

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

Interim       Final

**Date of Interim Audit Report:** [Click or tap here to enter text.](#)       N/A

*If no Interim Audit Report, select N/A*

**Date of Final Audit Report:** 11-28-2020

### Auditor Information

<b>Name:</b> David "Will" Weir	<b>Email:</b> Will@PREAAmerica.com
<b>Company Name:</b> PREA America, LLC	
<b>Mailing Address:</b> P. O. Box 1473	<b>City, State, Zip:</b> Raton, NM 87740
<b>Telephone:</b> 405-945-1951	<b>Date of Facility Visit:</b> 10/14/2020

### Agency Information

<b>Name of Agency:</b> Bridgeway, Inc.			
<b>Governing Authority or Parent Agency (If Applicable):</b> Contracts with Oklahoma Department of Corrections			
<b>Physical Address:</b> 620 W. Grand Avenue		<b>City, State, Zip:</b> Ponca City, OK 74601	
<b>Mailing Address:</b> <a href="#">Click or tap here to enter text.</a>		<b>City, State, Zip:</b> <a href="#">Click or tap here to enter text.</a>	
<b>The Agency Is:</b>	<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
<b>Agency Website with PREA Information:</b> <a href="http://doc.ok.gov/prison-rape-elimination-act-prea">http://doc.ok.gov/prison-rape-elimination-act-prea</a>			

### Agency Chief Executive Officer

<b>Name:</b> Stacey Wilson	
<b>Email:</b> WisoSC@bridgewayincpc.org	<b>Telephone:</b> 580-762-1462 ext. 109

### Agency-Wide PREA Coordinator

<b>Name:</b> Traci White	
<b>Email:</b> twhite@bridgewayincpc.org	<b>Telephone:</b> 580-762-1462 ext. 103
<b>PREA Coordinator Reports to:</b> Stacey Wilson, President/CEO	<b>Number of Compliance Managers who report to the PREA Coordinator:</b> 0

## Facility Information

**Name of Facility:** Bridgeway Halfway House

**Physical Address:** 620 W. Grand

**City, State, Zip:** Ponca City, OK 74601

**Mailing Address (if different from above):**  
Click or tap here to enter text.

**City, State, Zip:** Click or tap here to enter text.

**The Facility Is:**

Military

Private for Profit

Private not for Profit

Municipal

County

State

Federal

**Facility Website with PREA Information:** <http://doc.ok.gov/prison-rape-elimination-act-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: [Click or tap here to enter text.](#))

N/A

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

### Facility Director

**Name:** Stacey Wilson

**Email:** [WilsonSC@bridgewayincpc.org](mailto:WilsonSC@bridgewayincpc.org)

**Telephone:** 580-76-1462 ext. 109

### Facility PREA Compliance Manager

**Name:** Traci White

**Email:** [twhite@bridgewayincpc.org](mailto:twhite@bridgewayincpc.org)

**Telephone:** 580-763-1827

### Facility Health Service Administrator N/A

**Name:** Provided by Oklahoma Department of Corrections

**Email:** [Click or tap here to enter text.](#)

**Telephone:** [Click or tap here to enter text.](#)

### Facility Characteristics

**Designated Facility Capacity:**

121

**Current Population of Facility:**

108

Average daily population for the past 12 months:	78	
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 checked="" type="checkbox"/> Males <input type="checkbox"/> Both Females and Males	
Age range of population:	21-70	
Average length of stay or time under supervision	8 months	
Facility security levels/resident custody levels	Community minimum	
Number of residents admitted to facility during the past 12 months	137	
Number of residents admitted to facility during the past 12 months whose length of stay in the facility was for 72 hours or more:	136	
Number of residents admitted to facility during the past 12 months whose length of stay in the facility was for 30 days or more:	131	
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 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: <a href="#">Click or tap here to enter text.</a> <input type="checkbox"/> N/A	
Number of staff currently employed by the facility who may have contact with residents:	17	
Number of staff hired by the facility during the past 12 months who may have contact with residents:	0	
Number of contracts in the past 12 months for services with contractors who may have contact with residents:	0	
Number of individual contractors who have contact with residents, currently authorized to enter the facility:	0	
Number of volunteers who have contact with residents, currently authorized to enter the facility:	0	

## Physical Plant

<p><b>Number of buildings:</b></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>	6
<p><b>Number of resident housing units:</b></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>	3
<p><b>Number of single resident cells, rooms, or other enclosures:</b></p>	0
<p><b>Number of multiple occupancy cells, rooms, or other enclosures:</b></p>	28
<p><b>Number of open bay/dorm housing units:</b></p>	0
<p><b>Does the facility have a video monitoring system, electronic surveillance system, or other monitoring technology (e.g. cameras, etc.)?</b></p>	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
<p><b>Has the facility installed or updated a video monitoring system, electronic surveillance system, or other monitoring technology in the past 12 months?</b></p>	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No

## Medical and Mental Health Services and Forensic Medical Exams

<p><b>Are medical services provided on-site?</b></p>	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
<p><b>Are mental health services provided on-site?</b></p>	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No

<b>Where are sexual assault forensic medical exams provided? Select all that apply.</b>	<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: <a href="#">Click or tap here to enter text.</a> )
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**Investigations**

**Criminal Investigations**

<b>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:</b>	0
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<b>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.</b>	<input type="checkbox"/> Facility investigators <input type="checkbox"/> Agency investigators <input checked="" type="checkbox"/> An external investigative entity
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<b>Select all external entities responsible for CRIMINAL INVESTIGATIONS: Select all that apply (N/A if no external entities are responsible for criminal investigations)</b>	<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 (please name or describe: <b>Department of Corrections</b> ) <input type="checkbox"/> N/A
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**Administrative Investigations**

<b>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?</b>	0
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<b>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</b>	<input type="checkbox"/> Facility investigators <input type="checkbox"/> Agency investigators <input checked="" type="checkbox"/> An external investigative entity
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<b>Select all external entities responsible for ADMINISTRATIVE INVESTIGATIONS: Select all that apply (N/A if no external entities are responsible for administrative investigations)</b>	<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 checked="" type="checkbox"/> Other (please name or describe: <b>Department of Corrections</b> ) <input type="checkbox"/> N/A
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# Audit Findings

## Audit Narrative (including Audit Methodology)

*The auditor's description of the audit methodology should include a detailed description of the following processes during the pre-onsite audit, onsite audit, and post-audit phases: documents and files reviewed, discussions and types of interviews conducted, number of days spent on-site, observations made during the site-review, and a detailed description of any follow-up work conducted during the post-audit phase. The narrative should describe the techniques the auditor used to sample documentation and select interviewees, and the auditor's process for the site review.*

PREA America was retained on August 31, 2020, to perform the 2020 PREA Audit for Bridgeway Halfway House in Ponca City, Oklahoma. The Audit date was scheduled for October 14, 2020. Introductory communication with the PREA Coordinator, to discuss the Audit process, Audit preparation, the Pre-Audit Questionnaire (PAQ), and supporting documents and elements of the On-Site Visit, took place shortly after scheduling the On-Site Audit dates. It was decided that some documentation would be provided to the Audit Team via a flash drive that would be mailed, and that other documentation would be provided by email. The vast majority of the documentation was received by the end of September. The PREA America Audit Team consisted of Project Manager Tom Kovach and DOJ Certified PREA Auditor Will Weir, MCJ.

The Audit Notice Posting was sent, with instructions to print on colored paper and about proper distribution of the posting. An alternative-language posting was also made available. Proof of posting was verified by dated photos of the various locations in the facility where the postings were placed. The postings went up August 31, 2020. Also, the postings were observed later during the physical plant tour.

During the Pre-Audit Phase, an extensive desk audit of the facility/agency was conducted, including of its PAQ, policies, and procedures, as well as supporting documentation. Several emails and phone calls were exchanged to clarify issues. This phase of the Audit was used to collaborate with the facility staff on questions and concerns regarding documenting compliance. The communication with the facility staff was used not only to understand the policies and procedures unique to the facility, but also to understand how PREA was put into practice. Internet research was done on the facility.

All documents received were reviewed, including logs, training files, and curricula. To verify compliance with regulations regarding training and background checks (including 5-year rechecks), such files were reviewed of randomly selected staff. Files of residents were randomly selected to verify that PREA education and PREA Screenings were being completed in a timely manner. Phone calls were made to listed advocates, to verify the advocacy required by the Standards.

The October 14, 2020, the On-Site Audit started with an Introductory Briefing attended by the CEO, the PREA Coordinator, the DOC Contract Monitor, and other staff designated to assist with the logistics of the audit. The current population, 112 residents, was confirmed, and a review of the agenda and logistics was completed, along with a discussion of mandatory reporting, and clarification of the need to allow any staff or resident who requests an interview to get one. The Audit Team checked to see if there were questions or concerns.

The Site Review included obtaining and studying the facility diagram of the physical plant. The supervision and movement of staff and residents were observed, along with casual conversation to ascertain whether observations made were of "normal" supervision and movement. Random checks

were made to assure that doors intended to be secured were locked. Random checks of PREA Hotline phones for functionality were made. All housing units and bathroom facilities were inspected for compliance for cross-gender supervision. This included a camera review for those areas with cameras. All areas of the physical plants were observed, with attention to those areas which statistically are high-risk for sexual abuse. PREA Postings in the Visitation area, including third-party reporting postings, were checked. Confirmation of the availability to staff of First Responder Duties was also a part of the tour. Blind spots were identified, and procedures for checking them were verified.

Interviews of residents were selected in accordance with the guidance of the PREA Auditor Handbook, with random selections of residents to ensure diversity of geographic location (from each housing unit), race, and those with risk factors. Random interviews of staff were made to include gender, shift, and post diversity. Interviews were in a conversational manner, to gain the confidence of those interviewed and to put them at ease, so the Audit Team could better understand their comprehension of PREA and its practice in the facility.

20 of the 112 residents were interviewed. Only two of these interviews are considered "Targeted" interviews, according to the description of such interviews provided in the PREA Auditor Handbook. Auditors are required to attempt to interview residents with factors that may place them at risk for being sexually abused. These risk factors are identified by the facility during admission screenings intended to identify risk for vulnerability and abusiveness. Residents typically had a good memory of their screening being conducted, and most even remembered a reassessment after 30 days. Some believe they have had additional reassessments as well. They affirmed that the screenings were completed privately, confidentially, and in a manner that caused the residents to feel free to share. 4 residents who were interviewed had minor issues which did not limit functioning, but which provided a perspective regarding the facility's readiness to follow PREA Standards, should residents with more serious disabilities be placed at the facility. These residents had limited vision, medical diagnoses, mental illness, or history of learning disabilities. These interviews indicated facility practices consistent with this Standard. For example, the residents stated that when medical appointments, medications or new glasses are needed, the facility quickly facilitates these services.

Interviews included a gay resident and someone who had been sexually abused in the past. All residents at the facility are referred by the Oklahoma Department of Corrections after being deemed appropriate for the program. It is rare for DOC to refer anyone with significant risk factors. The list provided to the Audit Team for targeted interviews only included residents with the risk factors that the facility considered, after evaluation, to increase vulnerability to victimization. The facility was aware of all risk factors, and resident screenings included the risk factors, such as LGBTI status (or perceived status) and prior abuse as increasing the risk of abuse. However, residents with glasses or childhood diagnoses of learning disabilities, or treatable medical problems that did not affect their functioning, were not scored as having increased vulnerability.

The following interviews of staff were conducted. Agency Head, Agency PREA Coordinator, Facility Administrator, Agency Human Resources, staff who perform Screening and Intake, staff who monitor for Retaliation, and members of the Incident Review Team. One Oklahoma Department of Corrections Contract Monitor was interviewed, as well. An additional eight staff were selected randomly, representing various stations, housing units, shifts, and genders. This facility, not unlike many community correctional facilities, has minimal numbers of extra staff; so, staff often have multiple responsibilities. There were three unique specialized staff interviews, although all the positions listed above were covered. All available staff were interviewed, with a total of 12 staff being interviewed. Medical and mental health services are provided off-site, so some of the interviews to verify these services do not count within the number of facility and agency interviews.

The Exit Briefing addressed all aspects of the Audit to date. No determination of compliance was given. The recap of the aggregated information obtained and observed was summarized. By request of the facility staff, to assist in furthering the efforts of the facility to prevent and detect sexual abuse and harassment, this summary included a SWOT briefing: a review of Strengths, Weaknesses, Opportunities, and Threats.

During the 30 days after the On-Site Audit the facility updated its documentation regarding whether new hires had previously been administratively adjudicated to have committed sexual abuse and/or sexual harassment. They had been relying on the interview committee to remember to ask the questions verbally. During the 30 days after the On-Site Audit they reviewed all employee files and made sure they had documentation of the questions and answers, along with employee signatures. In addition, also to increase their ability to provide clear documentation of their work to follow all provisions of the PREA Standards, they updated their Staffing Plan to include more exact language. They also updated their MOU with Dearing House because it was time for it to be renewed. Also, there was a section of the policy that implied that a resident could be given sanctions for making a report that was investigated and found to be unfounded. Although nobody interpreted the policy as encouraging residents to be punished for reporting sexual abuse, the wording of the policy was changed to make sure residents are given sanctions only in cases where it is established that they report was made in bad faith. Finally, the latest Annual Report was completed during the 30-days after the On-Site Audit and made available to the public. After the Audit Team verified all the materials provided, the Auditor could establish that the agency and facility had shown full compliance with each of the PREA Standards during this Audit. These findings are explained in more detail, Standard by Standard, throughout the remainder of this report.



## Facility Characteristics

*The auditor's description of the audited facility should include details about the facility type, demographics and size of the resident, resident or detainee population, numbers and type of staff positions, configuration and layout of the facility, numbers of housing units, description of housing units including any special housing units, a description of programs and services, including food service and recreation. The auditor should describe how these details are relevant to PREA implementation and compliance.*

The Bridgeway Halfway House consists of 4 re-purposed buildings located at and around 620 West Grand Avenue in Ponca City, Oklahoma. The administration building has three offices and a conference room, with a lobby for residents seeing their case workers. Behind this building is a maintenance building, which is attached but separate.

The dorms are in three separate buildings, one of which has a staff office. The dorms are divided into rooms that can have multiple occupants. All dorms are served by one weight room, along with an outside recreation and picnic area. All staff work in all dorms. Also, there is one kitchen to serve all the residents, all of whom have the option of taking their food back to their rooms or eating in common areas. There are a couple of laundry areas. There are both an inside and an outside visitation area. All bathroom and shower facilities are outside resident rooms. The all-male facility enforces a rule that allows only one resident at a time in any of the toilet or shower rooms. Entrances to the dorm rooms and bathrooms are monitored by video cameras, as are the insides of mop, pantry, and utility rooms, which also have limited, controlled access.

## 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:** 0

**List of Standards Exceeded:** [Click or tap here to enter text.](#)

### Standards Met

**Number of Standards Met:** 41

### Standards Not Met

**Number of Standards Not Met:** 0

**List of Standards Not Met:** [Click or tap here to enter text.](#)

## 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*)

#### Instructions for Overall Compliance Determination Narrative

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

Documentation received during the Pre-Audit process, and observations made by the Auditor during the On-Site Audit, verify that Bridgeway has a written policy mandating zero tolerance toward all forms of sexual abuse and sexual harassment. They have a written policy outlining how they will implement the agency's approach to preventing, detecting, and responding to sexual abuse and sexual harassment. The Bridgeway Halfway House PREA Policy and Guidelines include definitions of

prohibited behaviors regarding sexual abuse and sexual harassment, sanctions for those found to have participated in prohibited behaviors, and a description of agency strategies and responses to reduce and prevent sexual abuse and sexual harassment of residents. The zero-tolerance policy is also repeated on handouts, on a card attached to the employee ID, in trainings, and on posters and notices throughout the facility. Bridgeway employs an upper-level, agency-wide PREA Coordinator, who answers directly to the President/CEO.

Analysis: Evidence used to determine compliance with this Standard includes: Interviews with the PREA Coordinator and the CEO; PREA Policy 3-1 and 4-1; and the Agency Organizational Chart.

Finding: The agency and facility comply materially with what is required by this Standard.

## 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*)

### Instructions for Overall Compliance Determination Narrative

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

N/A. Bridgeway takes residents from ODOC, through a contractual agreement, but does not contract out for the confinement of its residents. ODOC requires PREA compliance.

Analysis: Evidence used to determine compliance with this Standard includes: PAQ documentation received, and interviews with the agency Contract Administrator, as well as the ODOC Contract Monitor, verified that there are no contracts for the confinement of residents. When a PREA Standard does not apply to an agency, it indicates the agency is in compliance with the Standard.

Finding: As the Standard is not applicable, the agency is not out of compliance.

## 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?  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?  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?  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.)  
 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?  Yes  No
- In the past 12 months, has the facility assessed, determined, and documented whether adjustments are needed to prevailing staffing patterns?  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?  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?  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*)

### Instructions for Overall Compliance Determination Narrative

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

Bridgeway develops and documents a staffing plan that provides for adequate levels of staffing and video monitoring to protect residents against sexual abuse. In calculating adequate staffing levels and determining the need for video monitoring, they consider the physical layout of the facility, the composition of the resident population, the prevalence of substantiated and unsubstantiated incidents of sexual abuse, and any other relevant factors. Staff and resident interviews indicate no deviations from the staffing plan, and no concern about inadequate supervision. Deviations would have to be documented and justified. Whenever necessary, but no less frequently than once each year, Bridgeway assesses, determines, and documents whether staffing plan adjustments are needed.

Analysis: Evidence used to determine compliance with this Standard includes: Interviews with the CEO, the PREA Coordinator, and intermediate-level staff; Documentation of staffing plan development process; Staffing plan; and Documentation of Annual Reviews. The Staffing Plan and Staffing Plan Review provided by the facility during the Audit inadvertently left out some of the provisions of this Standard. These plans were rewritten during the 30 days after the On-Site Audit, and proof of the revised plans being adopted was provided to the Audit Team. With these corrections being made, the agency/facility has provided proof of minimum compliance with all provisions of this Standard.

Finding: The agency and facility comply with all provisions of this Standard.

## 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?  
 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.)  
 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.)  Yes  No  NA

#### 115.215 (c)

- Does the facility document all cross-gender strip searches and cross-gender visual body cavity searches?  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).  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?  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?  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?  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?  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?  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?  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?  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*)

#### Instructions for Overall Compliance Determination Narrative

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

Bridgeway policy forbids body cavity searches. Cross-gender searches are forbidden. Exceptions must be documented. Policies and procedures have been implemented and verified 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). These policies require staff of the opposite gender to announce their presence when entering a resident housing unit. Policy prohibits staff from searching or physically examining a transgender or inter-sex resident for the sole purpose of determining the resident's genital status.

Analysis: Evidence used to determine compliance with this Standard includes: Interviews with randomly selected staff and residents; Policies governing searches and the other provisions of this Standard (PREA Policy section I subsections E and F, page 18); forms to be used for exceptions and exigent circumstances; Training curricula regarding cross-gender pat-down searches and searches of transgender and intersex residents; and Staff training logs. According to documentation provided to the Audit Team, and interviews with both staff and residents, no violations or exceptions related to this Standard are known to have occurred in the past year.

Finding: The agency is in compliance with this Standard.

## **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)

### Instructions for Overall Compliance Determination Narrative

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

Bridgeway has established procedures to provide disabled residents with 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. They have established procedures to provide residents who have limited English proficiency with equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment. Agency policy prohibits use of resident interpreters, resident readers, or other types of resident assistants, except in limited circumstances where an extended delay in obtaining an effective interpreter could compromise the resident's safety, the performance of first-response duties under §115.264, and/or the investigation of the resident allegations. The agency is required to document the limited circumstances in individual cases where resident interpreters, readers, or other types of resident assistants are used, although there have been no exceptions in the past year. Bridgeway, Inc., operates a counseling center in the same complex as the halfway house, with experienced staff qualified to work with individuals with physical and mental health disabilities.

Analysis: Evidence used to determine compliance with this Standard includes the following. Interviews with the Agency Head, randomly selected staff, and residents were conducted. Policies relating to this Standard were reviewed, as found in PREA Policy, Section V, along with other written materials used for effective communication about PREA with residents with disabilities, limited reading skills, or limited English proficiency; and documentation of staff training on PREA-compliant practices for residents with disabilities. 4 residents who were interviewed had minor issues relating to this Standard, which did not limit functioning, but which provided a perspective regarding the facility's readiness to follow this Standard, should residents with more serious disabilities be placed at the facility. These residents had limited vision, medical diagnoses, mental illness, or history of learning disabilities. These interviews indicated facility practices consistent with this Standard. For example, when medical appointments or new glasses are needed, the facility quickly facilitates these services.

Finding: A triangulation of evidence indicates compliance with this Standard.

## 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)?  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?  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?  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)?  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?  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?  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?  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?  Yes  No

#### 115.217 (c)

- Before hiring new employees who may have contact with residents, does the agency: Perform a criminal background records check?  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?  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?  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?  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?  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?  Yes  No
- Does the agency impose upon employees a continuing affirmative duty to disclose any such misconduct?  Yes  No

#### 115.217 (g)

- Does the agency consider material omissions regarding such misconduct, or the provision of materially false information, grounds for termination?  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*)

#### Instructions for Overall Compliance Determination Narrative

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

Bridgeway's PREA 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 (as defined in 42 U.S.C. 1997); has been convicted of engaging or attempting to engage in sexual activity in the community facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse; or has been civilly or administratively adjudicated to have engaged in any of this activity. 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. Policy requires each of the following: (1) that before the facility hires any new employees who may have contact with residents, it conducts criminal background record checks; and, consistent with federal, state, and local law, it 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; (2) that a criminal background record check be completed before enlisting the services of any contractor who may have contact with residents; and (3) that either criminal background record checks are conducted at least every 5 years for current employees and contractors who may have contact with residents; or, that a system is in place for otherwise capturing such information for current employees. Policy clearly states that material omissions regarding such misconduct, or the provision of materially false information, shall be grounds for termination. Policy also clearly states that all applicants and employees who may have contact with residents will be asked directly about previous misconduct described in paragraph (a) of this section, in written applications or interviews for hiring or promotions, and in any interviews or written self-evaluations conducted as part of reviews of current employees. All interviews with administrators involved in hiring confirm these policies are being followed. However, during the 30 days after the On-Site Audit the facility updated its documentation regarding whether new hires had previously been administratively adjudicated to have committed sexual abuse and/or sexual harassment. They had been relying on the interview committee to remember to ask the questions verbally. During the 30 days after the On-Site Audit they reviewed all employee files and made sure they had documentation of the questions and answers, along with employee signatures, and provided these to the audit team. The agency also imposes upon employees a continuing affirmative duty to disclose any such misconduct. Moreover, their policies clearly state that unless prohibited by law, the agency will 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. Several personnel files were randomly pulled, verifying current background checks have been performed.

Analysis: Evidence used to determine compliance with this Standard includes: Interviews with Human Resources staff. Policies on promotions and hiring of employees and contractors, including policies governing criminal background checks, of current employees and contractors who may have contact with residents (PREA Policy III D pg. 12). Files of persons hired or promoted in the last 12 months, to determine whether proper criminal record background checks have been conducted, and whether questions regarding past conduct were asked and answered. Files of personnel hired in the past 12 months, to determine that the agency has completed checks consistent with 115.317(c). Documentation of background records checks of current employees at five-year intervals, when applicable.

Finding: The documentation, policies, and interviews were consistent with this PREA Standard.

## **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*)

### Instructions for Overall Compliance Determination Narrative

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

Bridgeway has neither acquired a new facility, nor made a substantial expansion or modification to existing facilities, since the last Audit. They have not updated their video monitoring system, other than adding cameras several years ago.

Analysis: Evidence used to determine compliance with this Standard includes: Interviews were conducted with the CEO and the PC, as well as with staff who have worked at the facility many years.

Finding: Nothing was found that would indicate lack of compliance with this Standard.

## 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.)  
 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.)  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.)  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?  Yes  No
- Are such examinations performed by Sexual Assault Forensic Examiners (SAFEs) or Sexual Assault Nurse Examiners (SANEs) where possible?  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)?  Yes  No
- Has the agency documented its efforts to provide SAFEs or SANEs?  Yes  No

#### 115.221 (d)

- Does the agency attempt to make available to the victim a victim advocate from a rape crisis center?  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.)  Yes  No  NA
- Has the agency documented its efforts to secure services from rape crisis centers?  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?  Yes  No
- As requested by the victim, does this person provide emotional support, crisis intervention, information, and referrals?  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.)  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.)  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*)

#### Instructions for Overall Compliance Determination Narrative

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

Bridgeway is not responsible for conducting administrative or criminal sexual abuse investigations (including resident-on-resident sexual abuse or staff sexual misconduct). ODOC and local law enforcement have responsibility for conducting administrative and criminal investigations at Bridgeway, and these agencies follow PREA and professional standards for investigating, as required by Bridgeway policy. All residents who experience sexual abuse have access to forensic medical examinations at an outside facility, without financial cost to the victim. Where possible, examinations are conducted by Sexual Assault Forensic Examiners (SAFEs) or Sexual Assault Nurse Examiners (SANEs). SANEs and advocates are available via the MOU with the Dearing House, but when SANEs or SAFEs are not available, a qualified medical practitioner performs forensic medical examinations. The facility documents efforts to provide SANEs or SAFEs. In the past 12 months, there have been no forensic medical exams conducted, because there were no allegations. 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 documented. When a rape crisis center is not available to provide victim advocate services, the facility provides a qualified staff member from a community-based organization or a qualified agency staff member. If requested by the victim, a victim advocate, qualified agency staff member, or qualified community-based organization staff member accompanies and supports the victim through the forensic medical examination process and investigatory interviews and provides emotional support, crisis intervention, information, and referrals.

Analysis: Evidence used to determine compliance with this Standard includes: Interviews with randomly selected staff and SANE Nurse at local hospital. Documentation that forensic medical exams are offered for free. PREA Policy page 21, #6. Documentation of agreement with rape crisis center for services. Documentation that a qualified community-based organization staff member accompanies and supports the victim, per Standard 115.321(e), if requested by the victim (MOU with the Dearing House).

Finding: The agency and facility are in full compliance with this Standard.

## **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?  Yes  No
- Does the agency ensure an administrative or criminal investigation is completed for all allegations of sexual harassment?  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?  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?  Yes  No
- Does the agency document all such referrals?  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).)  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*)
- 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

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

Bridgeway ensures that 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 past 12 months, there have been no allegations of sexual abuse or sexual harassment. The agency has a policy that requires that criminal allegations of sexual abuse or sexual harassment be referred for investigation to an agency with the legal authority to conduct criminal investigations, which would include the ODOC and the Ponca City Police Department. ODOC completes administrative investigations. Agency policy regarding the referral of allegations of sexual

abuse or sexual harassment for investigation is available to the public. The agency documents all referrals of allegations of sexual abuse or sexual harassment for investigation.

Analysis: Evidence used to determine compliance with this Standard includes: Interviews with Agency Head; contract with Oklahoma Department of Corrections; and PREA Policy III A, page 11. In addition, the Audit Team reviewed the website and public postings, tested the reporting system, and questioned residents regarding whether they believe there would be any problem making reports of sexual abuse and/or sexual harassment.

Finding: No interviews, nor information obtained during the Audit indicated any lack of compliance with this Standard.

## 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?  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?  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  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?  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?  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?  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?  Yes  No
- Does the agency train all employees who may have contact with residents on: How to avoid inappropriate relationships with residents?  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?  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?  Yes  No

#### 115.231 (b)

- Is such training tailored to the gender of the residents at the employee's facility?  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?  Yes  No

#### 115.231 (c)

- Have all current employees who may have contact with residents received such training?  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*)

#### Instructions for Overall Compliance Determination Narrative

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

Bridgeway 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) Residents' right to be free from sexual abuse and sexual harassment; (4) The right of residents and employees to be free from retaliation for reporting sexual abuse and sexual harassment; (5) The dynamics of sexual abuse and sexual harassment in confinement; (6) The common reactions of sexual abuse and sexual harassment victims; (7) How to detect and respond to signs of threatened and actual sexual abuse; (8) How to avoid inappropriate relationships with residents; (9) How to communicate effectively and professionally with residents, including lesbian, gay, bisexual, transgender, intersex, or gender nonconforming residents; and (10) How to comply with relevant laws related to mandatory reporting of sexual abuse to outside authorities.

Training is tailored to the gender of the residents at the facility, all of which are male. Interviews with both staff and residents indicate staff seem to understand the essence of their PREA training. Residents indicate they believe staff are very serious about following PREA and keeping them safe. Between trainings, the agency provides all employees who may have contact with residents with annual refresher information about current policies regarding sexual abuse and sexual harassment, which include reviews, updates, new information. The agency documents that employees understand the training they have received through employees' signatures. Also, each section of the training is initialed by the employee.

Analysis: Evidence used to determine compliance with this Standard includes: Interviews with randomly selected staff; training policy and procedures (DOC OP030601; 12, IV); staff training curricula; and 10 randomly selected staff files documenting staff training regarding compliance with this Standard. Documentation includes the record of training as well as staff acknowledgements of the training.

Finding: The agency conducts itself in accordance with this Standard.

## 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?  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)?  Yes  No

#### 115.232 (c)

- Does the agency maintain documentation confirming that volunteers and contractors 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*)

## Instructions for Overall Compliance Determination Narrative

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

All volunteers and contractors who have contact with Bridgeway residents are to be trained on their responsibilities under the agency's policies and procedures regarding sexual abuse/harassment prevention, detection, and response. Residents who attend church activities, attend these off-site. Transportation is provided by trained Bridgeway staff when needed, but most church services attended by residents are within walking distance. The level and type of training provided to volunteers and contractors is to be based on the services they provide and the level of contact they have with residents.

Analysis: No contractors or volunteers have been allowed in the facility this year. Any contractors or volunteers who return to the facility must be re-trained before having contact with residents, since their annual training is past due. Evidence used to determine compliance with this Standard is as follows. The training policy that is used when they do have contractors and volunteers was reviewed (DOC OP030601; 12, IV). Interviews with Bridgeway administrators, and documentation provided (including training curriculum), confirm that they will make sure that all volunteers and contractors who will have contact with residents will at least be informed of the agency's zero-tolerance policy regarding sexual abuse and sexual harassment, and informed how to report such incidents.

Finding: This Standard is fulfilled fully by the agency and the facility.

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



### 115.233 (b)

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

### 115.233 (c)

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

### 115.233 (d)

- Does the agency maintain documentation of resident participation in these education sessions?  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?  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*)

### Instructions for Overall Compliance Determination Narrative

*The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does*

*not meet the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.*

At time of Intake, residents receive information about the zero-tolerance policy, how to report incidents or suspicions of sexual abuse or harassment, and their rights: to be free from sexual abuse and sexual harassment; to be free from retaliation for reporting such incidents; and regarding agency policies and procedures for responding to such incidents. Resident PREA education is available in accessible formats for all residents, including for those who are limited English proficient, deaf, visually impaired, otherwise disabled, and/or limited in reading skills. The agency ensures that key information about the agency's PREA policies is continuously and readily available or visible through posters, resident handbooks, or other written formats.

Analysis: Evidence used to determine compliance with this Standard includes: Interviews with Intake Staff and randomly selected residents. Agency policy governing PREA education of residents, Policy (DOC OP030601; 15, IV). Intake records of 9 residents entering the facility in the 12 months prior to the completion of the PAQ. Signatures on the Offender Acknowledgment of Training. Resident educational materials in formats accessible to those who are limited English proficient, deaf, visually impaired, or otherwise disabled, as well as to those who have limited reading skills. Log of PREA education being completed within 10 days of Intake. Education and informational materials (posters) in compliance with the Standard. Resident interviews indicate a good understanding of PREA. They indicate no doubt or hesitation that all residents know the information, and residents believe Bridgeway is committed to their safety.

Finding: Bridgeway upholds the principles of this Standard.

## **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*)

#### Instructions for Overall Compliance Determination Narrative

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

Bridgeway and ODOC policies require that investigators are trained in conducting sexual abuse investigations in confinement settings. Bridgeway does not have any trained sexual abuse investigators at this time, but it does not conduct its own investigations. Bridgeway policy mirrors ODOC policy, requiring that whichever agency does investigations maintains documentation showing that investigators have completed the required training. According to this policy, and interviews with Bridgeway administration, the Auditor is assured that, in addition to the general training provided to all employees pursuant to § 115.231, the agency will ensure that, to the extent the agency itself would conduct sexual abuse investigations, its investigators would have received training in conducting such investigations in confinement settings. Specialized training includes techniques for interviewing sexual abuse victims, proper use of Miranda and Garrity warnings, sexual abuse evidence collection in confinement settings, and the criteria and evidence required to substantiate a case for administrative action or prosecution referral.

Analysis: Evidence used to determine compliance with this Standard emphasizes an interview with the Agency Head, indicating that all investigations are done by Oklahoma Department of Corrections Staff. In addition, the interview with the DOC contract monitor and the DOC contract itself, appears consistent with this Standard.

Finding: The agency acts in a manner consistent with the Standard.

## 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*)

#### Instructions for Overall Compliance Determination Narrative

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

Bridgeway also has a policy related to the training of medical and mental health practitioners. All medical and mental health care practitioners who may work with victims of sexual abuse are to be properly trained. Although medical and mental health care will probably be provided by the Dearing House, ODOC, or other providers, medical staff who conduct forensic exams are to be properly trained, and documentation of this training should be maintained by their employing agency. The training must include: how to detect and assess signs of sexual abuse and sexual harassment; how to preserve physical evidence of sexual abuse; how to respond effectively and professionally to victims of sexual abuse and sexual harassment; and, how and to whom to report allegations or suspicions of sexual abuse and sexual harassment

Analysis: Evidence used to determine compliance with this Standard includes: Interviews with the Agency head, indicating that all medical and mental health services are facilitated via the Oklahoma Department of Corrections Staff. Forms used for this purpose were reviewed, and residents who have received this care, for minor issues not related to sexual abuse, were interviewed. The content of policy, DOC contract, and interviews were consistent with compliance with this Standard.

Finding: A triangulation of the evidence assures that Bridgeway is in compliance with this Standard.

## 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?  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?  Yes  No

#### 115.241 (b)

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

#### 115.241 (c)

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

#### 115.241 (g)

- Does the facility reassess a resident's risk level when warranted due to a: Referral?  Yes  No
- Does the facility reassess a resident's risk level when warranted due to a: Request?  Yes  No
- Does the facility reassess a resident's risk level when warranted due to a: Incident of sexual abuse?  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?  
 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?  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?  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*)

#### Instructions for Overall Compliance Determination Narrative

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

Bridgeway has a policy and practice such that, within 72 hours of each resident's Intake, the facility is required to screen each resident, for risk of sexual abuse victimization, or sexual abusiveness toward other residents. This risk assessment is conducted using an objective screening instrument, and policy also requires that the facility reassess each resident's risk of victimization or abusiveness within a set time period, not to exceed 30 days after the resident's arrival at the facility, based upon any additional, relevant information received by the facility since the Intake screening. The screening considers whether the resident has a mental, physical, or developmental disability; the age of the resident; the physical build of the resident; whether the resident has previously been incarcerated; whether the resident's criminal history is exclusively nonviolent; whether the resident has prior convictions for sex offenses against an adult or child; whether the resident is or is perceived to be gay, lesbian, bisexual, transgender, intersex, or gender non-conforming; whether the resident has previously experienced sexual victimization; and the resident's own perception of vulnerability. Policy prohibits disciplining residents for not disclosing completely regarding, or refusing to answer, questions regarding whether or not the resident has a mental, physical, or developmental disability; whether or not the resident is or is perceived to be gay, lesbian, bisexual, transgender, inter-sex, or gender non-conforming; whether or



not the resident has previously experienced sexual victimization; and the resident's own perception of vulnerability.

Analysis: Evidence used to determine compliance with this Standard includes the following. Interviews were conducted with Risk Screening staff, with randomly selected residents, and with the PREA Coordinator. Agency policy and procedures governing screening of residents, upon admission to the facility, or transfer to another facility, and during reassessments were reviewed (PREA Policy 178-VI). Screening instrument used to determine risk of victimization or abusiveness was reviewed. And records for 9 residents, all of whom were admitted to the facility within the past 12 months, were reviewed for evidence of appropriate screening within 72 hours. The residents interviewed indicated they have been screened, and that they believe the information collected is kept confidential and is being discretely used to keep them safe.

Finding: The Audit Team's review indicates that Bridgeway complies with this Standard.

## 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?  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?  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?  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?  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?  Yes  No

#### 115.242 (b)

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

#### 115.242 (e)

- Are transgender and intersex residents given the opportunity to shower separately from other residents?  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.)  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.)  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.)  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*)

## Instructions for Overall Compliance Determination Narrative

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

Bridgeway uses information from the risk screening required by § 115.241 to inform housing, bed, work, education, and program assignments, with the goal of keeping separate those residents at high risk of being sexually victimized from those at high risk of being sexually abusive. Case managers and the PREA Coordinator do the screenings and make individualized determinations about how to ensure the safety of each resident, according to the information they gave to the Auditor during interviews. Bridgeway makes housing and program assignments for transgender or inter-sex residents in the facility on a case-by-case basis. A transgender or intersex resident's own view with respect to their own safety is given serious consideration. All residents at Bridgeway shower separately and are forbidden to share bathrooms or showers. This provides a guarantee that a transgender resident would be able to shower separately, as required in policy. The agency does not place gay, bisexual, transgender, or intersex residents in dedicated facilities, units, or wings solely based on such identification or status. Interviews indicate that very few residents have identified as LGBTI, and those that do so, only do so to some people. Staff indicate they treat such information with discretion, and with confidentiality, while treating all residents with equal dignity and respect

Analysis: Evidence used to determine compliance with this Standard includes the following. Interviews were conducted with the PREA Coordinator and Risk Screening Staff; Documentation was reviewed of the use of screening information of 9 randomly selected residents to assure that it was used to inform housing, bed, work, education, and program assignments, as applicable, with the goal of keeping all residents safe and free from sexual abuse. For those residents whose stay has lasted longer than 30 days, the facility's 30-day reviews were examined. Facility policies regarding all the provisions of this Standard were reviewed and are found in Policy 179-VII.

Finding: Bridgeway complies with this Standard.

# 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*)

### Instructions for Overall Compliance Determination Narrative

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

Bridgeway has established procedures allowing for multiple internal ways for residents to report privately to agency officials about sexual abuse or sexual harassment, retaliation by other residents or staff for reporting sexual abuse and sexual harassment, and staff neglect or violation of responsibilities that may have contributed to such incidents. The agency provides at least one way for residents to report abuse or harassment to an entity that is not part of the agency. In addition to being able to report to the Director, PREA Coordinator, Case Manager, or staff, they can call the DOC PREA Hotline (855-871-4139). Moreover, Dearing House is an external source of support, providing advocacy and assistance by phone (580-762-5266), and advocacy and counseling, in person or by writing (Dearing House, 311 South 13th St. Ponca City, Oklahoma 74601). Bridgeway also has a policy mandating that staff accept reports of sexual abuse and sexual harassment made verbally, in writing, anonymously, and from third parties. Staff are required to document verbal reports either immediately or by the end of the shift. The agency has established procedures for staff to privately report sexual abuse and sexual harassment of residents. They can report privately through the PREA hotline, through the DOC website, or by email. Staff and residents are informed of these procedures through their original training, their refresher training, signs posted around the facility, handouts, and their employee orientation packets.

Analysis: Evidence used to determine compliance with this Standard includes: (1) Interviews with randomly selected staff and residents; and (2) Reviews of all of the following policies and agreements: resident reporting policy; documentation on resident reporting; documentation of agreement with outside entity responsible for taking reports; resident reporting policy relevant to reporting to outside entity (PREA policy 15-V); policy mandating that staff accept reports of sexual abuse and sexual harassment made verbally, in writing, anonymously and from third parties; and policy and documentation (e.g., staff handbooks) outlining procedures for staff to privately report sexual abuse and sexual harassment of residents.

Finding: Agency and facility policies and practices uphold this Standard.

## 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.  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.)  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.)  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.)  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.)  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.)  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.)  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.)  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.)

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.)

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.)

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.)  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.)

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.)  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.)

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.)  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.)  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.)  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.)  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*)

## Instructions for Overall Compliance Determination Narrative

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

Bridgeway has an administrative procedure for dealing with resident grievances regarding sexual abuse. 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 policy does not require a resident to use an informal grievance process, nor otherwise to attempt to resolve with staff, an alleged incident of sexual abuse. Agency policy requires that a resident grievance alleging sexual abuse not be referred to the staff member who is the subject of the complaint. A decision on the merits of any grievance or portion of a grievance alleging sexual abuse must be made within 90 days of the filing of the grievance. In the past 12 months, there have been no grievances filed that alleged sexual abuse. The agency always notifies the resident in writing when the agency files for an extension, including notice of the date by which a decision will be made. Third parties, including fellow residents, staff members, family members, attorneys, and outside advocates, may assist residents in filing requests for administrative remedies relating to allegations of sexual abuse, and to file such requests on behalf of residents. If the resident declines to have third-party assistance in filing a grievance alleging sexual abuse, the agency documents the resident's decision to decline. The agency also 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. These require an initial response within 48 hours and a final agency decision within five days. There was a section of the policy that implied that a resident could be given sanctions for making a report that was investigated and found to be unfounded. Although nobody interpreted the policy as encouraging residents to be punished for reporting sexual abuse, the wording of the policy was improved in the 30 days after the On-Site Audit, to make sure residents are given sanctions only in cases where it is established that they report was made in bad faith.

Policy limits the ability to discipline a resident for filing a grievance alleging sexual abuse to occasions where the agency demonstrates that the resident filed the grievance in bad faith.

Analysis: Evidence used to determine compliance with this Standard includes: policy regarding resident grievances of sexual abuse; policy for filing an emergency grievance alleging that a resident is subject to a substantial risk of imminent sexual abuse; policy limiting the agency's ability to discipline a resident for filing a grievance related to alleged sexual abuse to occasions where the agency demonstrates that the resident filed the grievance in bad faith (PREA Policy 20-IX); Resident Handouts and educational materials.



Finding: The Audit Team observes that policies and procedures of the facility and agency are compliant with this Standard.

## 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?  Yes  No
- Does the facility enable reasonable communication between residents and these organizations and agencies, in as confidential a manner as possible?  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?  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?  Yes  No
- Does the agency maintain copies of agreements or documentation showing attempts to enter into such agreements?  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*)

### Instructions for Overall Compliance Determination Narrative

*The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does*

*not meet the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.*

Bridgeway 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) for local, state, or national victim advocacy or rape crisis organizations, and by enabling reasonable communication between residents and these organizations in as confidential a manner as possible. The facility informs residents, prior to giving them access to outside support services, of the extent to which such communications will be monitored, and of 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. Bridgeway maintains a memorandum of understanding (MOU) with Dearing House to provide residents with emotional support services related to sexual abuse.

Analysis: Evidence used to determine compliance with this Standard includes: Interviews with randomly selected residents and with the Superintendent; Policies governing resident access to outside victim advocates for emotional support services related to sexual abuse (PREA Policy 20-IX); Resident handout pertinent to reporting sexual abuse and access to support services; and the MOU with Dearing House.

Finding: A triangulation of the evidence suggests that Bridgeway upholds this Standard.

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

#### **Instructions for Overall Compliance Determination Narrative**

*The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's*

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

Bridgeway and ODOC provide methods to receive third-party reports of resident sexual abuse or sexual harassment. These can be given by phone, in writing, verbally, and through the ODOC website. They publicly distribute information on how to report resident sexual abuse or sexual harassment on behalf of residents through posters, handbooks, handouts, and through the ODOC website.

Analysis: Evidence used to determine compliance with this Standard includes: Publicly distributed information on how to report sexual abuse or sexual harassment on behalf of residents; DOC website; Site Review; and PREA Policy 30-IX.

Finding: Sufficient evidence exists to show compliance with this Standard.

# 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*)

## Instructions for Overall Compliance Determination Narrative

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

Bridgeway 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. They are also required to report any retaliation against residents or staff who reported such an incident. In addition, they must report any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation. These requirements also apply to information received from third parties and anonymous sources. 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. At the initiation of services, medical and mental health practitioners are required to report sexual abuse, and to inform residents of the practitioner's duty to report, and of the limitations of confidentiality. If the alleged victim is under the age of 18 or is considered a vulnerable adult under a State or local vulnerable persons statute, the agency will report the allegation to the designated State or local services agency under applicable mandatory reporting laws, which is the Oklahoma Department of Human Services.

Analysis: Evidence used to determine compliance with this Standard includes: Interviews with randomly selected staff, and with the administrators; and policy and training materials governing the reporting by staff of incidents of sexual abuse or sexual harassment (PREA Policy 20-IX). Staff and offenders interviewed were asked whether they had made any reports of sexual abuse or harassment or knew of any that had been made within the past year regarding Bridgeway. All indicated they knew of no reports and of no abuse. They also verified that they know how to make reports and would be able to do so if the need arises. They believe that if a report is made, appropriate steps will be taken to protect.

Finding: There have been no indications that Bridgeway has been out of compliance with this Standard.

## 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?  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*)

### Instructions for Overall Compliance Determination Narrative

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

When Bridgeway learns that a resident is subject to a substantial risk of imminent sexual abuse, it takes immediate action to protect the resident (i.e., it takes some action to assess and implement appropriate protective measures without unreasonable delay). In the past 12 months, there have been no times the agency determined that a resident was subject to substantial risk of imminent sexual abuse. This information was verified by both a reading of policy and interviews with residents and staff.

Analysis: Evidence used to determine compliance with this Standard includes: Interviews with the Agency and Facility administrators, and with randomly selected staff; and relevant policy governing the agency's protection duties, when residents are subject to a substantial risk of imminent sexual abuse (PREA Policy 3-1).

Finding: Both the policies and procedures of both the agency and facility comply with both the intent and the requirements of this Standard.

## 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?  Yes  No

#### 115.263 (b)

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

#### 115.263 (c)

- Does the agency document that it has provided such notification?  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?  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*)

### Instructions for Overall Compliance Determination Narrative

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

Bridgeway policy requires that, upon receiving an allegation that a resident was sexually abused while confined at another facility, the head of the Bridgeway facility must notify the head of the other facility, or the appropriate office of the other agency or facility, where sexual abuse is alleged to have occurred. In the past 12 months, there have been no allegations the facility received that a resident was abused while confined at another facility. Policy also requires the facility head to provide such notification as soon as possible, but no later than 72 hours after receiving the allegation, and to document such notification within 72 hours of receiving the allegation. In addition, the agency policy requires that allegations received from other facilities/agencies are investigated in accordance with the PREA Standards.

Analysis: Evidence used to determine compliance with this Standard includes: Interviews with the Agency Head and facility leadership; Agency policy regarding reporting of allegations of sexual abuse of residents while confined at another facility; and Agency policy requiring that allegations of sexual abuse of residents received from other agencies or facilities are investigated in accordance with the PREA Standards (PREA Policy 23-X). In the past 12 months, there have been no allegations of sexual abuse the facility received from other facilities, so the Auditor was not able to review such documentation and response. However, no information was found, whether in the documentation or materials provided, or from individuals contacted in the process of conducting this Audit, that indicated any lack of compliance with this Standard.

Finding: Bridgeway is not out of compliance with this Standard.

## 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?  
 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?  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?  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?  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?  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*)

### Instructions for Overall Compliance Determination Narrative



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

Bridgeway has a First Responder policy for allegations of sexual abuse. This policy requires that, upon learning of an allegation that a resident was sexually abused, the first security staff member to respond to the report will be required to separate the alleged victim and abuser and to preserve and protect any crime scene until appropriate steps can be taken to collect any evidence. If the abuse occurred within a time period that still allows for the collection of physical evidence, the First Responder is 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, staff is 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. In the past 12 months, there have been no allegations that a resident was sexually abused. Interviews indicate staff understand their First Responder duties.

Analysis: Verification was provided that staff and administrators reviewed First Responder Duties during the Pre-Audit Process. Evidence used to determine compliance with this Standard includes: Interviews with administrators and staff, training materials, and PREA Policy 20-IX.

Finding: All stipulations of this Standard are upheld by Bridgeway.

## **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*)

#### **Instructions for Overall Compliance Determination Narrative**

*The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's*

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

Bridgeway has developed a written institutional plan, among staff First Responders, medical and mental health practitioners, investigators, and facility leadership, to coordinate actions taken in response to an incident of sexual abuse.

Analysis: Evidence used to determine compliance with this Standard includes: Interviews with staff and administrators; Agency policy (PREA Policy 20-IX); training materials; and the Coordinated Response Plan. The MOU with the Dearing House and the contract with DOC are consistent with this plan, as well.

Finding: Bridgeway and its agency fulfill this Standard.

## 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*)

### Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does

*not meet the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.*

The agency has neither entered into nor renewed any collective bargaining agreement or other agreement since the last Audit. They retain the ability to protect residents from abuse.

Analysis: No sources indicate any lack of compliance with this Standard.

Finding: The facility is in compliance with this Standard.

## **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?  Yes  No
- Has the agency designated which staff members or departments are charged with monitoring retaliation?  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?  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?  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?  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?  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?  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?  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?  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?  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?  Yes  No
- Does the agency continue such monitoring beyond 90 days if the initial monitoring indicates a continuing need?  Yes  No

#### 115.267 (d)

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

#### 115.267 (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*)

## Instructions for Overall Compliance Determination Narrative

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

Bridgeway has a policy to protect all residents and staff who report sexual abuse or sexual harassment, or who cooperate with sexual abuse or sexual harassment investigations, from retaliation by other residents or staff. The PREA Coordinator and the Facility Director monitor for retaliation themselves, and they delegate staff member(s) to assist with monitoring for possible retaliation, on a case-by-case basis, to assure full compliance with this Standard. They indicate that they monitor through checking with the entire chain of command, and in reviewing and monitoring all reports. Policy and interviews indicate they monitor the conduct or treatment of residents or staff who reported sexual abuse, and of residents who were reported to have suffered sexual abuse, to see if there are any changes that may suggest possible retaliation by residents or staff. They indicate they will utilize shift supervisors, as well, in monitoring conduct and treatment for 90 days, or longer if indicated, and to act promptly to remedy any retaliation. No incidents of retaliation in the past 12 months are known. They use 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. They monitor resident disciplinary reports, housing, and program changes, as well as negative performance reviews and reassignments of staff. Monitoring includes periodic status checks.

Analysis: Policy protecting residents and staff from retaliation found in PREA Policy 22-IX C, training materials, and interviews with agency and facility staff responsible for retaliation monitoring were utilized to determine compliance with this Standard. No logs are available due to no allegations being made in the 12 months prior to the Audit.

Finding: The facility and agency are both in material compliance with the terms of this Standard.

## 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).)  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).)  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?  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?  Yes  No
- Do investigators interview alleged victims, suspected perpetrators, and witnesses?  Yes  No
- Do investigators review prior reports and complaints of sexual abuse involving the suspected perpetrator?  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  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?  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?  Yes  No

#### 115.271 (f)

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

#### 115.271 (h)

- Are all substantiated allegations of conduct that appears to be criminal referred for prosecution?  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?  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?  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).)  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*)

### **Instructions for Overall Compliance Determination Narrative**

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

Bridgeway and ODOC have written policy related to criminal and administrative agency investigations, neither of which are performed by the facility, itself. Substantiated allegations of conduct that appear to be criminal are referred for prosecution. There were no allegations of sexual abuse or harassment in the past 12 months. Policy requires the agency to retain all written reports pertaining to the administrative or criminal investigations of alleged sexual abuse or sexual harassment for as long as the alleged abuser is incarcerated or employed by the agency, plus five years. Investigations are to be done promptly, thoroughly, and objectively for all allegations, including third-party and anonymous reports. Investigators who have received special training in sexual abuse investigations must be used (by the State and/or law enforcement). Investigators will gather and preserve direct and circumstantial evidence, including any available physical and DNA evidence and any available electronic monitoring data; will interview alleged victims, suspected perpetrators, and witnesses; and will review prior complaints and reports of sexual abuse involving the suspected perpetrator. When the quality of evidence appears to support criminal prosecution, the agency will conduct compelled interviews only after consulting with prosecutors as to whether compelled interviews may be an obstacle for subsequent criminal prosecution. The credibility of an alleged victim, suspect, or witness will be assessed on an individual basis and will not be determined by the person's status as resident or staff. No polygraph examination or other truth-telling device is required as a condition for proceeding with the investigation of such an allegation. Administrative investigations will include an effort to determine whether staff actions or failures to act contributed to the abuse; and will be documented in written reports that include a description of the physical and testimonial evidence, the reasoning behind credibility assessments, and investigative facts and findings. Criminal investigations will be documented in a written report that contains a thorough description of physical, testimonial, and documentary evidence and attaches copies of all documentary evidence, where feasible. All written reports are retained for as long as the alleged abuser is incarcerated or employed by the agency, plus five years. The departure of the alleged abuser or victim from the employment or control of the facility or agency will not provide a basis for terminating an investigation.

**Analysis:** Evidence used to determine compliance with this Standard includes: Interviews with the Director and with the PREA Coordinator. Agency and DOC policies related to criminal and administrative agency investigations (PREA Policy 23-X). All investigations are conducted by the Ponca City Police Department and/or the Oklahoma Department of Corrections Staff.

**Finding:** Bridgeway complies in all necessary ways with this Standard.



## 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*)

### Instructions for Overall Compliance Determination Narrative

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

Both Bridgeway and ODOC policy state, and interviews verify, that the agencies impose 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

Analysis: Evidence used to determine compliance with this Standard includes: PREA Policy 5-II and interviews with agency staff from Bridgeway as well as DOC. Training materials are also consistent with this Standard.

Finding: The Audit Team has concluded that Bridgeway fulfills the provisions of this Standard.

## 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?  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.)  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?  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?  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?  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?  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?  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?  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*)

## Instructions for Overall Compliance Determination Narrative

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

The agency has a policy requiring that any resident who makes an allegation that he 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. In the past 12 months there have been no criminal and/or administrative investigations of alleged resident sexual abuse; therefore, no notifications have occurred this past year. According to policy and interviews with PREA Coordinator, 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. Also, following a resident's allegation that a staff member has committed sexual abuse against the resident, the agency/facility subsequently informs the resident (unless the agency has determined that the allegation is unfounded), whenever the staff member is no longer posted within the residence, the staff member is no longer employed at the facility, the agency learns that the staff member has been indicted on a charge related to sexual abuse within the facility, or the agency learns that the staff member has been convicted on a charge related to sexual abuse within the facility. Following a resident's allegation that he has been sexually abused by another resident in an agency (ODOC) facility, the agency subsequently informs the alleged victim whenever the agency learns that the alleged abuser has been indicted on a charge related to sexual abuse within the facility, or the agency learns that the alleged abuser has been convicted on a charge related to sexual abuse within the facility. By policy, and by contractual agreement with ODOC, all notifications to residents described under this Standard are documented.

Analysis: Evidence used to determine compliance with this Standard includes: Interviews with CEO and facility administrators. Agency PREA Policy 27-XI. All investigations are conducted by the Ponca City Policy Department and/or the Oklahoma Department of Corrections Staff. Since there were no allegations, there were no examples of notifications. However, the forms to be used to notify residents were provided for review.

Finding: The policies and procedures of Bridgeway uphold this Standard.

## 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*)

#### Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does

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

Bridgeway staff are subject to disciplinary sanctions up to and including termination, for violating agency sexual abuse or sexual harassment policies. 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 sanction imposed for comparable offenses by other staff with similar histories. All terminations for violations of agency sexual abuse or sexual harassment policies, or resignations by staff who would have been terminated if not for their resignation, are reported to law enforcement agencies, unless the activity was clearly not criminal, and to any relevant licensing bodies.

Analysis: Evidence used to determine compliance with this Standard includes: Staff disciplinary policy regarding violations of Agency sexual abuse or sexual harassment policies (PREA Policy 28-XI B). There have not been any staff from the facility who have been alleged to have violated agency sexual abuse or sexual harassment policies in the past 12 months; but interviews indicate that supervisors are familiar with, and committed to, the policy regarding the discipline of staff.

Finding: Bridgeway is in compliance with this Standard.

## 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?  Yes  No
- Is any contractor or volunteer who engages in sexual abuse reported to: Law enforcement agencies unless the activity was clearly not criminal?  Yes  No
- Is any contractor or volunteer who engages in sexual abuse reported to: Relevant licensing bodies?  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?  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)

### Instructions for Overall Compliance Determination Narrative

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

Bridgeway policy requires that any contractor or volunteer who engages in sexual abuse be reported to law enforcement agencies, unless the activity was clearly not criminal, and to relevant licensing bodies. Agency policy requires that any contractor or volunteer who engages in sexual abuse be prohibited from contact with residents. Bridgeway 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, but the Director and the PREA Coordinator indicate that any violation will probably result in the volunteer being dismissed.

Analysis: Evidence used to determine compliance with this Standard includes: An interview with the CEO, and Agency policy requiring that any contractor or volunteer who engages in sexual abuse against an inmate shall be reported to law enforcement, unless the activity clearly was not criminal in nature (PREA Policy 28-XI C). No contractors or volunteers have been reported to law enforcement agencies and relevant licensing bodies for engaging in sexual abuse of residents, since there have been no allegations. In addition, no contractors or volunteers are allowed to enter the facility at this time.

Finding: While there are likely not to be contractors or volunteers allowed to enter the facility for quite some time in light of the pandemic, policies and procedures are in place to uphold the Standard.

## 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?  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?  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?  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?  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?  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.)  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*)

### Instructions for Overall Compliance Determination Narrative

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

Residents are subject to disciplinary sanctions only pursuant to a formal disciplinary process, following an administrative finding that the resident engaged in resident-on-resident sexual abuse. Sanctions are

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. The disciplinary process considers whether a resident's mental disabilities or mental illness contributed to his behavior when determining what type of sanction, if any, should be imposed. Bridgeway offers therapy, counseling, or other interventions designed to address and correct the underlying reasons or motivations for abuse. The facility considers whether to require the offending resident to participate in such interventions as a condition of access to programming or other benefits, but since Bridgeway is a halfway house not set up to provide such interventions, the offender would likely go back to ODOC for assistance. Bridgeway disciplines residents for sexual conduct with staff only upon finding that the staff member did not consent to such contact.

Analysis: Evidence used to determine compliance with this Standard includes: Interviews with agency administrators and mental health staff; and policy which states that 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 (PREA Policy 29-XI D). There have been no allegations of sexual abuse or harassment by residents in the past 12 months. The PREA Standard requires that disciplinary action be prohibited regarding a report of sexual abuse made in good faith based upon a reasonable belief that the alleged conduct occurred, even if an investigation does not establish evidence sufficient to substantiate the allegation. However, their policy stated, "Investigators are responsible for ensuring all substantiated allegations of prohibited conduct and all allegations that are substantiated or unfounded are referred appropriately for disciplinary action." The language should not include "unfounded" allegations among those to be referred for disciplinary action. Corrected language has been drafted and is awaiting Board approval but has been put into immediate effect at the facility by order of the Director/CEO. It now states, ". . . all substantiated allegations of prohibited conduct are referred appropriately for disciplinary action; for the purpose of disciplinary action, a report of sexual abuse made in good faith based upon a reasonable belief that the alleged conduct occurred shall not constitute falsely reporting an incident or lying, even if an investigation does not establish evidence sufficient to substantiate the allegation (115.278)".

Finding: With corrected policies in effect, Bridgeway is fully compliant with the Standard.



## 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?  
 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?  Yes  No
- Do security staff first responders immediately notify the appropriate medical and mental health practitioners?  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?  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?  
 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*)

#### Instructions for Overall Compliance Determination Narrative

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

Bridgeway resident victims of sexual abuse receive timely, unimpeded access to emergency medical treatment and crisis intervention services. The nature and scope of such services are determined by medical and mental health practitioners according to their professional judgment. Medical and mental health staff maintain secondary materials documenting the timeliness of emergency medical treatment and crisis intervention services that were provided the appropriate response by non-health staff, in the event health staff are not present at the time the incident is reported, and the provision of appropriate and timely information and services concerning sexually transmitted infection prophylaxis. 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.

Analysis: Evidence used to determine compliance with this Standard includes: There are no onsite emergency medical or mental health services, but staff who provide these services were interviewed. Policy (PREA policy 30 XIII) and the contract with the Oklahoma Department of Corrections indicate residents must be provided these services. The DOC contract monitor was interviewed and indicates compliance with these obligations. Contract monitoring documentation was provided.

Finding: The Audit Team concludes that the provisions in place are compliant with this Standard.

## **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?  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?  Yes  No

#### **115.283 (c)**

- Does the facility provide such victims with medical and mental health services consistent with the community level of care?  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.*)  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.*)  Yes  No  NA

#### 115.283 (f)

- Are resident victims of sexual abuse while incarcerated offered tests for sexually transmitted infections as medically appropriate?  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?  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?  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*)

### Instructions for Overall Compliance Determination Narrative

*The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor’s analysis and reasoning, and the auditor’s conclusions. This discussion must also include corrective action recommendations where the facility does*

*not meet the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.*

Bridgeway offers medical and mental health evaluation and, as appropriate, treatment, to all residents who have been victimized by sexual abuse in any prison, jail, lockup, or juvenile facility. Since they do not house female residents, portions of the Standards dealing with female residents are not applicable. Resident victims of sexual abuse while incarcerated are offered tests for sexually transmitted infections as medically appropriate, and 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. 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 (in the community) when deemed appropriate by mental health practitioners.

Analysis: Evidence used to determine compliance with this Standard includes: Policy and procedures governing ongoing medical and mental health care for sexual abuse victims and abusers (PREA Policy 29-XI D) and interviews with administrators and residents. Moreover, a review of counseling services available to residents of Bridgeway in the community, as well as at DOC facilities to which they are transported regularly, was also helpful in determining compliance with this Standard. In addition, the contract with DOC obligates Bridgeway residents to be provided this level of care.

Finding: The policies and procedures of Bridgeway comply with this Standard.

## 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?  Yes  No

#### 115.286 (b)

- Does such review ordinarily occur within 30 days of the conclusion of the investigation?  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?  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?  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?  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?  Yes  No
- Does the review team: Assess the adequacy of staffing levels in that area during different shifts?  Yes  No
- Does the review team: Assess whether monitoring technology should be deployed or augmented to supplement supervision by staff?  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?  Yes  No

## 115.286 (e)

- Does the facility implement the recommendations for improvement, or document its reasons for not doing so?  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*)

### Instructions for Overall Compliance Determination Narrative

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

Policy requires that the facility conduct sexual abuse Incident Reviews within 30 days of the conclusion of every criminal or administrative sexual abuse investigation, unless the allegation has been determined to be unfounded. Interviews with the Director and the PREA Coordinator verify that the Review Team will consider whether the allegation or investigation indicates a need to change policy or practice to better prevent, detect, or respond to sexual abuse. Bridgeway has streamlined the system for instituting policy changes. Also, the Review Team will consider whether the incident or allegation was motivated by race; ethnicity; gender identity; lesbian, gay, bisexual, transgender, or intersex identification, status, or perceived status; or gang affiliation; or was motivated or otherwise caused by other group dynamics at the facility. They will examine the area in the facility where the incident allegedly occurred, to assess whether physical barriers in the area may enable abuse. They will assess the adequacy of staffing levels in that area during different shifts. They will assess whether monitoring technology should be augmented to supplement supervision by staff. They will prepare a report of findings and implement the changes or document why changes could not be implemented. The sexual abuse Incident Review Team includes upper-level management officials, and it allows for input from line supervisors, investigators, and medical or mental health practitioners.

Analysis: Evidence used to determine compliance with this Standard includes interviews with the Director, with the PREA Coordinator, and with Incident Review Team members; and a review of policies and procedures on conducting sexual abuse Incident Reviews found in PREA Policy 25 XI. Determining compliance with this Standard relied heavily on investigations and policy, since there were no allegations, and thus, there was no documentation of sexual abuse Incident Reviews to review.

Finding: Nothing was found or heard that would suggest lack of compliance with this Standard at Bridgeway.

## 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?  Yes  No

**115.287 (b)**

- Does the agency aggregate the incident-based sexual abuse data at least annually?  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*)

**Instructions for Overall Compliance Determination Narrative**

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

The agency collects accurate, uniform data for every allegation of sexual abuse, using a standardized instrument and set of definitions. The standardized instrument includes the data necessary to answer all questions from the most recent version of the Survey of Sexual Victimization conducted by the Department of Justice. Incident-based sexual abuse data is aggregated at least annually. Data is maintained, reviewed, and collected as needed, from all available incident-based documents, including reports, investigation files, and sexual abuse incident reviews. The information is available to the Department of Justice upon request.

Analysis: Evidence used to determine compliance with this Standard includes: the policy regarding sexual abuse data collection and the set of definitions used for collecting data on sexual abuse allegations at facilities (found in PREA Policy 31-XIV); and the data collection instrument used for collecting data on sexual abuse allegations at facilities. Since there were no investigations conducted during the past year, there were no corrective actions from Incident Reviews of investigations.

Finding: Bridgeway acts in accordance with this Standard.

## **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

- 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*)

### Instructions for Overall Compliance Determination Narrative

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

Bridgeway reviews data collected and aggregated pursuant to §115.287 in order to assess and improve the effectiveness of 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 findings from data review and any corrective actions. The Annual Report, which is approved by the agency head, includes a comparison of the current year's data and corrective action with those from prior years. The Annual Report provides an assessment of progress in addressing sexual abuse. The latest Annual Report was completed during the 30-days after the On-Site Audit and made available to the public.

Analysis: Evidence used to determine compliance with this Standard includes: Interviews with the Agency Head and PREA Coordinator; a review of policy and Annual Reports; and a posted notice, which explains the Reports and which notes that PREA Policy is available to anyone who asks.

Finding: Bridgeway upholds the components of this Standard.

## 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?  
 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?  Yes  No

#### 115.289 (c)

- Does the agency remove all personal identifiers before making aggregated sexual abuse data publicly available?  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*)

### Instructions for Overall Compliance Determination Narrative

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

The agency ensures that incident-based and aggregate data are securely retained. ODOC and Bridgeway policy require that aggregated sexual abuse data be made readily available to the public. Before making aggregated sexual abuse data publicly available, the agency removes all personal identifiers. Sexual abuse data collected pursuant to §115.287 is maintained for at least 10 years after the date of initial collection. The current Annual Report was completed during the 30-days after the On-Site Audit and made available to the public.

Analysis: Evidence used to determine compliance with this Standard includes: Interview with PREA Coordinator; policy requiring that incident-based and aggregate data are securely retained; and policy requiring that aggregated sexual abuse data, from facilities under its direct control (PREA Policy 31-XIV D). The reports are made readily available to the public during business hours. A digital photo of the

public posting in the lobby of the facility was provided to the Audit Team during the 30 days after the On-Site Audit.

Finding: The agency and facility materially comply with this Standard.

## 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*)

### Instructions for Overall Compliance Determination Narrative

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

Bridgeway operates only one facility. This is their third PREA audit. The COVID-19 pandemic kept the Audit from being held during the first year of the audit cycle.

Finding: Given the extraordinary circumstances and the leniency extended, Bridgeway is not out of compliance with this Standard.

## 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.)  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*)

### **Instructions for Overall Compliance Determination Narrative**

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

Bridgeway utilizes the website of the Oklahoma Department of Corrections for the publication of their Audit Reports. The previous report (2017) can be found at [http://doc.omes.acsitefactory.com/sites/g/files/gmc771/f/documents/2020/bridgeway\\_prea\\_audit\\_final\\_report\\_2017.pdf](http://doc.omes.acsitefactory.com/sites/g/files/gmc771/f/documents/2020/bridgeway_prea_audit_final_report_2017.pdf).

The 2015 audit is as

[http://doc.omes.acsitefactory.com/sites/g/files/gmc771/f/documents/2020/bridgeway\\_prea\\_audit\\_final\\_report\\_july\\_2015\\_0.pdf](http://doc.omes.acsitefactory.com/sites/g/files/gmc771/f/documents/2020/bridgeway_prea_audit_final_report_july_2015_0.pdf).

Finding: Bridgeway fulfills the obligations of this Standard.

## 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.<sup>1</sup> Auditors are not permitted to submit audit reports that have been scanned.<sup>2</sup> See the PREA Auditor Handbook for a full discussion of audit report formatting requirements.

D. Will Weir

11-28-2020

**Auditor Signature**

**Date**

<sup>1</sup> See additional instructions here: <https://support.office.com/en-us/article/Save-or-convert-to-PDF-d85416c5-7d77-4fd6-a216-6f4bf7c7c110>.

<sup>2</sup> See *PREA Auditor Handbook*, Version 1.0, August 2017; Pages 68-69.