from this standard.) X Yes No NA
- After receiving an emergency grievance alleging a resident is subject to a substantial risk of imminent sexual abuse, does the agency immediately forward the grievance (or any portion thereof that alleges the substantial risk of imminent sexual abuse) to a level of review at which immediate corrective action may be taken? (N/A if agency is exempt from this standard.) X Yes No NA
- After receiving an emergency grievance described above, does the agency provide an initial response within 48 hours? (N/A if agency is exempt from this standard.) X Yes No NA
- After receiving an emergency grievance described above, does the agency issue a final agency decision within 5 calendar days? (N/A if agency is exempt from this standard.) X Yes No NA
- Does the initial response and final agency decision document the agency's determination whether the resident is in substantial risk of imminent sexual abuse? (N/A if agency is exempt from this standard.) X Yes No NA
- Does the initial response document the agency's action(s) taken in response to the emergency grievance? (N/A if agency is exempt from this standard.) X Yes No NA
- Does the agency's final decision document the agency's action(s) taken in response to the emergency grievance? (N/A if agency is exempt from this standard.) X Yes No NA

115.252 (g)

- If the agency disciplines a resident for filing a grievance related to alleged sexual abuse, does it do so ONLY where the agency demonstrates that the resident filed the grievance in bad faith? (N/A if agency is exempt from this standard.) X Yes No NA

Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- X **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

Pursuant to the PAQ, the Director self reports the agency does utilize the ODOC grievance procedure to address grievances regarding sexual abuse reported by ODOC residents. ODOC resident grievances are filed as Emergency or Sensitive grievances pursuant to this policy. Such grievances are filed directly to the reviewing authority (defined as the Director), without an informal resolution process. No time limit is applied to any part of the grievance that deals with sexual abuse and the grievance may be filed at any time, regardless of the time the incident occurred.

Pursuant to CC Policy 14-2 CC entitled Sexual Abuse, page 15, section K(1)(d)(i and ii), CoreCivic facilities do not maintain administrative procedures to address resident grievances regarding sexual abuse, unless specifically mandated by contract. Allegations of sexual abuse and/or sexual harassment are not processed through the facility resident grievance process.

Should a report of sexual abuse or sexual harassment be submitted and received as a resident grievance, whether inadvertently or due to contracting agency requirements, it will immediately be referred to the designated facility investigator or facility Director for investigation and reporting in accordance with this policy. This protocol pertains to FBOP residents.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 15, section K(1)(d)(i and ii) and ODOC OP-090124 entitled Inmate/Offender Grievance Process, page 15, section VIII(A) address 115.252(a).

The Director relates there has been no residents, within the audit period, who filed or attempted to file a PREA-related issue pursuant to the grievance policies.

Pursuant to the PAQ, the Director self reports agency policy or procedure 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. The Director further self reports agency 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.

ODOC OP-090124 entitled Inmate/Offender Grievance Process, page 15, section VIII (A) and (B) addresses 115.252(b).

The PCM asserts grievance is addressed in the OROC Booklet and the same is posted on the dormitory bulletin boards. ODOC OP-090124 entitled Inmate/Offender Grievance Process, pages 15, 17, and 18 is also posted on the D Unit bulletin boards.

Pursuant to the PAQ, the Director self reports agency policy and procedure allows a resident to submit a grievance alleging sexual abuse without submitting it to the staff member who is the subject of the complaint. Agency policy and procedure requires that a resident grievance alleging sexual abuse not be referred to the staff member who is the subject of the complaint.

ODOC OP-090124 entitled Inmate/Offender Grievance Process, page 17, section VIII(A)(4) addresses 115.252(c). This provision specifies residents forward their grievance(s) directly to the reviewing authority as described in the narrative for 115.252(a) and if the complaint involves the reviewing authority, the resident may bring the grievance to the administrative review authority (ARA).

Pursuant to the PAQ, the Director self reports agency policy and procedure requires that a decision on the merits of any grievance or portion of a grievance alleging sexual abuse be made within 90 days of the filing of the grievance. The Director self reports zero grievances were filed within the last 12 months wherein sexual abuse was alleged. The Director further self reports the agency notifies the resident, in writing, when the agency files for an extension, including notice of the date by which a decision will be made.

ODOC OP-090124 entitled Inmate/Offender Grievance Process, page 17, section VII(B) addresses 115.252(d). This policy applies to ODOC residents only.

The auditor notes the time frames for grievance resolution are more stringent than those required by 115.252(d). Specifically, a decision must be made as to whether the grievance meets the criteria for an

emergency or sensitive complaint. If determined to be emergency or sensitive, a response is completed within 48 hours of receipt of the grievance, excluding weekends and holidays. The resident may appeal that response and the ARA, in turn, provides an expedited response within 72 hours of receipt of the grievance, excluding weekends and holidays.

The PCM asserts zero current residents (at the time of the on-site audit) have alleged sexual abuse at OROC and accordingly, such interview(s) of affected resident(s) could not be facilitated. The auditor validated the same pursuant to review of the seven 2019 and 2020 sexual abuse/harassment investigations.

Pursuant to the PAQ, the Director self reports 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 to file such requests on behalf of residents. The Director further self reports agency policy and procedure requires that if the resident declines to have third-party assistance in filing a grievance alleging sexual abuse, the agency documents the inmate's decision to decline. Zero grievances alleging sexual abuse were filed by residents during the last 12 months in which the resident declined third-party assistance, ensuring documentation of the resident's decision to decline.

ODOC OP-090124 entitled Inmate/Offender Grievance Process, pages 17 and 18, section VIII(C)(1-3) addresses 115.252(e).

Pursuant to the PAQ, the Director self reports the agency 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. The Director further self reports the agency policy and procedure for emergency grievances alleging substantial risk of imminent sexual abuse requires an initial response within 48 hours. Zero emergency grievances alleging substantial risk of imminent sexual abuse were reportedly filed within the last 12 months. Agency policy and procedure for emergency grievances alleging substantial risk of imminent sexual abuse requires that a final agency decision be issued within five days.

The policy citation reflected in the narrative for 115.252(d) is also applicable to 115.252(f). Additionally, the explanation of response time frames is applicable to 115.252(f).

Pursuant to the PAQ, the Director self reports the agency has a written policy that limits its 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. The Director further self reports that, during the last 12 months, there were zero instances of resident discipline for incidents of this nature.

ODOC OP-090124 entitled Inmate/Offender Grievance Process, page 18, section X(A)(1)(a-e) addresses 115.252(g).

In view of the above, the auditor finds OROC substantially compliant with 115.252.

Standard 115.253: Resident access to outside confidential support services

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.253 (a)

- Does the facility provide residents with access to outside victim advocates for emotional support services related to sexual abuse by giving residents mailing addresses and telephone numbers, including toll-free hotline numbers where available, of local, State, or national victim advocacy or rape crisis organizations? X Yes No
- Does the facility enable reasonable communication between residents and these organizations and agencies, in as confidential a manner as possible? X Yes No

115.253 (b)

- Does the facility inform residents, prior to giving them access, of the extent to which such communications will be monitored and the extent to which reports of abuse will be forwarded to authorities in accordance with mandatory reporting laws? X Yes No

115.253 (c)

- Does the agency maintain or attempt to enter into memoranda of understanding or other agreements with community service providers that are able to provide residents with confidential emotional support services related to sexual abuse? X Yes No
- Does the agency maintain copies of agreements or documentation showing attempts to enter into such agreements? X Yes No

Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- X **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

Pursuant to the PAQ, the Director self reports the facility provides residents with access to outside victim advocates for emotional support services related to sexual abuse by:

Giving residents mailing addresses and telephone numbers (including toll-free hotline numbers where available) for local, state, or national victim advocacy or rape crisis organizations; and
Enabling reasonable communication between residents and these organizations in as confidential manner as possible.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 8, section F(3 and 4) and ODOC OP-030601 entitled PREA, page 24, section D address 115.253(a). Additionally, CC APS OP 030601 entitled Oklahoma PREA, page 12, section L(2) addresses 115.253(a).

The auditor's review of the CC PREA: Prevent. Detect. Respond. tri-fold brochure reveals partial compliance with 115.253. Limitations of confidentiality and mandatory reporting are clearly captured in the same [115/253(b)] and the brochure is provided to all incoming residents.

The auditor's review of the YWCA Oklahoma City Domestic Violence, Sexual Assault and Stalking Services tri-fold brochure provides the telephone number and address for that agency. During the facility tour, the auditor did not find any evidence of document posting on the FBOP resident bulletin board(s) and additionally, the PCM asserts the same is not provided to incoming FBOP residents at intake. The auditor did note the YWCA Oklahoma City tri-fold brochure is posted in ODOC resident dormitories. Accordingly, there is no evidence validating that 115.253(a) information is provided to FBOP residents.

In view of the above, the auditor finds OROC non-compliant with 115.253(a) as applied to FBOP residents. Accordingly, the auditor is imposing a 180-day corrective action period wherein OROC will demonstrate institutionalization of 115.253(a) requirements. Corrective action must be concluded on or before September 22, 2021.

Pursuant to conversation with the PCM, the auditor has been assured that going forward, this tri-fold brochure will be provided to FBOP residents at intake. To ensure all stakeholders (e.g. monitors, intake staff and case managers) are aware of this requirement, the PCM will provide instruction regarding dissemination of the brochure and evidence of receipt of the same (e.g. in-person, email with evidence of recipients, or a memorandum signed by all recipients). A copy of the subject-matter presented will also be provided to the auditor. Upon receipt of the same, the auditor will assess whether closure of the standard is appropriate.

July 1, 2021 Update:

The auditor's review of corrective action relative to 115.253(a) reveals partial compliance with 115.253(a). The PCM self reports that the YWCA Oklahoma City Domestic Violence, Sexual Assault and Stalking Services tri-fold brochure is now provided to incoming FBOP residents. A receipt for the above trifold, as well as, the CC trifold as previously mentioned has been developed and is now in use. Additionally, the YWCA Oklahoma City Domestic Violence, Sexual Assault and Stalking Services tri-fold has been placed on each FBOP room bulletin board. The auditor has validated the same pursuant to review of photographs provided.

The auditor's review of a training lesson plan relative to the above reveals substantial compliance with 115.253(a). Training attendees are referenced in the narrative for 115.241(g).

The auditor finds corrective action is complete with respect to 115.253(a) and accordingly, OROC is substantially compliant with 115.253.

The PCM asserts an informative tri-fold brochure from YWCA Oklahoma City is available to residents pursuant to posting on a bulletin board. During the on-site audit, the auditor validated the same in terms of the ODOC housing units (see preceding paragraphs). Accordingly, ODOC residents have substantial access to information provided in the same.

The auditor notes the telephone number for the YWCA Oklahoma City is also contained within the OROC Resident Booklet on page 8 of the same.

Sixteen of the 17 random resident interviewees were aware of services available outside of the facility for dealing with sexual abuse, if needed. Eight of 17 interviewees assert that counseling and YWCA Oklahoma City victim advocates (VAs) are available to provide services. Six of 17 interviewees assert they have been apprised of the name(s)/addresses/ and telephone numbers applicable to such services. Some interviewees assert the telephone number is posted on a placard near the resident telephones (ODOC Unit). Six interviewees assert they are aware such calls are free and confidential. Sixteen interviewees assert they can make contact with staff from such agency(ies) at any time.

As previously indicated, zero residents who reported a sexual abuse were confined at OROC at the time of the on-site audit.

Pursuant to the PAQ, the Director self reports the facility informs residents, prior to giving them access to outside support services, of the extent to which such communications will be monitored. The Director further self reports 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.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 8, section F(5)(a and b) addresses 115.253(a). Additionally, CC APS OP 030601 entitled Oklahoma PREA, page 12, section L(3) addresses 115.253(a).

The auditor's review of the CoreCivic PREA- Prevent. Detect. Respond. tri-fold brochure reveals compliance with 115.253(b). The same is provided to all OROC residents.

All 17 random resident interviewees assert they believe their dialogue with people from these services remains private. Of these interviewees however, seven assert the conversations could be told to or listened to by someone else. The reasons for such sharing of information are based upon follow-up regarding criminal activity, reports of self injurious behavior, or reports of community child abuse.

Pursuant to the PAQ, the Director self reports the facility maintains memoranda of understanding (MOUs) or other agreements with community service providers that are able to provide residents with emotional support services related to sexual abuse. The Director further self reports the facility maintains copies of the agreement.

The auditor's review of the MOU with YWCA Oklahoma City reveals the same is commensurate with 115.253(c).

In view of the above, the auditor finds OROC substantially compliant with 115.253.

Standard 115.254: Third-party reporting

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.254 (a)

- Has the agency established a method to receive third-party reports of sexual abuse and sexual harassment? X Yes No

- Has the agency distributed publicly information on how to report sexual abuse and sexual harassment on behalf of a resident? X Yes No

Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- X **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

Pursuant to the PAQ, the Director self reports the facility provides a method to receive third-party reports of resident sexual abuse or sexual harassment. The CC website provides information regarding third-person reporting options.

According to the Director, PREA posters are posted throughout the facility addressing reporting via the ODOC OIG and OCPD. The auditor did observe a poster bearing a notification telephone number as he entered the facility lobby.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 16, section K(2)(f and g) and ODOC OP-030601 entitled PREA, page 19, section X(A)(3) address 115.254(a). Additionally, CC APS OP 030601 entitled Oklahoma PREA, page 9, section J(4) addresses 115.254(a).

The auditor's review of Page 8 of the OROC Resident Handbook reveals the telephone number(s) for reporting of sexual abuse/harassment allegations, specifically referencing third-party reporters. Additionally, the previously referenced Oklahoma and CC PREA Zero Tolerance Acknowledgments for Inmates (FBOP) form references third-party reporting methods. Residents are at liberty to share this information with family and friends.

In view of the above, the auditor finds OROC substantially compliant with 115.254.

OFFICIAL RESPONSE FOLLOWING A RESIDENT REPORT

Standard 115.261: Staff and agency reporting duties

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.261 (a)

- Does the agency require all staff to report immediately and according to agency policy any knowledge, suspicion, or information regarding an incident of sexual abuse or sexual harassment that occurred in a facility, whether or not it is part of the agency? Yes No
- Does the agency require all staff to report immediately and according to agency policy any knowledge, suspicion, or information regarding retaliation against residents or staff who reported an incident of sexual abuse or sexual harassment? Yes No
- Does the agency require all staff to report immediately and according to agency policy any knowledge, suspicion, or information regarding any staff neglect or violation of responsibilities that may have contributed to an incident of sexual abuse or sexual harassment or retaliation? Yes No

115.261 (b)

- Apart from reporting to designated supervisors or officials, do staff always refrain from revealing any information related to a sexual abuse report to anyone other than to the extent necessary, as specified in agency policy, to make treatment, investigation, and other security and management decisions? Yes No

115.261 (c)

- Unless otherwise precluded by Federal, State, or local law, are medical and mental health practitioners required to report sexual abuse pursuant to paragraph (a) of this section? Yes No
- Are medical and mental health practitioners required to inform residents of the practitioner's duty to report, and the limitations of confidentiality, at the initiation of services? Yes No

115.261 (d)

- If the alleged victim is under the age of 18 or considered a vulnerable adult under a State or local vulnerable persons statute, does the agency report the allegation to the designated State or local services agency under applicable mandatory reporting laws? Yes No

115.261 (e)

- Does the facility report all allegations of sexual abuse and sexual harassment, including third-party and anonymous reports, to the facility's designated investigators? Yes No

Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

Pursuant to the PAQ, the Director self reports the agency 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;
Any retaliation against residents or staff who reported such an incident; and
Any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation.

CC Policy 14-2 CC entitled CC Sexual Abuse Prevention and Response, page 15, section K(2)(a), PCN 14-2(01), and ODOC OP-030601 entitled PREA, page 19, section X(A)(1-3) address 115.261(a). Additionally, CC APS OP 030601 entitled Oklahoma PREA, page 9, section J(2)(a)(i-iii) addresses 115.261(a).

All 12 random staff interviewees assert the agency requires all staff to report any knowledge, suspicion, or information regarding any incident of sexual abuse or sexual harassment that occurred in a facility; retaliation against residents or staff who reported such an incident; and any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation. All interviewees assert policy requires immediate reporting to either their immediate supervisor, the Director, assistant director, PCM, os, ADO, or the highest ranking supervisor on-site. Of note, such allegations are not reported to any of the aforementioned supervisors if the resident names them as the perpetrator.

Pursuant to the PAQ, the Director self reports apart from reporting to designated supervisors or officials and designated state or local service 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.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 15, section K(2)(d) and ODOC OP-030601 entitled PREA, page 10, section IV(A)(3) address 115.261(b). Additionally, CC APS OP 030601 entitled Oklahoma PREA, page 9, section J(2)(c) addresses 115.261(b).

Of note, the auditor's review of investigations reveals no deviation from either standard or relevant policies.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 16, section K(2)(e) and ODOC OP-030601 entitled PREA, page 11, section IV(C)(2) address 115.261(c). Additionally, CC APS OP 030601 entitled Oklahoma PREA, page 9, section J(2)(e) addresses 115.261(c).

As noted in the narrative for 115.235, medical and mental health providers are not employed at OROC. Accordingly, such interviews were not facilitated.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 16, section K(2)(h) and ODOC OP-030601 entitled PREA, page 10, section IV(A)(5) address 115.261(d).

According to the Director and PCM, no residents under the age of 18 are housed at OROC. With respect to a vulnerable adult being subjected to sexual abuse or sexual harassment, an investigation would be immediately initiated, as is the case with any allegation, and notification to ODOC and the FBOP monitors would result in notification(s) to any relevant state or federal agencies.

The auditor has not been provided any information relative to allegation(s) received from vulnerable adults, nor has he discovered any such allegations pursuant to random and specialized staff or resident interviews.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 16, section K(2)(i) and ODOC OP-030601 entitled PREA, page 19, section X(A)(3) address 115.261(e).

The Director asserts all allegations of sexual abuse and sexual harassment, including those from third-party and anonymous sources, are reported directly to the designated facility investigator. The Director asserts staff generally contact the PCM during the day shift and the ad during evening hours. Of note, the PCM and ad are trained sexual abuse/harassment investigator(s).

In view of the above, the auditor finds OROC substantially compliant with 115.261.

Standard 115.262: Agency protection duties

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.262 (a)

- When the agency learns that a resident is subject to a substantial risk of imminent sexual abuse, does it take immediate action to protect the resident? X Yes No

Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- X **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

Pursuant to the PAQ, the Director self reports when the agency or facility learns that a resident is subject to a substantial risk of imminent sexual abuse, it takes immediate action to protect the resident (e.g., it takes some action to assess and implement appropriate protective measures without unreasonable delay). The Director further self reports in the last 12 months, there were zero times the facility determined a resident was subject to substantial risk of imminent sexual abuse.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 17, section M(1) and ODOC OP-030601 entitled PREA, page 5, section II address 115.262(a). Additionally, CC APS OP 030601 entitled Oklahoma PREA, page 9, section J(2)(c) addresses 115.262(a).

The auditor's review of the CC PREA Overview Facilitator Guide reveals removal of the resident victim from the danger zone is paramount to assurance of the potential victim's safety.

The Agency Head interviewee advises immediate isolation of the potential victim is the initial response to a report of substantial risk of imminent sexual abuse. It may be feasible to move the potential victim to another housing unit within the facility, dependent upon the circumstances. The potential perpetrator may also be placed under direct staff supervision status. The contractual requirements of the governmental partner will dictate the ability to transfer both the potential victim and potential perpetrator. Minimally, we would work with on-site contract monitors to make the best decision under the circumstances.

The Director asserts when staff learn a resident is at risk of imminent sexual abuse, he or she is removed from the danger zone and placed in another area under staff supervision. If necessary, the victim may be moved to another facility pursuant to agreement and assistance by the ODOC contract monitor. There are

limited viable options to separate the potential victim from the potential perpetrator in view of facility configuration.

All 12 random staff interviewees corroborate the assertions of the Agency Head interviewee and the Director to the extent the potential victim would be removed from the danger zone. Eleven of 12 interviewees assert the potential victim is immediately removed from the danger zone.

In view of the above, the auditor finds OROC substantially compliant with 115.262.

Standard 115.263: Reporting to other confinement facilities

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.263 (a)

- Upon receiving an allegation that a resident was sexually abused while confined at another facility, does the head of the facility that received the allegation notify the head of the facility or appropriate office of the agency where the alleged abuse occurred? X Yes No

115.263 (b)

- Is such notification provided as soon as possible, but no later than 72 hours after receiving the allegation? X Yes No

115.263 (c)

- Does the agency document that it has provided such notification? X Yes No

115.263 (d)

- Does the facility head or agency office that receives such notification ensure that the allegation is investigated in accordance with these standards? X Yes No

Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- X **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

Pursuant to the PAQ, the Director self reports the agency has a policy requiring that, upon receiving an allegation 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. The Director further self reports in the last 12 months, the facility received zero allegations that a resident was sexually abused while confined at another facility.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 21, section M(16)(a)(i) and ODOC OP-030601 entitled PREA, page 23, section XI(A) address 115.263(a).

Pursuant to a memorandum from the PCM, zero 115.263(a) allegations were received at OROC during the last 12 months. The auditor has found no contradicting information.

Pursuant to the PAQ, the Director self reports agency policy requires that the facility head provides such notification as soon as possible, but no later than 72 hours after receiving the allegation.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 21, section M(16)(a)(i) and ODOC OP-030601 entitled PREA, page 23, section XI(A)(1) address 115.263(b).

Pursuant to the PAQ, the Director self reports the facility documents that it has provided such notification within 72 hours of receiving the allegation.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 21, section M(16)(a)(iii) and ODOC OP-030601 entitled PREA, page 23, section XI(A)(2) address 115.263(c).

Pursuant to the PAQ, the Director self reports facility policy requires allegations received from other facilities/agencies are investigated in accordance with PREA standards. The Director further self reports in the last 12 months, zero allegations of sexual abuse originating at OROC, were received by the facility from other facilities.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 21, section M(16)(b)(i-iii) and ODOC OP-030601 entitled PREA, page 23, section XI(A)(3) address 115.263(d).

The auditor's review of one 2020 sexual abuse investigation that allegedly occurred at CTC (the predecessor facility to OROC) during November, 2019 reveals the same was reported to CTC officials by an ODOC official. Additionally, an alleged conjunctive sexual abuse allegation was referred to CTC staff. The matters were investigated in accordance with 115.271 and determined to be unsubstantiated. The auditor notes the reporting ODOC staff member reported the alleged incidents via email.

The specifics regarding these two allegations are addressed in the narrative for 115.271(a). The auditor finds OROC substantially compliant with 115.263(d).

The Agency Head interviewee advises if another agency or facility within another agency refers allegations of sexual abuse or sexual harassment that occurred within a CC facility, the Director is generally the administrator who receives the call. Subsequent to receipt of such a call, the Director would advise the facility investigator to open an investigation. Dependent upon the circumstances, the investigator would initiate an administrative investigation or contact ODOC OIG/OCPD to initiate a criminal investigation.

According to the Director, when an allegation is received from another facility regarding an incident that allegedly occurred at OROC, a full investigation would be initiated pursuant to standard procedure. The alleged victim is interviewed at the facility at which housed to secure a statement. The Director subsequently responds to the reporting administrator regarding the outcome of the investigation.

The Director asserts she is not aware of any such allegation(s) that occurred during her tenure at OROC.

In view of the above, the auditor finds OROC substantially compliant with 115.263.

Standard 115.264: Staff first responder duties

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.264 (a)

- Upon learning of an allegation that a resident was sexually abused, is the first security staff member to respond to the report required to: Separate the alleged victim and abuser?
X Yes No

- Upon learning of an allegation that a resident was sexually abused, is the first security staff member to respond to the report required to: Preserve and protect any crime scene until appropriate steps can be taken to collect any evidence? X Yes No
- Upon learning of an allegation that a resident was sexually abused, is the first security staff member to respond to the report required to: Request that the alleged victim not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating, if the abuse occurred within a time period that still allows for the collection of physical evidence? X Yes No
- Upon learning of an allegation that a resident was sexually abused, is the first security staff member to respond to the report required to: Ensure that the alleged abuser does not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating, if the abuse occurred within a time period that still allows for the collection of physical evidence? X Yes No

115.264 (b)

- If the first staff responder is not a security staff member, is the responder required to request that the alleged victim not take any actions that could destroy physical evidence, and then notify security staff? X Yes No

Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- X **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

Pursuant to the PAQ, the Director self reports the agency has a first responder policy for allegations of sexual abuse. Specifically, upon learning of an allegation 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
- 4) If the abuse occurred within a time period that still allows for the collection of physical evidence, ensure the alleged abuser does not take any actions that could destroy physical evidence such as those described in paragraph 3 above.

The Director self reports zero alleged incidents of sexual abuse occurred at OROC during the last 12 months.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 17, section M(2)(a-d), (5), (6) and ODOC OP-030601 entitled PREA, page 20, section (B)(2)(a)(1-4) address 115.264(a). The steps articulated in these policy provisions follow a chronological sequence with specific duties assigned (e.g the crime scene is secured by the highest ranking authority on-site and the safety of the victim is likewise ensured by this individual).

The auditor's review of a Priority: PREA laminated staff card reveals substantial compliance with 115.264(a).

The non-security first responder interviewee was able to accurately identify all steps involved in the first responder duty expectations. The security first responder interviewee asserts the first responder does not allow either the victim or perpetrator to destroy physical evidence.

Seven of the 12 random staff interviewees were able to correctly identify all four tasks as cited at 115.264(a). The majority of misinformation centers on telling or ensuring both the victim and perpetrator do not destroy physical evidence, as opposed to, requesting that the victim and ensuring the perpetrator do not destroy physical evidence.

As policy is clearly scripted in accordance with 115.264(a) and each interviewee was in possession of a CC First Responder card, the auditor finds OROC substantially compliant with 115.264(a). The auditor notes all staff receive the same first responder training.

The auditor's review of five 2019 and 2020 sexual abuse investigations, inclusive of incidents allegedly arising at CTC, reveals none of the fact patterns are consistent with the time period that allows for the collection of physical evidence.

Pursuant to the PAQ, the Director self reports agency policy requires if the first responder is not a security staff member, that responder shall be required to:

- 1) Request the alleged victim not take any actions that could destroy physical evidence; and
- 2) Notify security staff.

The Director further self reports zero incidents of sexual abuse were reported within the last 12 months.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 17, section M(3) and ODOC OP-030601 entitled PREA, page 20, section (B)(2)(b) address 115.264(b).

Of note, all staff receive the same First Responder training during both Pre-Service and In-Service training.

In view of the above, the auditor finds OROC substantially compliant with 115.264.

Standard 115.265: Coordinated response

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.265 (a)

- Has the facility developed a written institutional plan to coordinate actions among staff first responders, medical and mental health practitioners, investigators, and facility leadership taken in response to an incident of sexual abuse? Yes No

Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

Pursuant to the PAQ, the Director self reports 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.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, pages 16 through 20, sections L through M(14)(i) and CC APS OP-030601 entitled Oklahoma PREA, page 10, section 2 and 3, in total, address 115.265(a). Additionally, ODOC OP-030601 entitled Oklahoma PREA, pages 19-21, addresses 115.265(a).

The auditor's review of this plan, in addition to the aforementioned policy citations, reveals a comprehensive and substantive plan to enable proper staff response to an incident of sexual abuse.

The Director asserts facility executive staff and ADOs are trained regarding the coordinated response plan on an annual basis.

According to the Director, the facility does have a plan to coordinate actions among staff first responders, medical and mental health practitioners, investigators, and facility leadership in response to an incident of sexual abuse. The plan is clearly articulated in CC Policy 14-2 CC.

In view of the above, the auditor finds OROC substantially compliant with 115.265.

Standard 115.266: Preservation of ability to protect residents from contact with abusers

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.266 (a)

- Are both the agency and any other governmental entities responsible for collective bargaining on the agency's behalf prohibited from entering into or renewing any collective bargaining agreement or other agreement that limits the agency's ability to remove alleged staff sexual abusers from contact with any residents pending the outcome of an investigation or of a determination of whether and to what extent discipline is warranted? Yes No

115.266 (b)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

Pursuant to the PAQ, the Director self reports the facility is not involved in any collective bargaining process, either currently or since the last PREA audit. During the on-site audit, the auditor confirmed this assertion.

The Agency Head interviewee advises there are five or fewer facilities under the CC umbrella that are unionized. Collective Bargaining Agreements permit the agency to remove alleged staff sexual abusers from contact with any inmate pending an investigation or a determination of whether and to what extent discipline is warranted.

Since the auditor finds no OROC deviation from standard, compliance with 115.266 is established.

Standard 115.267: Agency protection against retaliation

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.267 (a)

- Has the agency established a policy to protect all residents and staff who report sexual abuse or sexual harassment or cooperate with sexual abuse or sexual harassment investigations from retaliation by other residents or staff? X Yes No
- Has the agency designated which staff members or departments are charged with monitoring retaliation? X Yes No

115.267 (b)

- Does the agency employ multiple protection measures, such as housing changes or transfers for resident victims or abusers, removal of alleged staff or resident abusers from contact with victims, and emotional support services for residents or staff who fear retaliation for reporting sexual abuse or sexual harassment or for cooperating with investigations? X Yes No

115.267 (c)

- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor the conduct and treatment of residents or staff who reported the sexual abuse to see if there are changes that may suggest possible retaliation by residents or staff? X Yes No
- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor the conduct and treatment of residents who were reported to have suffered sexual abuse to see if there are changes that may suggest possible retaliation by residents or staff? X Yes No
- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Act promptly to remedy any such retaliation? X Yes No
- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor any resident disciplinary reports? X Yes No
- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor resident housing changes? X Yes No
- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor resident program changes? X Yes No

- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor negative performance reviews of staff? X Yes No
- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor reassignments of staff? X Yes No
- Does the agency continue such monitoring beyond 90 days if the initial monitoring indicates a continuing need? X Yes No

115.267 (d)

- In the case of residents, does such monitoring also include periodic status checks? X Yes No

115.267 (e)

- If any other individual who cooperates with an investigation expresses a fear of retaliation, does the agency take appropriate measures to protect that individual against retaliation? X Yes No

115.267 (f)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- X **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

Pursuant to the PAQ, the Director self reports 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. According to the PAQ, the Director self reports the PCM/American Correctional Association (ACA) Coordinator and the programs manager are designated as the Retaliation Monitors at OROC. The same is articulated in a memorandum included in the PAQ materials.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 19, section M(14)(b) and ODOC OP-030601 entitled PREA, page 21, section D address 115.267(a).

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 19, section M(14)(a) and ODOC OP-030601 entitled PREA, pages 21 and 22, section D(1-3) address 115.267(b).

According to the Agency Head interviewee, staff and residents who report sexual abuse/sexual harassment allegations are protected from retaliation pursuant to frequent retaliation monitoring check-ins (residents/staff), in addition to a 30/60/90 day formal review schedule. Staff charged with retaliation monitoring responsibilities follow disciplinary action(s), housing unit changes, removal of perpetrator(s) from area of victim housing, transfer of alleged abuser(s), and change in programming to monitor the

existence of or status of retaliation. In regard to alleged staff perpetrators, monitoring and follow-up regarding staff conduct is a primary consideration to the resident safety equation.

According to the Director and staff member charged with monitoring retaliation interviewee, the retaliation monitor follows up and checks-in with both resident and staff victims every two weeks. Formal 30/60/90 day retaliation meetings are conducted with the victim(s) with bi-weekly check-ins.

Relocation of the perpetrator is the primary response and secondarily, the victim, dependent upon the circumstances. A staff member suspected of perpetrating sexual abuse against a resident and/or perpetrator of retaliation may be moved to another facility, placed on unpaid administrative leave pending the conclusion of the investigation, or placed in a non-resident contact post. Support services are recommended, if appropriate. Minimally, the victim's housing within the facility, is considered and if appropriate, the same would be changed.

The staff member charged with monitoring retaliation interviewee asserts she would reach out to the victim upon determination that abuse had occurred. Her primary obligation is to ensure the safety of the victim.

The staff perpetrator can be placed on administrative leave and a resident perpetrator is generally removed from the facility. Generally, services and treatment may be increased for the resident victim and the Employee Assistance Program (EAP) is offered to the staff victim of sexual abuse/retaliation to ensure better mental well-being. Any informal meetings between the monitor and victim are documented on the ODOC Incident Form (ODOC victims) and an FBOP form with respect to FBOP residents.

The auditor's review of the Protection Against Retaliation-Inmates and Staff forms reveals several actions that can be taken and accounted for throughout the retaliation monitoring process.

Pursuant to the PAQ, the Director self reports the facility monitors the conduct or treatment of residents or staff who reported sexual abuse/harassment 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 Director further self reports retaliation monitoring is continued for at least 90 days or more, if necessary. The facility does act promptly to remedy such retaliation. The facility continues such monitoring beyond 90 days if the initial monitoring indicates a continuing need. The Director self reports retaliation has not occurred within the last 12 months.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 19 and 20, section M(14)(c), (d)(iv), (e)(i, ii), (f) and ODOC OP-030601 entitled PREA, page 22, section D(4)(a-f) address 115.267(c).

The Director and designated staff member charged with retaliation monitoring interviewee assert they monitor changes in resident behavior(s) (increase in receipt of misconduct reports), hygiene changes, wandering eyes while communicating, isolation, aggression, tardiness at work, and change(s) in attitude and demeanor. In regard to staff victims, a decrease in work productivity, increase in call-offs, increase in corrective actions, depression, isolation, change in demeanor, and change in appearance are key indicators.

Monitoring is continued for a minimum of 90 days however, the same may be extended, dependent upon the circumstances. The Director and the designated staff member charged with monitoring retaliation interviewee make the determination. Monitoring can be continued until the threat level is reduced.

The auditor notes CC policy requires the conduct of 30/60/90 retaliation monitoring in sexual abuse situations.

The auditor notes 90-day retaliation monitoring was required in two 2019 cases and the PCM advises she is unable to locate any requisite documents validating compliance. Pursuant to clarification, one of the alleged victims was confined at another facility when he reported the alleged incident and in the

second scenario, the investigation was determined to be unfounded. Accordingly, retaliation monitoring was not warranted at OROC in either case.

Given additional research, the auditor determined there are two additional CTC cases wherein retaliation monitoring was warranted. However, the PCM was unable to locate the requisite documentation as described above. Accordingly, the auditor finds OROC non-compliant with 115.267(c) and (d) throughout the entire audit period.

In view of the above, the auditor is placing OROC on a 180-day corrective action period, ending on September 22, 2021. To demonstrate compliance with 115.267, the PCM will provide training to all OROC staff stakeholders regarding the 30/60/90 day retaliation monitoring reviews and periodic status checks, inclusive of documentation of the same. Upon completion of this training, the PCM will provide to the auditor a copy of the lesson plan and documentation certifying stakeholders completed the training. Additionally, the PCM will provide to the auditor a copy of all sexual abuse investigations and accompanying retaliation monitoring documentation for incidents occurring between the date of the Interim Report and September 22, 2021. Upon review of relevant evidence, the auditor will make a determination regarding compliance, maintaining relevant documents in the audit file.

July 1, 2021 Update:

The auditor's review of the lesson plan regarding 115.267(c) and (d), as well as, relevant policy provisions from CC Policy 14-2 reveals substantial compliance with 115.267(c) and (d). Both documents were provided to the training attendees mentioned in the narrative for 115.241(g).

September 1, 2021 Update:

As zero incidents of sexual abuse occurred at OROC between the date of the interim report and this date, the auditor agreed to facilitation of a mock scenario wherein 115.267(c) and (d) requirements were addressed. The auditor's review of the mock scenario reveals completion of requisite steps in a timely manner pursuant to the scenario. Given the date on which the alleged scenario incident occurred (July 18, 2021), only one 30-day entry was noted for both the victim and a resident witness.

In view of the above, the auditor finds OROC substantially compliant with 115.267.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 19, section M(14)(d)(iv)/(g) and ODOC OP-030601 entitled PREA, page 22, section D(4)(g) address 115.267(d).

Pursuant to due diligence, the auditor has not discovered the relevant documents as described in the narrative for 115.267(d). Specifically, the PCM asserts, as reflected in the narrative for 115.267(c) above, relevant documentation cannot be located. Accordingly, there is no evidence substantiating the completion of periodic status checks and the auditor also finds OROC non-compliant with 115.267(d). Corrective action, as articulated in the narrative for 115.267(c), is also applicable to 115.267(d).

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 20, section M(14)(i) and ODOC OP-030601 entitled PREA, page 21, section D addresses 115.267(e).

Pursuant to contact with the PCM, she is not aware of any other incidents that occurred during the last 24 months wherein other individual(s) who cooperated with an investigation, expressed a fear of retaliation.

When a resident who cooperates with an investigation expresses a fear of retaliation, the Agency Head interviewee asserts he/she receives the same benefits and treatment as articulated in the narrative for 115.267(b) above.

In view of the above, the auditor finds OROC substantially compliant with 115.267.

INVESTIGATIONS

Standard 115.271: Criminal and administrative agency investigations

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.271 (a)

- When the agency conducts its own investigations into allegations of sexual abuse and sexual harassment, does it do so promptly, thoroughly, and objectively? (N/A if the agency/facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations. See 115.221(a).) X Yes No NA
- Does the agency conduct such investigations for all allegations, including third party and anonymous reports? (N/A if the agency/facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations. See 115.221(a).) X Yes No NA

115.271 (b)

- Where sexual abuse is alleged, does the agency use investigators who have received specialized training in sexual abuse investigations as required by 115.234? X Yes No

115.271 (c)

- Do investigators gather and preserve direct and circumstantial evidence, including any available physical and DNA evidence and any available electronic monitoring data? X Yes No
- Do investigators interview alleged victims, suspected perpetrators, and witnesses? X Yes No
- Do investigators review prior reports and complaints of sexual abuse involving the suspected perpetrator? X Yes No

115.271 (d)

- When the quality of evidence appears to support criminal prosecution, does the agency conduct compelled interviews only after consulting with prosecutors as to whether compelled interviews may be an obstacle for subsequent criminal prosecution? Yes X No

115.271 (e)

- Do agency investigators assess the credibility of an alleged victim, suspect, or witness on an individual basis and not on the basis of that individual's status as resident or staff? X Yes No
- Does the agency investigate allegations of sexual abuse without requiring a resident who alleges sexual abuse to submit to a polygraph examination or other truth-telling device as a condition for proceeding? X Yes No

115.271 (f)

- Do administrative investigations include an effort to determine whether staff actions or failures to act contributed to the abuse? X Yes No

- Are administrative investigations documented in written reports that include a description of the physical evidence and testimonial evidence, the reasoning behind credibility assessments, and investigative facts and findings? X Yes No

115.271 (g)

- Are criminal investigations documented in a written report that contains a thorough description of the physical, testimonial, and documentary evidence and attaches copies of all documentary evidence where feasible? X Yes No

115.271 (h)

- Are all substantiated allegations of conduct that appears to be criminal referred for prosecution? X Yes No

115.271 (i)

- Does the agency retain all written reports referenced in 115.271(f) and (g) for as long as the alleged abuser is incarcerated or employed by the agency, plus five years? X Yes No

115.271 (j)

- Does the agency ensure that the departure of an alleged abuser or victim from the employment or control of the agency does not provide a basis for terminating an investigation? X Yes No

115.271 (k)

- Auditor is not required to audit this provision.

115.271 (l)

- When an outside entity investigates sexual abuse, does the facility cooperate with outside investigators and endeavor to remain informed about the progress of the investigation? (N/A if an outside agency does not conduct administrative or criminal sexual abuse investigations. See 115.221(a).) X Yes No NA

Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- X **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

Pursuant to the PAQ, the Director self reports the facility has a policy related to criminal and administrative agency investigations.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 22, section N(4) and ODOC OP-040117 entitled Investigations, page 2, section I(B) and page 3, section II(A) address 115.271(a).

The auditor's review of three 2019 and 2020 sexual abuse/harassment investigations conducted at CTC reveals substantial compliance with 115.271. Two of the three investigations were determined to be unsubstantiated while one was determined to be sexual harassment. Two investigations were determined to be unsubstantiated while one was determined to be unfounded. While ODOC OIG did not label the unfounded matter as a PREA incident, OROC staff chose to label the same as PREA-related. Sexual abuse investigations were referred to ODOC OIG and one was subsequently remanded to OROC investigator(s) for investigation.

The auditor's further review of four additional 2019 sexual abuse investigations reveals substantial compliance with 115.271. Two of these investigations were facilitated by ODOC OIG investigators and both were referred for prosecution. One of the four cases was determined to be unfounded while another was initially determined to be unfounded and later (in conjunction with litigation) determined to be unsubstantiated.

Investigations appear to be substantive and inclusive of all requirements of 115.271. The auditor finds OROC substantially compliant with 115.271(a), (b), (c), (e), (f), (i), (j), and (l).

The investigative staff interviewee asserts an investigation is initiated immediately following receipt of an allegation of sexual abuse. If she is on-site, she immediately commences the investigation. If a sexual abuse allegation is reported during off-duty hours, she would immediately report to the facility to commence a sexual abuse investigation. The general protocol requires the shift supervisor to contact the ADO and the ADO reports to the facility in the case of a sexual harassment allegation. Dependent upon the circumstances, she may report to the facility for a sexual harassment allegation.

The ODOC OIG interviewee asserts any allegation of sexual abuse/harassment is immediately referred to his office. If the incident occurred within a 72 hour time frame, OIG investigators immediately report to the facility. The interviewee asserts facility investigators are very responsive in terms of the entire process.

The OCPD interviewee asserts the sexual abuse report is generally received by Dispatch. After securing relevant information, the call is disseminated to generally a line officer who would report to OROC if warranted based on the know fact pattern. Response time to the scene is generally dictated by priority based on all calls received.

If warranted based on the fact pattern and known circumstances, the allegation is referred to the Detective Unit and further dissemination, if warranted. An OCPD Sex Crimes Unit may be activated, if warranted.

The facility investigative interviewee asserts upon arrival at the facility, she commences her duties by collecting reports and non-physical evidence. The ADO also assists her with these tasks.

In regard to anonymous or third-party reports of sexual abuse/harassment, the interviewee, the ODOC OIG interviewee, and the ODOC interviewee assert such allegations are handled in the same manner as any sexual abuse investigation. In regard to anonymous or third-party reports, such reports can be challenging to investigate, absent some specifics, however, such allegations are taken seriously and are thoroughly investigated.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 23, section N(5) and ODOC OP-040117 entitled Investigations, page 3, section II(A)(3) address 115.271(b).

Trained sexual abuse/harassment investigators are addressed in the narrative for 115.234.

According to the investigative staff interviewee, she completed a 1.5 hour RELIAS course as described in the narrative for 115.234. The same was completed in 2021.

This course included topics such as interviewing techniques relative to victims and perpetrators in a confinement setting, execution of Miranda and Garrity warnings, evidence collection in sexual abuse cases, and the evidence standard necessary to substantiate a case for administrative action or prosecution referral.

Pursuant to a memorandum dated July 28, 2020, all 12 ODOC OIG sexual abuse investigators have received specialized sexual abuse investigative training.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 24, section N(6)(a) and ODOC OP-040117 entitled Investigations, pages 3 and 4, section II(A)(5) and (6) address 115.271(c).

The investigative staff interviewee asserts the initial steps to initiate an investigation and time frames for implementation of each step are as follows:

- Check crime scene relative to first responder effectiveness and ensure no evidence tampering (10 minutes);
- Conduct threshold interview with victim to establish a preliminary fact pattern (30 minutes);
- Review staff statements, victim statement(s)- threshold questions, and witness statement(s) (30-60 minutes);
- Assess victim safety (15 minutes);
- Retrieve video and facilitate resident/staff file reviews (90 minutes);
- Interview witnesses and subsequently the perpetrator (if the case is released for local investigation) (30 minutes to two hours);
- Write report (two hours).

Of note, the ODOC OIG and OCPD interviewees assert they follow a similar protocol as reflected above however, physical evidence collection and compelled interview(s) are also part of their protocol.

Direct and circumstantial evidence the facility investigative interviewee is responsible for collecting entails written statements, video, files, and interview notes. All physical evidence is collected by ODOC OIG or OCPD investigators.

The OCPD interviewee exercises quality control over the indirect evidence provided by the facility investigator. In other words he reviews all statements, video monitoring, files, etc. to ensure he has a decent snapshot of a timeline and known facts. He subsequently focuses on in-depth interviews with the victim(s), witnesses, and perpetrator at some point. As evidence is identified, re-interviews may be facilitated. The last step is report writing.

Pursuant to the auditor's review of seven sexual abuse/harassment investigations facilitated by OROC investigator(s) and ODOC OIG investigator(s), the auditor finds no deviation from either standard or protocol.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 24, section N(6)(b) and ODOC OP-040117 entitled Investigations, page 8, section V(B)(3) and (4) and C(1) address 115.271(d). Additionally, ODOC OP-030601 entitled Oklahoma PREA, page 26, section D(3)(c) addresses 115.271(d).

The auditor's review of the CC/OCPD MOU regarding criminal sexual abuse investigations generically addresses the conduct of such investigations. While not specific regarding the requirements of 115.271(d), the overall requirements of a criminal investigation are addressed by OCPD regulations.

The investigative staff interviewee asserts compelled interviews are not conducted by OROC staff. The same would be facilitated by ODOC OIG or OCPD investigator(s) and they would likewise maintain contact with prosecutors. The ODOC OIG and OCPD interviewees confirm this statement.

The auditor's review of relevant investigation(s), as previously described, reveals the matter(s) was/were referred for criminal investigation to ODOC OIG.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 24, section O(6)(c) and ODOC OP-040117 entitled Investigations, page 8, section V(B)(5) address 115.271(e). Additionally, ODOC OP-030601 entitled Oklahoma PREA, page 10, section IV(A)(6) addresses 115.271(e).

In regard to credibility assessments relative to staff and resident witnesses, the facility investigative staff interviewee, ODOC OIG, and OCPD interviewees assert credibility is established based on the premise the victim/witness/perpetrator is credible until proven otherwise. The interviewees further relate they would not,

under any circumstances, require a resident who alleges sexual abuse to submit to a polygraph examination or truth-telling device as a condition for proceeding with an investigation.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 23, section N(6) and ODOC OP-040117 entitled Investigations, page 2, section I(A)(1) address 115.271(f). ODOC OP-040117 entitled Investigations, page 6, section I(A), (B); and page 6, section IV(E) addresses 115.271(f).

With respect to determining whether staff actions or failure to act contributed to the incident of sexual abuse, the facility investigative staff interviewee asserts she assesses facts against policy/Code of Ethics deviations.

The interviewee asserts administrative investigations are documented in written reports. The reports generally address the following format:

Executive Digest [general synopsis of the allegation(s) and some findings], inclusive of establishment of a timeline;
Citation of circumstantial evidence and credibility assessments;
Video and file review analysis;
Interview findings;
Recommendations if policy/Code of Ethics violations discovered.

According to the PCM, she is not in possession of any criminal reports regarding sexual abuse that arose during the last 12 months. However, the auditor has been provided one partial criminal investigation report regarding an incident that allegedly occurred in March, 2020. Pursuant to review, the auditor finds the same to be commensurate with 115.271(g).

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 24, section O(6)(f) and ODOC OP-040117 entitled Investigations, page 6, section IV(E) address 115.271(g).

The investigative staff interviewee asserts criminal investigations are documented. In actuality, the reports are similar to the administrative reports completed by the interviewee and as described above in the narrative for 115.271(f). The ODOC OIG and OCPD interviewees affirm this statement.

Pursuant to the PAQ, the Director self reports substantiated allegations of conduct that appear to be criminal are referred for prosecution. The Director further self reports, to the best of her knowledge, zero administrative or criminal findings were referred for prosecution since the last PREA audit. The auditor notes that two referrals for prosecution are addressed in the narrative for 115.271(a).

The investigative staff interviewee asserts all cases are automatically referred to ODOC OIG and they make any and all prosecution referrals. The ODOC OIG and OCPD interviewees assert probable cause must be present and there is a potential violation of the criminal code before a case is referred for prosecution. The OCPD interviewee also asserts all named suspect cases are referred to the DAs Office for review and a determination regarding prosecution.

Pursuant to the PAQ, the Director self reports the agency retains all written reports referenced in the above paragraphs of this section for as long as the alleged abuser is incarcerated or employed by the agency, plus five years.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 24, section O(6)(g) and ODOC OP-040117 entitled Investigations, page 6, section IV(D)(4) address 115.271(i).

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 24, section O(6)(d) and ODOC OP-040117 entitled Investigations, page 3, section II(A) address 115.271(j).

Pursuant to the CCPC, standard practice requires continuation of an investigation into a PREA allegation even if a resident is terminated from the program.

The investigative staff interviewee, the ODOC OIG, and OCPD interviewees assert they continue the investigation regardless of whether a staff member alleged to have committed a sexual abuse act terminates employment prior to a completed investigation into his/her conduct and/or when a victim who alleges sexual abuse/harassment or an alleged abuser leaves the facility prior to a completed investigation into the incident.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 24, section O(5) addresses 115.271(l).

The Director asserts the assistant director telephonically follows-up with the investigative entity on a bi-weekly basis. Generally, the entity follows-up in writing and if they do not, the assistant director documents the contact. The PCM asserts the Director may facilitate this duty or the same may be delegated to facility investigators.

According to the facility investigative staff interviewee, she acts as a liaison or facilitator, providing total support.

In view of the above, the auditor finds OROC substantially compliant with 115.271.

Standard 115.272: Evidentiary standard for administrative investigations

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.272 (a)

- Is it true that the agency does not impose a standard higher than a preponderance of the evidence in determining whether allegations of sexual abuse or sexual harassment are substantiated? Yes No

Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

Pursuant to the PAQ, the Director self reports the agency imposes a standard of a preponderance of the evidence or a lower standard of proof when determining whether allegations of sexual abuse or sexual harassment are substantiated.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 23, section N(8) and ODOC OP-030601 entitled Oklahoma PREA, page 6, section III address 115.272(a). Additionally, CC APS OP 030601, entitled Oklahoma PREA, page 12, section L(6) addresses 115.272(a).

The auditor's review of the seven 2019/2020 sexual abuse/harassment investigations referenced in the narrative for 115.271(a) reveals substantial compliance with 115.272(a) as the preponderance of evidence standard was met.

The investigative staff interviewee asserts she relies on a preponderance of evidence to substantiate allegations of sexual abuse/harassment. She asserts this equates to, "more evidence the incident occurred, than not."

In view of the above, the auditor finds OROC substantially compliant with 115.272.

Standard 115.273: Reporting to residents

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.273 (a)

- Following an investigation into a resident's allegation that he or she suffered sexual abuse in an agency facility, does the agency inform the resident as to whether the allegation has been determined to be substantiated, unsubstantiated, or unfounded? X Yes No

115.273 (b)

- If the agency did not conduct the investigation into a resident's allegation of sexual abuse in the agency's facility, does the agency request the relevant information from the investigative agency in order to inform the resident? (N/A if the agency/facility is responsible for conducting administrative and criminal investigations.) X Yes No NA

115.273 (c)

- Following a resident's allegation that a staff member has committed sexual abuse against the resident, unless the agency has determined that the allegation is unfounded, or unless the resident has been released from custody, does the agency subsequently inform the resident whenever: The staff member is no longer posted within the resident's unit? X Yes No
- Following a resident's allegation that a staff member has committed sexual abuse against the resident, unless the agency has determined that the allegation is unfounded, or unless the resident has been released from custody, does the agency subsequently inform the resident whenever: The staff member is no longer employed at the facility? X Yes No
- Following a resident's allegation that a staff member has committed sexual abuse against the resident, unless the agency has determined that the allegation is unfounded, or unless the resident has been released from custody, does the agency subsequently inform the resident whenever: The agency learns that the staff member has been indicted on a charge related to sexual abuse in the facility? X Yes No
- Following a resident's allegation that a staff member has committed sexual abuse against the resident, unless the agency has determined that the allegation is unfounded, or unless the resident has been released from custody, does the agency subsequently inform the resident whenever: The agency learns that the staff member has been convicted on a charge related to sexual abuse within the facility? X Yes No

115.273 (d)

- Following a resident's allegation that he or she has been sexually abused by another resident, does the agency subsequently inform the alleged victim whenever: The agency learns that the alleged abuser has been indicted on a charge related to sexual abuse within the facility? X Yes No
- Following a resident's allegation that he or she has been sexually abused by another resident, does the agency subsequently inform the alleged victim whenever: The agency learns that the alleged abuser has been convicted on a charge related to sexual abuse within the facility? X Yes No

115.273 (e)

- Does the agency document all such notifications or attempted notifications? Yes No

115.273 (f)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

Pursuant to the PAQ, the Director self reports the agency has a policy requiring that any resident who makes an allegation he or she suffered sexual abuse in an agency facility is informed, verbally or in writing, as to whether the allegation has been determined to be substantiated, unsubstantiated, or unfounded following an investigation by the agency. The Director self reports zero criminal/administrative sexual abuse/harassment investigations were completed during the last 12 months.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 25, section R(1) and ODOC OP-030601 entitled PREA, page 27, section XII(A) address 115.273(a).

The auditor's review of three 2019 and 2020 sexual abuse/harassment investigations reveals the requisite 115.273(a), (c), and (e) notifications were completed in the one sexual abuse case.

The auditor's further review of four additional 2019 Sexual Abuse Incident Review (SAIR) reports and accompanying documentation reveals the requisite written notification to resident was completed in three cases. In one matter, the resident had been released from the facility and accordingly, notification was not required pursuant to 115.273(f).

According to the Director, the facility does notify a resident who makes an allegation of sexual abuse when the allegation has been determined to be substantiated, unsubstantiated, or unfounded following an investigation. She asserts all such notifications are effected pursuant to a Notice of Investigation Status Form. The investigative staff interviewee substantiates the Director's statement.

Pursuant to the PAQ, if an outside entity conducts such investigations, the agency requests the relevant information from the investigative entity in order to inform the resident of the outcome of the investigation. The Director further self reports, in the last 12 months, zero investigations were completed by an outside agency.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 25, section R(1) addresses 115.273(b).

Pursuant to the PAQ, the Director self reports following a resident's allegation that a staff member has committed sexual abuse against the resident, the facility subsequently informs the resident (unless the agency has determined 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 the staff member has been indicted on a charge related to sexual abuse within the facility; or

The agency learns the staff member has been convicted on a charge related to sexual abuse within the facility.

The Director further asserts zero staff-on-resident sexual abuse or sexual misconduct allegation(s) have been received during during the last 12 months.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 25, section R(2)(a-d) and ODOC OP-030601 entitled PREA, pages 27 and 28, section XII(B)(1)(a-d) address 115.273(c).

Pursuant to the PAQ, following a resident's allegation he or she has been sexually abused by another resident at OROC, the agency subsequently informs the alleged victim whenever:

The agency learns the alleged abuser has been indicted on a charge related to sexual abuse within the facility; or

The agency learns the alleged abuser has been convicted on a charge related to sexual abuse within the facility.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 25, section R(3)(a and b) and ODOC OP-030601 entitled PREA, page 28, section XII(D)(1) address 115.273(d).

The auditor finds no investigations regarding resident-on-resident sexual abuse conducted during the last 12 months. Furthermore, the auditor finds no such investigations during 2019 and 2020 when the facility was known as CTC.

Pursuant to the PAQ, the Director self reports the agency has a policy that all notifications to residents described under this standard are documented.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 25, section R(4) and ODOC OP-030601 entitled PREA, page 28, section XII(D)(2) address 115.273(e).

In view of the above, the auditor finds OROC substantially compliant with 115.273.

DISCIPLINE

Standard 115.276: Disciplinary sanctions for staff

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.276 (a)

- Are staff subject to disciplinary sanctions up to and including termination for violating agency sexual abuse or sexual harassment policies? Yes No

115.276 (b)

- Is termination the presumptive disciplinary sanction for staff who have engaged in sexual abuse? Yes No

115.276 (c)

- Are disciplinary sanctions for violations of agency policies relating to sexual abuse or sexual harassment (other than actually engaging in sexual abuse) commensurate with the nature and circumstances of the acts committed, the staff member's disciplinary history, and the sanctions imposed for comparable offenses by other staff with similar histories? Yes No

115.276 (d)

- Are all terminations for violations of agency sexual abuse or sexual harassment policies, or resignations by staff who would have been terminated if not for their resignation, reported to: Law enforcement agencies unless the activity was clearly not criminal? Yes No
- Are all terminations for violations of agency sexual abuse or sexual harassment policies, or resignations by staff who would have been terminated if not for their resignation, reported to: Relevant licensing bodies? Yes No

Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

Pursuant to the PAQ, the Director self reports staff is subject to disciplinary sanctions up to and including termination for violating agency sexual abuse or sexual harassment policies.

CC Policy 14-2 CC entitled Sexual Abuse Prevention, page 26, section S(2)(a) and ODOC OP 030601 entitled Oklahoma PREA, page 6, section III, second paragraph address 115.276(a). Page 6, section III, second paragraph of the same ODOC policy, as well as, CC APS-030601 entitled Oklahoma Prison Rape Elimination Act, page 13, section 2(a) also address 115.276(a).

Pursuant to the PAQ, the Director self reports in the last 12 months, zero facility staff members are alleged to have violated agency sexual abuse/ harassment policies.

CC Policy 14-2 CC entitled Sexual Abuse Prevention, page 26, section S(2)(b) and ODOC OP 030601 entitled Oklahoma PREA, page 5, section II address 115.276(b). CC APS-030601 entitled Oklahoma Prison Rape Elimination Act, page 13, section 2(a) also addresses 115.276(b).

The auditor's review of a CC Facility Employee Problem Solving Notice reveals one employee was terminated based on a substantiated allegation of sexual abuse occurring in July, 2019. Accordingly, the auditor finds OROC substantially compliant with 115.276(b). That particular allegation(s) was/were investigated by ODOC OIG investigator(s). The previous employee's occupation did not require any licensing and accordingly, notification to licensing authorities was not warranted.

Pursuant to the PAQ, the Director self reports 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. The Director further self reports that in the last 12 months, zero staff from the facility have been disciplined, short of termination, for violation of agency sexual abuse or sexual harassment policies.

CC Policy 14-2 CC entitled Sexual Abuse Prevention, page 26, section S(2)(c) and CC APS-030601 entitled Oklahoma Prison Rape Elimination Act, page 13, section 2(b) address 115.276(c).

Pursuant to the PAQ, the Director self reports 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. The Director further self reports during the last 12 months, zero facility staff have been reported to law enforcement or licensing boards following termination (or resignation prior to termination) for violating agency sexual abuse or sexual harassment policies.

CC Policy 14-2 CC entitled Sexual Abuse Prevention, page 26, section S(2)(d) and ODOC OP 030601 entitled Oklahoma PREA, page 5, section II, paragraph 4 address 115.276(d). Page 11, section d of the latter policy and CC APS-030601 entitled Oklahoma Prison Rape Elimination Act, page 13, section 2(c) also address 115.276(d).

In view of the above, the auditor finds OROC substantially compliant with 115.276.

Standard 115.277: Corrective action for contractors and volunteers

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.277 (a)

- Is any contractor or volunteer who engages in sexual abuse prohibited from contact with residents? X Yes No
- Is any contractor or volunteer who engages in sexual abuse reported to: Law enforcement agencies unless the activity was clearly not criminal? X Yes No
- Is any contractor or volunteer who engages in sexual abuse reported to: Relevant licensing bodies? X Yes No

115.277 (b)

- In the case of any other violation of agency sexual abuse or sexual harassment policies by a contractor or volunteer, does the facility take appropriate remedial measures, and consider whether to prohibit further contact with residents? X Yes No

Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

Pursuant to the PAQ, the Director self reports 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. Additionally, the Director self reports agency policy requires any contractor or volunteer who engages in sexual abuse be prohibited from contact with residents. According to the Director, in the last 12 months, no contractors or volunteers have been reported to law enforcement agencies and relevant licensing bodies.

CC Policy 14-2 CC entitled Sexual Abuse Prevention, page 26, section S(2)(e) and ODOC OP-090211 entitled Volunteer Services, page 14, section K(2) address 115.277(a). It is noted that pursuant to ODOC OP-030601 entitled Oklahoma PREA, page 5, section II, paragraph 4, the terms "staff" and "employee" includes all ODOC employees, contract personnel, contract employers, and volunteers. CC APS OP 030601 entitled Oklahoma PREA, page 14, section N(3) also addresses both 115.277(a) and (b). In addition to the above, the CoreCivic Zero Tolerance Policy- Prohibited Sexual Behavior document, signed and dated by each contractor/volunteer, reflects the requirements of 115.277 in the section entitled Corrective Action for Contractors and Volunteers that Engage in Prohibited Sexual Behavior.

Pursuant to staff/resident interviews and documentation review, the auditor has not found any incidents wherein the requirements of 115.277 were invoked or would require the same.

Pursuant to the PAQ, the Director self reports 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.

CC Policy 14-2 CC entitled Sexual Abuse Prevention, page 26, section S(2)(f) and ODOC OP-090211 entitled Volunteer Services, page 14, section K(4) address 115.277(b). It is noted that pursuant to ODOC OP-030601 entitled Oklahoma PREA, page 5, section II, paragraph 4, the terms "staff" and "employee" includes all ODOC employees, contract personnel, contract employers, and volunteers. CC APS OP 030601 entitled Oklahoma PREA, page 14, section N(3) also addresses both 115.277(a) and (b).

The Director asserts she suspends contractor/volunteer facility access privileges pending the outcome of an investigation and eliminates contact with residents should a contractor/volunteer become involved in a sexual abuse/harassment incident with a resident. She terminates the contract or volunteer activity if the investigation is substantiated.

In view of the above, the auditor finds OROC substantially compliant with 115.277.

Standard 115.278: Interventions and disciplinary sanctions for residents

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.278 (a)

- Following an administrative finding that a resident engaged in resident-on-resident sexual abuse, or following a criminal finding of guilt for resident-on-resident sexual abuse, are residents subject to disciplinary sanctions pursuant to a formal disciplinary process? Yes No

115.278 (b)

- Are sanctions commensurate with the nature and circumstances of the abuse committed, the resident's disciplinary history, and the sanctions imposed for comparable offenses by other residents with similar histories? X Yes No

115.278 (c)

- When determining what types of sanction, if any, should be imposed, does the disciplinary process consider whether a resident's mental disabilities or mental illness contributed to his or her behavior? X Yes No

115.278 (d)

- If the facility offers therapy, counseling, or other interventions designed to address and correct underlying reasons or motivations for the abuse, does the facility consider whether to require the offending resident to participate in such interventions as a condition of access to programming and other benefits? X Yes No

115.278 (e)

- Does the agency discipline a resident for sexual contact with staff only upon a finding that the staff member did not consent to such contact? X Yes No

115.278 (f)

- For the purpose of disciplinary action does a report of sexual abuse made in good faith based upon a reasonable belief that the alleged conduct occurred NOT constitute falsely reporting an incident or lying, even if an investigation does not establish evidence sufficient to substantiate the allegation? X Yes No

115.278 (g)

- If the agency prohibits all sexual activity between residents, does the agency always refrain from considering non-coercive sexual activity between residents to be sexual abuse? (N/A if the agency does not prohibit all sexual activity between residents.) X Yes No NA

Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- X **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

Pursuant to the PAQ, the Director self reports residents are subject to disciplinary sanctions only pursuant to a formal disciplinary process following an administrative finding that the resident engaged in resident-on-resident sexual abuse. The Director further self reports 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 last 12 months, there was zero administrative and/or criminal findings of resident-on-resident sexual abuse that occurred at the facility.

CC Policy 14-2 CC entitled Sexual Abuse Prevention, page 26, section S(1)(a) and ODOC OP-030601 entitled Oklahoma PREA, page 12, section d address 115.278(a). CC APS OP 030601 entitled Oklahoma PREA, page 12, section N(1)(a)(i) also addresses 115.278(a).

The auditor's review of ODOC OP-060125 entitled Inmate/Offender Disciplinary Procedures, Attachment A reveals substantial compliance with 115.278 in terms of administrative charges and sanctions. Additionally, the OROC Resident Handbook (relative to ODOC residents) provides requisite information. The disciplinary policy is posted on the bulletin board and a copy of the Handbook is also available in each dorm information area.

In regard to FBOP residents, the case manager addresses resident disciplinary procedures during intake/orientation and requisite information is provided in the OROC FBOP Resident Handbook. The auditor's review validates the same.

The auditor's review of an Orientation Checklist, OROC FBOP Resident Handbook receipt, and Zero Tolerance Acknowledgment for Offender documents, all signed and dated by two female and three male FBOP residents indicating understanding of the subject-matter presented, reveals substantial compliance with 115.278.

The auditor notes FBOP residents are subject to the FBOP Discipline policy as reflected in the aforementioned FBOP-related handbook. Facility administrative disciplinary hearings, wherein disciplinary transfers/loss of Statutory Good Time/etc. can be imposed, are facilitated by FBOP staff. Accordingly, the hearing officials are responsible for consideration of whether mental disabilities or mental illness contributed to his/her behavior when determining what type of sanction, if any, should be imposed.

With respect to ODOC resident disciplinary hearings, as described in the preceding paragraph, are facilitated by OROC and reviewed by ODOC staff. It is noted residents have the right to appeal findings.

CC Policy 14-2 CC entitled Sexual Abuse Prevention, page 26, section S(1)(c) and CC APS OP 030601 entitled Oklahoma PREA, page 13, section N(1)(a)(iii) address 115.278(b).

According to the Director, residents who facilitate a resident-on-resident sexual abuse incident may normally be recommended, subsequent to an administrative disciplinary process, for termination from the program and transfer to another facility. An administrative transfer and loss of Good Time are potential sanctions.

CC Policy 14-2 CC entitled Sexual Abuse Prevention, page 26, section S(1)(d) and CC APS OP 030601 entitled Oklahoma PREA, page 13, section N(1)(a)(iv) address 115.278(c).

Pursuant to the PAQ, the Director self reports the facility does not offer therapy, counseling, or other interventions designed to address and correct the underlying reasons or motivations for abuse. Specifically, in the case of substantiated abuse, the perpetrator would be placed into custody and terminated from the program. Additionally, the alleged perpetrator is separated from the victim. In view of the above, facility staff do not consider whether to require the offending resident to participate in such interventions as a condition of access to programming or other benefits.

CC Policy 14-2 CC entitled Sexual Abuse Prevention, page 26, section S(1)(i) and CC APS OP 030601 entitled Oklahoma PREA, page 13, section N(1)(c) address 115.278(d).

As previously mentioned in the narrative for 115.235, according to the Director and the auditor's observations, medical and mental health staff are not employed at OROC.

Pursuant to the PAQ, the Director self reports the agency disciplines residents for sexual conduct with staff only upon finding that the staff member did not consent to such contact.

CC Policy 14-2 CC entitled Sexual Abuse Prevention, page 26, section S(1)(e) and CC APS OP 030601 entitled Oklahoma PREA, page 13, section N(1)(a)(v) address 115.278(e).

The auditor finds no allegations or investigations relative to resident sexual contact with staff, conducted during the last 12 months, addressing the subject-matter of 115.278(e).

CC Policy 14-2 CC entitled Sexual Abuse Prevention, page 26, section S(1)(g) and CC APS OP 030601 entitled Oklahoma PREA, page 13, section N(1)(b)(i) address 115.278(f).

CC Policy 14-2 CC entitled Sexual Abuse Prevention, page 26, section S(1)(g) and CC APS OP 030601 entitled Oklahoma PREA, page 13, section N(1)(b)(i) address 115.278(f).

The auditor has found no evidence of deviation from the requirements of 115.278(f).

Pursuant to the PAQ, the Director self reports the agency prohibits all sexual activity between residents. The Director further self reports the agency deems such activity to constitute sexual abuse only if it determines that the activity is coerced.

CC Policy 14-2 CC entitled Sexual Abuse Prevention, page 27, section S(1)(f) and ODOC OP-060125 entitled Inmate/Offender Disciplinary Procedures, Attachment A address 115.278(g).

The auditor did not find any incidents of resident discipline for sexual abuse linked to consensual sex.

In view of the above, the auditor finds OROC substantially compliant with 115.278.

MEDICAL AND MENTAL CARE

Standard 115.282: Access to emergency medical and mental health services

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.282 (a)

- Do resident victims of sexual abuse receive timely, unimpeded access to emergency medical treatment and crisis intervention services, the nature and scope of which are determined by medical and mental health practitioners according to their professional judgment?
X Yes No

115.282 (b)

- If no qualified medical or mental health practitioners are on duty at the time a report of recent sexual abuse is made, do security staff first responders take preliminary steps to protect the victim pursuant to § 115.262? X Yes No
- Do security staff first responders immediately notify the appropriate medical and mental health practitioners? X Yes No

115.282 (c)

- Are resident victims of sexual abuse offered timely information about and timely access to emergency contraception and sexually transmitted infections prophylaxis, in accordance with professionally accepted standards of care, where medically appropriate? X Yes No

115.282 (d)

- Are treatment services provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident?
X Yes No

Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- X **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

Pursuant to the PAQ, the Director self reports resident victims of sexual abuse receive timely, unimpeded access to emergency medical treatment and crisis intervention services. The Director further self reports the nature and scope of such services are determined by medical and mental health practitioners according to their professional judgment. However, such services are provided by community providers at a designated location. The Director self reports that as medical and mental health care are not provided at OROC, such secondary materials are maintained at the respective hospital(s).

CC Policy 14-2 CC entitled Sexual Abuse Prevention, page 20, section M(15)(a) and ODOC OP-030601 entitled PREA, pages 10 and 11, section B(1)(b); ODOC OP-140118 entitled Emergency Care, page 4, section C(5) address 115.282(a).

The PCM asserts ODOC is engaged in agreements with several local hospitals and SANE examinations can be conducted at some of those facilities. CC piggy-backs on the ODOC agreements pursuant to the CC/ ODOC contract. With respect to FBOP residents, they will be transported to outside medical facilities as directed.

CC Policy 14-2 CC entitled Sexual Abuse Prevention, page 20, section M(15)(b) and ODOC OP-030601 entitled PREA, page 20, section B(2)(a)(1)/ Page 21, section B(4); ODOC OP-140118 entitled Emergency Care, page 4, section C(5) address 115.282(b).

The non-security first responder interviewee was able to accurately identify all steps involved in the 115.264(a) first responder duty expectations. The security first responder interviewee asserts the first responder does not allow either the victim or perpetrator to destroy physical evidence.

The auditor has found no incidents during this audit period wherein medical care and follow-up were warranted.

Pursuant to the PAQ, the Director self reports 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. The Director self reports that as medical and mental health care is not provided at OROC, such secondary materials are maintained at the hospital.

CC Policy 14-2 CC entitled Sexual Abuse Prevention, page 20, section M(15)(c) and ODOC OP-140118 entitled Emergency Care, page 3, section C(4) address 115.282(c).

Pursuant to the PAQ, the Director self reports 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.

CC Policy 14-2 CC entitled Sexual Abuse Prevention, page 20, section M(15)(d) and ODOC OP-140118 entitled Emergency Care, page 5, section C(5)(d) address 115.282(d).

In view of the above, the auditor finds OROC substantially compliant with 115.282.

Standard 115.283: Ongoing medical and mental health care for sexual abuse victims and abusers

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.283 (a)

- Does the facility offer medical and mental health evaluation and, as appropriate, treatment to all residents who have been victimized by sexual abuse in any prison, jail, lockup, or juvenile facility? X Yes No

115.283 (b)

- Does the evaluation and treatment of such victims include, as appropriate, follow-up services, treatment plans, and, when necessary, referrals for continued care following their transfer to, or placement in, other facilities, or their release from custody? X Yes No

115.283 (c)

- Does the facility provide such victims with medical and mental health services consistent with the community level of care? X Yes No

115.283 (d)

- Are resident victims of sexually abusive vaginal penetration while incarcerated offered pregnancy tests? (N/A if "all-male" facility. *Note: in "all-male" facilities, there may be residents who identify as transgender men who may have female genitalia. Auditors should be sure to know whether such individuals may be in the population and whether this provision may apply in specific circumstances.*) X Yes No NA

115.283 (e)

- If pregnancy results from the conduct described in paragraph § 115.283(d), do such victims receive timely and comprehensive information about and timely access to all lawful pregnancy-related medical services? (N/A if "all-male" facility. *Note: in "all-male" facilities, there may be residents who identify as transgender men who may have female genitalia. Auditors should be sure to know whether such individuals may be in the population and whether this provision may apply in specific circumstances.*) X Yes No NA

115.283 (f)

- Are resident victims of sexual abuse while incarcerated offered tests for sexually transmitted infections as medically appropriate? X Yes No

115.283 (g)

- Are treatment services provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident? X Yes No

115.283 (h)

- Does the facility attempt to conduct a mental health evaluation of all known resident-on-resident abusers within 60 days of learning of such abuse history and offer treatment when deemed appropriate by mental health practitioners? X Yes No

Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- X **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

Pursuant to the PAQ, the Director self reports 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.

CC Policy 14-2 CC entitled Sexual Abuse Prevention, page 20, section M(15)(e) and ODOC OP-030601 entitled Oklahoma PREA, page 16, section VII address 115.283(a).

The PCM asserts, during the last 12 months, zero residents have reported, at intake during their initial sexual abuse victimization screening, that they were sexually abused at a prior confinement facility. In such cases, the ad (specifically FBOP residents) or ODOC staff (specifically ODOC residents) facilitate a referral to community provider(s) and ODOC staff follow-up regarding ODOC resident care while OROC staff follow-up regarding FBOP resident care. Residents can decline the same.

Pursuant to interviews and review of random resident files, the auditor has found no contradictory evidence regarding such resident reporting as reflected above.

CC Policy 14-2 CC entitled Sexual Abuse Prevention, page 21, section M(15)(f) and (g) addresses 115.283(b) and (c).

As reflected in the narrative for 115.235, medical and mental health staff are not employed at OROC. Medical and mental health care is provided at community facilities.

The auditor has not been provided nor has he discovered any evidence substantiating 115.283(a) and (b) issues. This information is validated pursuant to interviews and review of random resident files.

As previously indicated, zero residents who reported a sexual abuse at OROC, were housed at the facility during the on-site audit.

CC Policy 14-2 CC entitled Sexual Abuse Prevention, page 21, section M(15)(g) addresses 115.283(c).

Provision of medical and mental health care at community hospitals equates to the community standard of care.

Pursuant to the PAQ, the Director self reports female victims of sexually abusive vaginal penetration while incarcerated are offered pregnancy tests.

CC Policy 14-2 CC entitled Sexual Abuse Prevention, page 21, section M(15)(h) and ODOC OP-140118 entitled Emergency Care, page 6, section C(5)(j) address 115.283(d).

The PCM asserts no female incidents of sexual abuse have been reported during the last 12 months.

Pursuant to the PAQ, the Director self reports if pregnancy results from sexual abuse while incarcerated, victims receive timely and comprehensive information about, and timely access to, all lawful pregnancy-related medical services.

CC Policy 14-2 CC entitled Sexual Abuse Prevention, page 21, section M(15)(h) and ODOC OP-140118 entitled Emergency Care, page 6, section C(5)(j) address 115.283(e).

Pursuant to the PAQ, the Director self reports resident victims of sexual abuse while incarcerated are offered tests for sexually transmitted infections as medically appropriate.

CC Policy 14-2 CC entitled Sexual Abuse Prevention, page 21, section M(15)(i) and ODOC OP-140118 entitled Emergency Care, page 5, section C(5)(f) address 115.283(f).

The auditor's review of the previously referenced five 2019/2020 sexual abuse investigations (CTC) reveals a forensic examination and 115.283(f) tests for sexually transmitted infections were not facilitated in any of the cases. The one substantiated 2019 case involving sexual abuse (reported sexual intercourse) was referred to ODOC OIG for criminal investigation and documentation reveals the 115.283(f) tests were not conducted. The auditor's review of the timeline relevant to this investigation suggests a forensic examination would have been untimely in view of the date on which the alleged incident was reported.

Pursuant to the PAQ, the Director self reports treatment services are provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident.

CC Policy 14-2 CC entitled Sexual Abuse Prevention, page 21, section M(15)(j) and ODOC OP-140118 entitled Emergency Care, page 5, section C(5)(d) address 115.283(g).

Pursuant to the PAQ, the Director self reports 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.

CC Policy 14-2 CC entitled Sexual Abuse Prevention, page 10, section G(15) and ODOC OP-030601 entitled Oklahoma PREA, page 16, section VII address 115.283(h).

Pursuant to interviews and the auditor's random review of resident files, he has not discovered any incidents wherein 115.283(h) requirements were invoked.

In view of the above, the auditor finds OROC substantially compliant with 115.283.

DATA COLLECTION AND REVIEW

Standard 115.286: Sexual abuse incident reviews

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.286 (a)

- Does the facility conduct a sexual abuse incident review at the conclusion of every sexual abuse investigation, including where the allegation has not been substantiated, unless the allegation has been determined to be unfounded? X Yes No

115.286 (b)

- Does such review ordinarily occur within 30 days of the conclusion of the investigation? X Yes No

115.286 (c)

- Does the review team include upper-level management officials, with input from line supervisors, investigators, and medical or mental health practitioners? X Yes No

115.286 (d)

- Does the review team: Consider whether the allegation or investigation indicates a need to change policy or practice to better prevent, detect, or respond to sexual abuse? X Yes No
- Does the review team: Consider whether the incident or allegation was motivated by race; ethnicity; gender identity; lesbian, gay, bisexual, transgender, or intersex identification, status, or perceived status; gang affiliation; or other group dynamics at the facility? X Yes No
- Does the review team: Examine the area in the facility where the incident allegedly occurred to assess whether physical barriers in the area may enable abuse? X Yes No
- Does the review team: Assess the adequacy of staffing levels in that area during different shifts? X Yes No
- Does the review team: Assess whether monitoring technology should be deployed or augmented to supplement supervision by staff? X Yes No
- Does the review team: Prepare a report of its findings, including but not necessarily limited to determinations made pursuant to §§ 115.286(d)(1) - (d)(5), and any recommendations for improvement and submit such report to the facility head and PREA compliance manager? X Yes No

115.286 (e)

- Does the facility implement the recommendations for improvement, or document its reasons for not doing so? X Yes No

Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

Pursuant to the PAQ, the Director self reports 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. The Director further self reports in the last 12 months, zero criminal or administrative sexual abuse investigations were facilitated at OROC.

CC Policy 14-2 CC entitled Sexual Abuse Prevention, page 24, section P(1) and ODOC OP-030601 entitled Oklahoma PREA, page 28, section XIII address 115.286(a).

The auditor's review of one applicable sexual abuse investigation and applicable SAIR reveals substantial compliance with 115.286(a-e). As reflected in the narrative for 115.271(a), one of the remaining investigations was deemed to be sexual harassment and the other investigation was determined to be unfounded.

The auditor's review of four additional 2019 SAIR reports reveals a timely and comprehensive meeting was facilitated and timely/substantive report issued in accordance with 115.286(a-d) in three cases. The final sexual abuse investigation was determined to be unfounded and accordingly, such review is not required.

Pursuant to the PAQ, the Director self reports the facility ordinarily conducts a sexual abuse incident review within 30 days of completion of the conclusion of the criminal or administrative sexual abuse investigation. The Director further self reports in the last 12 months, zero criminal or administrative sexual abuse investigations were facilitated at OROC.

CC Policy 14-2 CC entitled Sexual Abuse Prevention, page 24, section P(3) and ODOC OP-030601 entitled Oklahoma PREA, page 28, section XIII address 115.286(b).

Pursuant to the PAQ, the Director self reports 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 auditor notes no medical or mental health staff are employed at OROC.

CC Policy 14-2 CC entitled Sexual Abuse Prevention, page 24, section P(2) and ODOC OP-030601 entitled Oklahoma PREA, page 28, section XIII address 115.286(c).

The auditor finds the composition of the SART review team, in question, to be commensurate with standard expectations. Commensurate with a memorandum included in the PAQ documentation, the Director, PCM, the ad, os, case manager supervisor, and program manager comprise the membership of the SART team.

The Director asserts the facility does have a sexual abuse incident review team. The team is comprised of the Director and those individuals mentioned above, allowing for input from line supervisors, and investigators.

Pursuant to the PAQ, the Director self reports 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 provision and any recommendations for improvement, and submits such report to the facility head and PCM.

CC Policy 14-2 CC entitled Sexual Abuse Prevention, pages 24 and 25, section P(3)(a-e), (4) and ODOC OP-030601 entitled Oklahoma PREA, pages 28 and 29, section XIII(A)(1-7) address 115.286(d).

The auditor's review of the CC Sexual Abuse/Harassment Incident Review Form reveals substantial compliance with 115.286(d).

According to the Director, the team works to determine whether the alleged incident was the result of a policy, technology, inadequate staffing, or performance failure. During the review, the team assesses a path to enhance the PREA program and resident sexual safety at OROC.

The team considers:

1. Was the incident motivated by race, ethnicity, gender identity, LGBTI identification status or perceived status or perceived status, or gang affiliation, or was it motivated or otherwise caused by other group dynamics at the facility;
2. Physical examination of the area, in the facility, where the incident allegedly occurred to assess whether physical barriers in the area may enable abuse;
3. Assessment of the adequacy of staffing levels in the area during different shifts; and
4. Assessment of whether monitoring technology should be deployed or augmented to supplement staff supervision.

Of note, the incident review team interviewee's statement parallels that of the Director in terms of issues assessed during the review.

According to the Director, reports are generated as part of the SAIR process. If recommendation(s) are made, she looks to implement the same unless there is a written basis for non-compliance with the recommendation(s).

Despite the incidents mentioned in 115.286(a) occurring prior to the mission change(s) at OROC, no trends have been noted.

Pursuant to the PAQ, the Director self reports the facility implements the recommendations for improvement or documents its reasons for not doing so.

CC Policy 14-2 CC entitled Sexual Abuse Prevention, page 25, section P(5) and ODOC OP-030601 entitled Oklahoma PREA, page 29, section XIII(A)(8) address 115.286(e).

In view of the above, the auditor finds OROC substantially compliant with 115.286.

Standard 115.287: Data collection

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.287 (a)

- Does the agency collect accurate, uniform data for every allegation of sexual abuse at facilities under its direct control using a standardized instrument and set of definitions? X Yes No

115.287 (b)

- Does the agency aggregate the incident-based sexual abuse data at least annually? X Yes No

115.287 (c)

- Does the incident-based data include, at a minimum, the data necessary to answer all questions from the most recent version of the Survey of Sexual Violence conducted by the Department of Justice? Yes No

115.287 (d)

- Does the agency maintain, review, and collect data as needed from all available incident-based documents, including reports, investigation files, and sexual abuse incident reviews? Yes No

115.287 (e)

- Does the agency also obtain incident-based and aggregated data from every private facility with which it contracts for the confinement of its residents? (N/A if agency does not contract for the confinement of its residents.) Yes No NA

115.287 (f)

- Does the agency, upon request, provide all such data from the previous calendar year to the Department of Justice no later than June 30? (N/A if DOJ has not requested agency data.) Yes No NA

Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

Pursuant to the PAQ, the Director self reports 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 Director further self reports 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.

CC Policy 14-2 CC entitled Sexual Abuse Prevention, page 27, section T(1) and ODOC OP-030601 entitled Oklahoma PREA, page 6, section XV(A) address 115.287(a/c).

The auditor's review of the CC Incident Reporting Definitions (IRD) and CC 5-1E forms reveals substantial compliance with 115.287(a/c).

Pursuant to the PAQ, the Director self reports the agency aggregates the incident-based sexual abuse data at least annually.

CC Policy 14-2 CC entitled Sexual Abuse Prevention, page 27, section T(3) and ODOC OP-030601 entitled Oklahoma PREA, page 6, section XV(A)(1) address 115.287(b).

The auditor's review of the CC website reveals substantial compliance with 115.287(b) as aggregated data is available for audit years.

Pursuant to the PAQ, the Director self reports the agency maintains, reviews, and collects data as needed from all available incident-based documents, including reports, investigation files, and sexual abuse incident reviews.

CC Policy 14-2 CC entitled Sexual Abuse Prevention, page 27, section T(2) and ODOC OP-030601 entitled Oklahoma PREA, page 6, section XV(A)(2) address 115.287(d).

Based on the PAQ review and on-site review of documents, the auditor finds OROC substantially compliant with 115.287(d).

OROC does not contract with any other facility(ies) for confinement of residents committed to the custody and care of the facility. Accordingly, the auditor finds 115.287(e) not applicable to OROC.

According to the Director, CoreCivic has provided sexual abuse/sexual harassment data to the U.S. Department of Justice during 2019. The same was provided for CTC.

In view of the above, the auditor finds OROC substantially compliant with 115.287.

Standard 115.288: Data review for corrective action

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.288 (a)

- Does the agency review data collected and aggregated pursuant to § 115.287 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training, including by: Identifying problem areas? Yes No
- Does the agency review data collected and aggregated pursuant to § 115.287 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training, including by: Taking corrective action on an ongoing basis? Yes No
- Does the agency review data collected and aggregated pursuant to § 115.287 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training, including by: Preparing an annual report of its findings and corrective actions for each facility, as well as the agency as a whole? Yes No

115.288 (b)

- Does the agency's annual report include a comparison of the current year's data and corrective actions with those from prior years and provide an assessment of the agency's progress in addressing sexual abuse? Yes No

115.288 (c)

- Is the agency's annual report approved by the agency head and made readily available to the public through its website or, if it does not have one, through other means? Yes No

115.288 (d)

- Does the agency indicate the nature of the material redacted where it redacts specific material from the reports when publication would present a clear and specific threat to the safety and security of a facility? Yes No

Auditor Overall Compliance Determination

- X **Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

Pursuant to the PAQ, the Director self reports 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, and 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 corrective actions for each facility, as well as, the agency as a whole.

CC Policy 14-2 CC entitled Sexual Abuse Prevention, page 27, section T(4 and 5) and CC APS OP-030601 entitled Oklahoma PREA, pages 17, 18, sections P(3)(a)(i-iii) address 115.288(a).

The auditor's review of the 2018 ODOC PREA Data Report and 2019 CC Annual Report reveals substantial compliance with 115.288(a), (b), and (c). The CC report is published on the CC website.

The Agency Head interviewee advises CC accesses information from several sources, using incident-based sexual abuse data to assess and improve sexual abuse prevention, detection, and response policies, practices, and training. Specifically, he advises that a 5-1 Incident Reporting System is implemented wherein incidents and reports are, minimally, reviewed by Corporate and designated facility staff within a 24-hour period. Monthly, a report of PREA related incidents details frequency and location(s) of incidents within the facility, amongst other criteria. Pursuant to this procedure, corporate and facility staff collaborate to diagnose any PREA-related issues, concerns, etc. These proactive steps, in addition to SART review findings and continual monitoring of data, are utilized to attain optimal efficiency in terms of sexual safety of inmates/residents at CC facilities.

In view of the above, the auditor finds CTC exceeds compliance expectations with respect to 115.288. This procedure is representative of CC's commitment and zeal in terms of enhancement of resident sexual safety within facilities.

While the CCPC interviewee was not interviewed during this audit, his statement with respect to previous CC audits is noteworthy. He asserts the agency does review data collected and aggregated in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies and training. Such data is securely retained in password protected programs at both the facility and CCPC's office. Access to this information is limited.

Auditor's Note: PREA investigation reports and ancillary documentation are, for the most part, electronically generated. The auditor observed this process throughout the on-site audit.

The CCPC further advises the agency takes corrective action on an ongoing basis based on this data. For example, anything identified pursuant to a mock audit or SART review is considered for implementation.

The PCM asserts the agency reviews data collected and aggregated pursuant to 115.287 in order to assess and improve effectiveness of its sexual abuse prevention, detection, and response policies, and training. Data and supporting documentation is maintained electronically by the CCPC and hard copies are maintained at the facility. Hard copies are maintained behind a locked door in the PCM's Office.

The PCM also asserts the agency prepares an annual report of findings from its data review(s) and any corrective actions for each facility, as well as, the agency as a whole. The CCPC actually compiles the report.

Pursuant to the PAQ, the Director self reports the annual report includes a comparison of the current year's data and corrective actions with those from prior years. The Director further self reports the annual report provides an assessment of the agency's progress in addressing sexual abuse.

CC Policy 14-2 CC entitled Sexual Abuse Prevention, page 27, section T(5) and CC APS OP-030601 entitled Oklahoma PREA, page 18, sections P(3)(b) address 115.288(b).

Pursuant to the PAQ, the Director self reports the agency makes its annual report readily available to the public at least annually through its website and the reports are approved by the agency head.

CC Policy 14-2 CC entitled Sexual Abuse Prevention, page 27, section T(8) and CC APS OP-030601 entitled Oklahoma PREA, page 18, sections P(3)(c) address 115.288(c). ODOC OP-030601 entitled Oklahoma PREA, page 30, section XV(B) also addresses 115.288(c).

According to the Agency Head interviewee, he reviews all PREA Annual Reports as he is the direct supervisor of the CCPC. He copiously reviews each report for comprehensiveness and content, forwarding the same to the CC Chief Corrections Officer for final review and signature.

Pursuant to the PAQ, the Director self reports 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. Furthermore, the agency indicates the nature of the material redacted.

CC Policy 14-2 CC entitled Sexual Abuse Prevention, page 27, section T(6) and CC APS OP-030601 entitled Oklahoma PREA, page 18, sections P(3)(d) address 115.288(d).

According to the PCM, personal names/identifiers and security information is typically redacted from the annual report and the agency indicates the nature of the redacted material. The report is generated by the CCPC.

In view of the above, the auditor finds OROC exceeds standard expectations with respect to 115.288.

Standard 115.289: Data storage, publication, and destruction

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.289 (a)

- Does the agency ensure that data collected pursuant to § 115.287 are securely retained?
X Yes No

115.289 (b)

- Does the agency make all aggregated sexual abuse data, from facilities under its direct control and private facilities with which it contracts, readily available to the public at least annually through its website or, if it does not have one, through other means? X Yes No

115.289 (c)

- Does the agency remove all personal identifiers before making aggregated sexual abuse data publicly available? X Yes No

115.289 (d)

- Does the agency maintain sexual abuse data collected pursuant to § 115.287 for at least 10 years after the date of the initial collection, unless Federal, State, or local law requires otherwise? Yes No

Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

Pursuant to the PAQ, the Director self reports the agency ensures incident-based and aggregate data are securely retained.

CC Policy 14-2 CC entitled Sexual Abuse Prevention, page 28, section T(11) and CC APS OP-030601 entitled Oklahoma PREA, page 17, section P(1)(a)(ii) address 115.289(a). ODOC OP-030601 entitled Oklahoma PREA, page 30, section XV(A) also addresses 115.289(a).

The PCM asserts the agency reviews data collected and aggregated pursuant to 115.287 in order to assess and improve effectiveness of its sexual abuse prevention, detection, and response policies, and training. Data and supporting documentation is maintained electronically by the CCPC and hard copies are maintained at the facility. Hard copies are maintained behind a locked door in the PCM's Office.

Pursuant to the PAQ, the Director self reports agency policy requires aggregated sexual abuse data from facilities under its direct control and private facilities with which it contracts be made readily available to the public, at least annually through its website.

CC Policy 14-2 CC entitled Sexual Abuse Prevention, page 27, section T(8) and CC APS OP-030601 entitled Oklahoma PREA, page 17, section P(2)(c)(i) address 115.289(b). ODOC OP-030601 entitled Oklahoma PREA, page 30, section XV(B) also addresses 115.289(b).

The auditor's review of the CC website reveals aggregated sexual abuse data is available on an annual basis.

Pursuant to the PAQ, the Director self reports before making aggregated sexual abuse data publicly available, the agency removes all personal identifiers.

CC Policy 14-2 CC entitled Sexual Abuse Prevention, page 27, section T(7) and CC APS OP-030601 entitled Oklahoma PREA, page 17, section P(2)(c)(ii) address 115.289(c). ODOC OP-030601 entitled Oklahoma PREA, page 30, section XV(B) also addresses 115.289(c).

The auditor's review of aggregated sexual abuse data on the website reveals all personal identifiers have been removed.

Pursuant to the PAQ, the Director self reports 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.

CC Policy 14-2 CC entitled Sexual Abuse Prevention, page 27, section T(10) and CC APS OP-030601 entitled Oklahoma PREA, page 17, section P(1) address 115.289(d). ODOC OP-030601 entitled Oklahoma PREA, page 31, section XV(C) also addresses 115.289(d).

The auditor's review of the CC Records Retention Schedule reveals substantial compliance with 115.289(d).

In view of the above, the auditor finds OROC substantially compliant with 115.289.

AUDITING AND CORRECTIVE ACTION

Standard 115.401: Frequency and scope of audits

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.401 (a)

- During the prior three-year audit period, did the agency ensure that each facility operated by the agency, or by a private organization on behalf of the agency, was audited at least once? (*Note: The response here is purely informational. A "no" response does not impact overall compliance with this standard.*) Yes No

115.401 (b)

- Is this the first year of the current audit cycle? (*Note: a "no" response does not impact overall compliance with this standard.*) Yes No
- If this is the second year of the current audit cycle, did the agency ensure that at least one-third of each facility type operated by the agency, or by a private organization on behalf of the agency, was audited during the first year of the current audit cycle? (N/A if this is **not** the *second* year of the current audit cycle.) Yes No NA
- If this is the third year of the current audit cycle, did the agency ensure that at least two-thirds of each facility type operated by the agency, or by a private organization on behalf of the agency, were audited during the first two years of the current audit cycle? (N/A if this is **not** the *third* year of the current audit cycle.) Yes No NA

115.401 (h)

- Did the auditor have access to, and the ability to observe, all areas of the audited facility? Yes No

115.401 (i)

- Was the auditor permitted to request and receive copies of any relevant documents (including electronically stored information)? Yes No

115.401 (m)

- Was the auditor permitted to conduct private interviews with residents? Yes No

115.401 (n)

- Were residents permitted to send confidential information or correspondence to the auditor in the same manner as if they were communicating with legal counsel? Yes No

Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)

- Does Not Meet Standard** (*Requires Corrective Action*)

As previously referenced throughout this report, OROC has been subjected to two mission changes within the last 12 months. Accordingly, the auditor's due diligence required research of documentation and actual practice when the facility was known as CTC.

Despite the above, OROC and CC staff were diligent in providing the auditor requested information. Provision of this information greatly enhanced the audit process and allows for creation of a path forward in terms of PREA compliance and resident sexual safety.

OROC staff were very facilitative in terms of facilitation of on-site tasks. Interviews, documentation reviews, and the facility tour were conducted in an efficient manner. Additionally, the PCM's diligence in terms of clarification was invaluable to the auditor, providing a better picture of PREA programs and operations at OROC.

Standard 115.403: Audit contents and findings

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.403 (f)

- The agency has published on its agency website, if it has one, or has otherwise made publicly available. The review period is for prior audits completed during the past three years PRECEDING THIS AGENCY AUDIT. The pendency of any agency appeal pursuant to 28 C.F.R. § 115.405 does not excuse noncompliance with this provision. (N/A if there have been no Final Audit Reports issued in the past three years, or in the case of single facility agencies that there has never been a Final Audit Report issued.) X Yes No NA

Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- X **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

None.

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.

Auditor Instructions:

Type your full name in the text box below for Auditor Signature. This will function as your official electronic signature. Auditors must deliver their final report to the PREA Resource Center as a searchable PDF format to ensure accessibility to people with disabilities. Save this report document into a PDF format prior to submission.¹ Auditors are not permitted to submit audit reports that have been scanned.² See the PREA Auditor Handbook for a full discussion of audit report formatting requirements.

K. E. Arnold

August 2, 2021

Auditor Signature

Date

¹ See additional instructions here: <https://support.office.com/en-us/article/Save-or-convert-to-PDF-d85416c5-7d77-4fd6-a216-6f4bf7c7c110> .

² See *PREA Auditor Handbook*, Version 1.0, August 2017; Pages 68-69.
PREA Audit Report, V6
change