

PREA Retaliation Monitoring Sheet

Resident or Staff Being Retaliated Against:

(For at least 90 days following a report of sexual abuse, the facility will monitor the conduct or treatment of residents or staff who reported the sexual abuse and 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, and shall act promptly to remedy any such retaliation).

Resident Name (Print)	Staff Name (Print)

Charge (s) Reported: _____ Sexual Abuse _____ Sexual Harassment _____ Bullying/Retaliation

Monitoring Information:

Date	Time	Shift

1. Are you experiencing any problems from other residents and/or staff since reporting these charges?
___ yes ___ No, If Yes, Explain.

2. Do you feel safe in the facility? ___ Yes ___ No, If No would you like to request to be moved and/or reassigned to another facility/office? ___ Yes ___ No, briefly explain reason why you aren't feeling safe.

3. Is there anything else that you would like for me to know as it pertains to you reporting this incident? ___ Yes ___ No
If yes please explain.

To Be Completed by PREA Retaliation Monitor and Director

- A. Is this resident on a Safety/Special Management Plan? ___ Yes ___ No, if no, when will one be created?

- B. If a Plan isn't created immediately, within 2 hours of notification of imminent threat, what measures were put in place to protect resident until Plan could be completed? Please give detailed description of actions taken to ensure no further bullying and/or retaliation could occur to include who, what, when, where, how until Safety/Special Management Plan could be created. **(Attach a copy of the Safety/Special Management Plan to this form).**
- C. What short and long term action have been or will be taken to protect the staff? Please attach a copy of all and any documentation to support action taken.
- D. If a move or reassignment of youth and/or staff is necessary please attach a copy of request and document location of youth and/or staff.

Staff Signature: _____ Date: _____

Printed Name: _____

Resident Signature: _____ Date: _____

Resident Name: _____

Monitor's Signature: _____ Date: _____

Director's Signature: _____ Date: _____

Please copy in the PREA Files for Agency PREA Coordinator Review.