

PREA Audit: PREA AUDITOR'S FINAL SUMMARY REPORT

Community Confinement Facilities

Name of facility: Western Ohio Regional Treatment and Habilitation Center (W.O.R.T.H. Center)
Physical address: 243 E. Bluelick Rd, Lima, OH 45801
Date report submitted: February 12, 2015

Auditor Information

Name: Michelle Bonner
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Date of facility visit: July 11, July 14, 2014

Facility Information

Facility mailing address: (if different from above) Same

Telephone number: 419-222-3339

The facility is: County

Facility Type Community Treatment Center

Name of Facility Head: Brent Burk
Title: Interim Executive Director
Email address: bburk@allencountyohio.com
Telephone number: 419-222-3339 x204
Name of PREA Compliance Manager (if applicable): Charles Honigford

Title: Clinical Services Director
Email address: chonigford@allencountyohio.com
Telephone number: 419-222-3339 x214

Agency Information**Name of Agency:****Governing authority or parent agency:** (if different from above)**Ohio Department of Rehabilitation and Correction (ODRC)****Telephone number:****Agency Chief Executive Officer****Name:** Gary C. Mohr**Title:** Director**Email address:** Gary.Mohr@odrc.state.oh.us**Telephone number:** 614-752-1164**Agency-Wide PREA Coordinator****Name:** Andrew Albright**Title:** Chief, Bureau of Agency Policy and Operational Compliance**Email address:** Andrew.Albright@odrc.state.oh.us**Telephone number:** 614-752-1708**AUDIT FINDINGS**

NARRATIVE: [The auditor should provide a summary of the audit process that includes the date of audit, who was in attendance, a description of sampling procedures and staff and residents interviewed, areas of facility toured as part of the audit, etc.]

Michelle Bonner, an independent contractor certified by the United States Department of Justice (DOJ) to conduct audits of community confinement facilities to assess their compliance with the DOJ-adopted standards of the Prison Rape Elimination Act of 2003 (PREA), conducted an onsite audit of the Western Ohio Regional Treatment and Habilitation Center (hereinafter, "WORTH Center"), 243 E. Bluelick Rd Lima, OH 45801, on July 11 and July 14, 2014. WORTH serves nine surrounding counties, and is located in Allen County, Ohio. During the audit, 71 residents were present at the facility, 23 of whom were women; and the facility employed 45 staff members.

WORTH is one of nineteen community based correctional facilities (CBCF's) in the state of Ohio. Ohio's Bureau of Community Sanctions, Ohio Department of Rehabilitation and Corrections (ODRC), defines CBCF's as "residential sanctions that provide local

Courts of Common Pleas a sanctioning alternative to prison. Each program is highly structured with assessment, treatment, and follow-up services for offenders. CBCFs provide intensive substance abuse treatment/education, educational services, job training, mental health and transitional services to the community.”¹ The CBCF’s employ cognitive behavioral techniques (CBT) in their programming.² WORTH is one such program; its mission is “enhancing the WORTH of individuals by giving them skills and insights to become successful, caring and involved community members.”

WORTH is the third of nine CBCF’s for which Auditor Bonner conducted audits in July 2014, through a memorandum of understanding between the auditor and CorJus, a nonprofit coalition of many of the CBCF’s in the state of Ohio. While ODRC provides partial to complete funding of these CBCF’s to serve multi-county regions of the state, the CBCF’s each stand alone as distinct agencies, with their own facility governing boards, staff, policies and procedures, and their individual PREA policies and implementation. Auditor Bonner is providing separate reports for each of the nine facilities, according to their individual audits. Auditor Bonner arrived at the WORTH Center at 8:40 am on Friday, July 11, 2014. There she was greeted by Clinical Director and PREA Coordinator Chuck Honigford, and met the other directors in the administration area’s conference room: Interim Facility Director Brent Burk, Interim Deputy Director Lorrie Wilson, and Director of Administration Peg Elmquist. The group was also met by immediate former facility director Mark Furstenau and PREA Consultant Jen Morgenstern. After a brief opening meeting, the group (minus former director and director of administration) toured the entire facility. The tour consisted of examining all rooms, offices, closets, restrooms, and exits of the men’s wing, female, wing, intake, segregation, kitchen, visitation/dining and control center. Then the group returned to administration area of the facility.

During the course of the two days, in addition to speaking with staff during the facility tour, Auditor Bonner conducted one-on-one interviews with the following staff for specialized staff inquiries and general staff inquiries:

- Interim Facility Director
- Clinical Director/PREA Coordinator
- Interim Deputy Director
- Director of Administration
- Contract Food Service Director
- Contract Medical LPN
- 2 Resident Specialists
- Resident Manager
- 2 Case Managers
- Intake Coordinator

¹ Annual Report 2014, Bureau of Community Sanctions, Christopher Galli, Chief, Ohio Department of Rehabilitation and Correction, p. 3.

² *Id.*, p. 8.

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- Sr. Manager of Security
 - Volunteer

Auditor Bonner also met individually with ten residents, three of whom were female residents. As no residents were specifically identified by sexual identity, disability, or report of sexual abuse or sexual harassment, these residents were chosen at random, based on color group assignment and dorm assignment. During the two-day audit, Auditor Bonner conducted document review which included review of employee files (including new hires, terminations, spot check of five year background checks and promotions), security logs, PREA assessments/reassessments/designation documents, client files (including disciplinary documents), staff/volunteer training logs/acknowledgements, employee training materials, resident orientation verifications, PREA specialized training certificates, PREA forms and data logs. Auditor was onsite for 8 hours on July 11 and 12 hours on July 14. Near the end of the second day, Auditor held a closeout session with the facility directors, during which she shared some of her immediate observations.

DESCRIPTION OF FACILITY CHARACTERISTICS: [The auditor should include a summary describing the facility.]

WORTH Center is a one level building, the majority of which was constructed in 1991, with the female wing being added in 1996. The older portion contains the male dorm area, kitchen, larger dining/visitation area, female dining, intake with segregation cells, the main control center, and administration. The male dorm area consists of a large central day room, around which are case management offices/classrooms, counselors offices, laundry, restrooms, a pat-down room, and nine residents' rooms that each contain 4 bunks (eight beds) with lockers. WORTH has four pan/tilt/zoom cameras covering the day room, along with cameras in each of the two restrooms and laundry room. The restroom cameras are angled so as not to show men exiting shower or using the toilets/urinals; and blackout boxes are strategically placed on monitors to further block where male genital area might appear on screen. The shower curtains have clear tops to see number of occupants in individual showers during monitoring rounds. There are no cameras in the classrooms, but mirrors are strategically placed to see blind spots from the windows in doors. All doors surrounding the day room have windows, including dorm doors. There is no camera in the pat-down room. Central Control looks out onto the day room. PREA signage is placed near the control room windows; and phone numbers to outside services are placed near the six pay phones positioned between the dorms.

The male recreation yard is covered by a camera on one side of the L-shaped yard. When residents are outside staff is placed at the bend of the L to see both sides of the yard. At the opposite end of the L from the camera there is a blind spot in this side yard that will be blocked off by a permanent fence.

The two dining areas, kitchen and storage separate the men's wing from the newer female wing. The larger dining area also acts as a group room and visitation for all residents; and it is monitored by three cameras and Central Control. The kitchen has five

cameras; and the female dining area has three cameras.

The older building also contains the administration area, which has two cameras along the halls, due to the space being cleaned by residents. The intake area has an office with intake staff, an aftercare office, and two holding cells. There are two cameras in the intake area and cameras in each of the holding cells, with blackout boxes positioned to block out toilet areas on the monitors. The lobby leading to administration, intake and visitation has camera coverage, as well as coverage by Central Control. Central Control is staffed 24 hours per day, and overlooks the male dayroom, lobby, and dining/visitation areas. All forty cameras are monitored in this area.

The female wing consists of its own day room, group rooms, case manager office, restroom, laundry, and intake area. The intake area consists of a nurse's station, holding cell, observation desk, and a strip search/shower area. There are five cameras in the female wing, including two in dayroom, one in holding cell, and the other two near a hall and observation desk area. There are two open bay dorms for women, each containing 6 bunks (12 beds) plus 1-2 cots. PREA signage is prominently displayed in dorms, restroom, and near phones. Residents are generally not in bedroom areas during the day; and there are no male monitors in the female wing after 8 pm. For the female recreation area, there is a camera on the door, and staff presence visibility. Where there are no cameras in intake, classroom, and laundry room, there are mirrors to aid in monitoring these areas.

SUMMARY OF AUDIT FINDINGS: [The auditor should include a summary statement of the overall audit findings. E.g.: On March 1, 2013 X number of site visits were completed at facility XYZ in X County, Maryland. The results indicate....Facility X exceeded X of standards; met X of standards; X of standards were not met.]

After a few years of management changes, WORTH Center is now in a phase of new leadership. An interim director, interim deputy director, and a new clinical director have led the facility for under six months. Fortunately, PREA is front and center in this new leadership's priorities. The clinical director volunteered to be the PREA Coordinator; and he reports directly to the interim director. The facility hired a PREA consultant (who is also a DOJ-Certified PREA auditor) to assist in the writing and implementation of PREA policies this year. This has resulted in a relatively smooth and even implementation for staff as well as residents.

In regards to the physical plant, WORTH Center is making the most with what it has in the realm of monitoring technology. Although they have acquired some new cameras, the facility is still in need of newer and additional cameras, especially exterior cameras. However, the facility does employ the use of mirrors to compensate for the lack of video monitoring in classrooms, the kitchen, and women's laundry. The facility anticipates that it will have a new control panel for its camera system sometime during the summer of 2014.

During the tour, staff endeavored to correct blind spots and safety monitoring challenges in real time by doing such simple, low cost items such as shortening women's shower curtains (to be replaced with ones with clear bottoms or tops to reduce water

splashing and wet, slippery floors), hanging a mirror in the kitchen's stock room, and moving bunks closer to the wall. During the tour, the interim director committed to fencing in yard area that is a major blind spot due to lack of camera coverage in the male rec yard. Also during the tour, the facility also made signs for phone numbers for outside services to be hung near resident pay phones throughout.

In addition to its PREA training, the facility held a very thorough, comprehensive half-day training on lesbian, gay, bisexual, transgender, intersex, and questioning (LGBTIQ) definitions and issues for its staff. While there has been some sexual harassment regarding sexual identity, WORTH Center tends to respond to offensive language, gestures, and writings before they become repeated forms of sexual harassment. Disciplinary sanctions involve behavioral management: not merely taking something away but causing the disciplined resident to process his behavior and better understand his actions, thereby positively changing his "cognitive blueprint." Interviewed residents said that a new resident might come in and make a sexually offensive remark, but the facility responds immediately, and that resident then no longer makes such comments. The new resident conforms to the culture of the facility that endeavors to remain free of sexual abuse and sexual harassment.

The new era of leadership at WORTH Center is committed to the effective implementation of PREA and to creating a culture free of sexual abuse and harassment of residents. Of course, the goal is for PREA to remain long beyond their individual tenures at the facility; and WORTH Center is laying a very good foundation to making this happen.

Number of standards exceeded:	4
Number of standards met:	34
Number of standards not met:	0
Number of standards N/A:	1

FOLLOWING INFORMATION TO BE POPULATED AUTOMATICALLY FROM AUDITOR COMPLIANCE TOOL:

PREVENTION PLANNING	
Overall Determination:	§115.211 -- Zero tolerance of sexual abuse and sexual harassment; PREA coordinator.
	<p>✓ Exceeds Standard (substantially exceeds requirement of standard) Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period) Does Not Meet Standard (requires corrective action)</p> <p>Auditor Comments (including corrective actions needed if does not meet standard):</p>

(a) The facility has a written policy mandating zero tolerance toward all forms of sexual abuse and sexual harassment in facilities it operates directly or under contract.

The facility has a written policy outlining how it will implement the facility's approach to preventing, detecting, and responding to sexual abuse and sexual harassment.

The policy includes definitions of prohibited behaviors regarding sexual abuse and sexual harassment.

The policy includes sanctions for those found to have participated in prohibited behaviors.

The policy includes a description of facility strategies and responses to reduce and prevent sexual abuse and sexual harassment of residents.

(b) The facility employs or designates an upper-level, facility-wide PREA coordinator.

The PREA coordinator has sufficient time and authority to develop, implement, and oversee facility efforts to comply with the PREA standards in all of its community confinement facilities. The PREA Coordinator volunteered for this position, and has put tremendous time and effort into the training of staff on PREA and LGBTIQ issues.

The position of the PREA coordinator in the facility's organizational structure: Clinical Director, reporting directly to Interim Director.

Overall Determination: **§115.212 -- Contracting with other entities for the confinement of residents.**

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

Auditor Comments (including corrective actions needed if does not meet standard):

Overall Determination: **§115.213 -- Supervision and monitoring.**

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

Auditor Comments (including corrective actions needed if does not meet standard):

- (a) The facility develops and documents a staffing plan that provides for adequate levels of staffing, and, where applicable, video monitoring to protect residents against sexual abuse. The facility has video monitoring in dorms, restrooms, and segregation cells, with strategically placed blackout areas over toilets to avoid monitoring of male residents' genital areas.
- (b) Facility policy is that each time the staffing plan is not complied with, the facility documents and justifies all deviations from the staffing plan. There have been no deviations from the staffing plan in the last 12 months.

Overall Determination: **§115.215 - Limits to cross--gender viewing and searches.**

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

Auditor Comments (including corrective actions needed if does not meet standard):

- (a) The facility does NOT conduct cross--gender strip or cross--gender visual body cavity searches of residents.
- (b) The facility does NOT permit cross--gender pat--down searches of female residents, absent exigent circumstances. There have been no exigent circumstances. The facility does not restrict female residents' access to regularly available programming or other outside opportunities in order to comply with this provision.
- (c) Facility policy requires that all cross--gender strip searches and cross--gender visual body cavity searches be documented.
- (d) Facility has implemented policies and procedures that enable residents to shower, perform bodily functions, and change clothing without non--medical staff of the opposite gender viewing their breasts, buttocks, or genitalia, except in exigent circumstances or when such viewing is incidental to routine cell checks (this includes viewing via video camera). Policies and procedures require staff of the opposite gender to announce their presence when entering a resident housing unit.
- (e) Facility has a policy prohibiting staff from searching or physically examining a transgender or intersex resident for the sole purpose of determining the resident's genital status.
- (f) All security staff have received training on conducting cross--gender pat--down searches and searches of transgender and intersex residents in a professional and respectful manner, consistent with security needs.

Overall Determination: **§115.216 - Residents with disabilities and residents who are limited English proficient**

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

Auditor Comments (including corrective actions needed if does not meet standard):

- (a) The facility has established procedures to provide disabled residents equal opportunity to participate in or benefit from all aspects of the facility's efforts to prevent, detect, and respond to sexual abuse and sexual harassment.
- (b) The facility has established procedures to provide residents with limited English proficiency equal opportunity to participate in or benefit from all aspects of the facility's efforts to prevent, detect, and respond to sexual abuse and sexual harassment. The facility would use Vocalink interpreting services if needed.
- (c) Facility policy prohibits use of resident interpreters, resident readers, or other types of resident assistants except in limited circumstances where an extended delay in obtaining an effective interpreter could compromise the resident's safety, the performance of first--response duties under § 115.264, or the investigation of the resident's allegations. The facility documents the limited circumstances in individual cases where resident interpreters, readers, or other types of resident assistants are used.

Overall Determination: **§115.217 - Hiring and promotion decisions.**

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

Auditor Comments (including corrective actions needed if does not meet standard):

- (a) Facility 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 the activity described in paragraph (a)(2) of this section.
- (b) Facility 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.
- (c) Facility policy requires that before it hires any new employees who may have contact with residents, it (1) conducts criminal background record checks, and (2) consistent with federal, state, and local law, makes its best efforts to contact all prior institutional employers for information on substantiated allegations of sexual abuse or any resignation during a pending investigation of an allegation of sexual abuse.
- (d) Facility policy requires that a criminal background record check be completed before enlisting the services of any contractor who may have contact with residents.
- (e) Facility policy requires that either criminal background record checks be conducted at least every five years for current employees and contractors who may have contact with residents or that a system is in place for otherwise capturing such information for current employees.
- (f) The facility shall 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 and in any interviews or written self-- evaluations conducted as part of reviews of current employees. The facility shall also impose upon employees a continuing affirmative duty to disclose any such misconduct.
- (g) Facility policy states that material omissions regarding such misconduct, or the provision of materially false information, shall be grounds for termination.
- (h) Unless prohibited by law, the facility shall 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.

Overall Determination: §115.218 - Upgrades to facilities and technology.

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

Auditor Comments (including corrective actions needed if does not meet standard):

(a) The facility has NOT acquired a new facility or made a substantial expansion or modification to existing facilities since August 20, 2012.

(b) The facility has installed or updated a video monitoring system, electronic surveillance system, or other monitoring technology since August 20, 2012. The facility has added two cameras in the holding cells with toilet area blocked out, two cameras in the administration wing, and one camera in the lobby.

RESPONSIVE PLANNING

Overall Determination: §115.221 - Evidence protocol and forensic medical examinations

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

Auditor Comments (including corrective actions needed if does not meet standard):

(a) The facility is responsible for conducting administrative sexual abuse investigations (including resident--on--resident sexual abuse or staff sexual misconduct). The Allen County Sheriff's Office has responsibility for conducting criminal investigations.

When conducting a sexual abuse investigation, the facility investigators follow a uniform evidence protocol.

(b) The protocol was adapted from or otherwise based on the most recent edition of the DOJ's Office on Violence Against Women publication, "A National Protocol for Sexual Assault Medical Forensic Examinations, Adults/Adolescents," or similarly comprehensive and authoritative protocols developed after 2011.

(c) The facility offers to all residents who experience sexual abuse access to forensic medical examinations at St. Rita's Medical

Center in Lima, OH. Forensic medical examinations are offered without financial cost to the victim. Where possible, examinations are conducted by Sexual Assault Forensic Examiners (SAFEs) or Sexual Assault Nurse Examiners (SANEs). When SANEs or SAFEs are not available, a qualified medical practitioner performs forensic medical examinations. The facility documents efforts to provide SANEs or SAFEs.

(d) The facility attempts to make a victim advocate from a rape crisis center available to the victim, either in person or by other means. These efforts are documented. The rape crisis center, Allen County Crime Victims Center, has four victim advocates on call a all times. However, if and when the rape crisis center is not available to provide victim advocate services, the facility provides a qualified facility staff member, the Clinical Director/PREA Coordinator, who is also a licensed counselor.

(e) If requested by the victim, a victim advocate, qualified facility 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.

(f) When the facility is not responsible for conducting criminal allegations of sexual abuse and relies on the Allen County Sheriff's Office to conduct these investigations, the facility has requested that the sheriff's office follow the requirements of paragraphs §115.221 (a) through (e) of the standards.

Overall Determination:	§115.222 - Policies to ensure referrals of allegations for investigations.
	Exceeds Standard (substantially exceeds requirement of standard)
✓	Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
	Does Not Meet Standard (requires corrective action)
	Auditor Comments (including corrective actions needed if does not meet standard):

(a) The facility 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, two allegations of sexual harassment were received, both resulting in administrative investigations. No allegations were referred for criminal investigation. Both administrative investigations were completed.

(b) The facility has a policy that requires that allegations of sexual abuse or sexual harassment be referred for investigation to an agency with the legal authority to conduct criminal investigations, unless the allegation does not involve potentially criminal behavior. Facility policy regarding the referral of allegations of sexual abuse or sexual harassment for criminal investigation is

published on the facility website or made publicly available via other means.

The facility documents all referrals of allegations of sexual abuse or sexual harassment for criminal investigation.

(c) Allen County Sheriff's Office is responsible for conducting criminal investigations; and such publication shall describe the responsibilities of both the facility and the investigating entity, i.e., the sheriff's office.

TRAINING AND EDUCATION	
Overall Determination:	<u>§115.231 - Employee training.</u>
	<p>✓ Exceeds Standard (substantially exceeds requirement of standard) Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period) Does Not Meet Standard (requires corrective action)</p> <p>Auditor Comments (including corrective actions needed if does not meet standard): THE FACILITY'S HALF-DAY TRAINING ON LBGTQI ISSUES IS A BEST PRACTICE. THE PREA COORDINATOR DESIGNED AND PROVIDED THIS TRAINING FOR ALL STAFF, GIVEN IMMEDIATELY AFTER THE MORE GENERAL PREA EMPLOYEE TRAINING. THE TRAINING ALSO INCLUDED AND DEFINED THOSE WHO ARE QUESTIONING THEIR SEXUAL IDENTITY, GENDER, OR SEXUAL ORIENTATION.</p>

(a) The facility trains all employees who may have contact with residents on the following matters.

- (1) Its zero--tolerance policy for sexual abuse and sexual harassment;
- (2) How to fulfill their responsibilities under facility sexual abuse and sexual harassment prevention, detection, reporting, and response policies and procedures;
- (3) Residents' rights to be free from sexual abuse and sexual harassment;
- (4) The right of residents and employees to be free from retaliation for reporting sexual abuse and sexual harassment;
- (5) The dynamics of sexual abuse and sexual harassment in confinement;
- (6) The common reactions of sexual abuse and sexual harassment victims;
- (7) How to detect and respond to signs of threatened and actual sexual abuse;
- (8) How to avoid inappropriate relationships with residents;

- (9) How to communicate effectively and professionally with residents, including lesbian, gay, bisexual, transgender, intersex, questioning or gender nonconforming residents – A BEST PRACTICE; and
- (10) How to comply with relevant laws related to mandatory reporting of sexual abuse to outside authorities.
- (b) Training is tailored to the gender of the residents at the facility.
- (c) Between trainings, the facility provides employees who may have contact with residents with refresher information about current policies regarding sexual abuse and sexual harassment. Employees who may have contact with residents receive refresher training on PREA requirements every two years.
- (d) The facility documents that employees who may have contact with residents understand the training they have received through employee signature or electronic verification.

Overall Determination: **§115.232 - Volunteer and contractor training**

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

Auditor Comments (including corrective actions needed if does not meet standard): FACILITY ENSURED THAT ALL VOLUNTEERS WHO WERE COMMITTED TO VOLUNTEERING WERE TRAINED VIA VIDEO AND PRESENTATION BY STAFF. 40 PACKETS FOR VOLUNTEERS WERE MADE AND KEPT AT FRONT DESK SO THAT VOLUNTEERS WOULD HAVE TO ATTEND TRAINING PRIOR TO REENTRY. AS OF 10/29/14, 23 VOLUNTEERS CERTIFIED THAT THEY RECEIVED PREA TRAINING.

- (a) All volunteers and contractors who have contact with residents have been trained on their responsibilities under the facility's policies and procedures regarding sexual abuse/harassment prevention, detection, and response.
- (b) The level and type of training provided to volunteers and contractors is based on the services they provide and level of contact they have with residents. Contractors who work with residents, such as medical and kitchen contractors, have been trained as staff have been trained.
All volunteers and contractors who have contact with residents have been notified of the facility's zero--tolerance policy regarding sexual abuse and sexual harassment and informed how to report such incidents.
- (c) The facility maintains documentation confirming that volunteers/contractors understand the training they have received.

Overall Determination: **§115.233 - Resident education.**

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

Auditor Comments (including corrective actions needed if does not meet standard):

- (a) Residents receive information at time of intake about the zero--tolerance policy, how to report incidents or suspicions of sexual abuse or harassment, their rights to be free from sexual abuse and sexual harassment and to be free from retaliation for reporting such incidents, and regarding facility policies and procedures for responding to such incidents. In addition to intake, residents receive a PREA orientation with the ODRC PREA education video within a week of their arrival.
- (b) The facility provides residents who are transferred from a different community confinement facility with refresher information referenced in 115.233(a).
- (c) Resident PREA education is available in accessible formats for residents including those who are: limited English proficient, limited in reading skills, otherwise disabled. Resident PREA education is NOT available in accessible formats for residents who are deaf or visually impaired.
- (d) The facility maintains documentation of resident participation in PREA education sessions.
- (e) The facility ensures that key information about the facility's PREA policies is continuously and readily available or visible through posters, resident handbooks, or other written formats.

Overall Determination: **§115.234 - Specialized training: Investigations.**

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

Auditor Comments (including corrective actions needed if does not meet standard):

- (a) Facility policy requires that investigators are trained in conducting sexual abuse investigations in confinement settings.
- (b) Specialized training shall include 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.
- (c) The facility maintains documentation showing that investigators have completed the required training. PREA Coordinator, Interim Deputy Director, and Interim Director have all received ACA Essential Learning on Investigations.

Overall Determination: **§115.235 - Specialized training: Medical and mental health care.**

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

Auditor Comments (including corrective actions needed if does not meet standard):

- (a) The facility has a policy related to the training of medical and mental health practitioners who work regularly in its facilities. All medical and mental health care practitioners who work regularly at this facility received the training.
- (b) Facility medical staff DO NOT conduct forensic exams.
- (c) The facility maintains documentation showing that medical and mental health practitioners have completed the required training.
- (d) Medical and mental health care practitioners also receive the training mandated for employees under § 115.231 or for contractors and volunteers under § 115.232, depending upon the practitioner's status at the facility.

SCREENING FOR RISK OF SEXUAL VICTIMIZATION AND ABUSIVENESS

Overall Determination: §115.241 - Screening for risk of victimization and abusiveness.

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

Auditor Comments (including corrective actions needed if does not meet standard):

- (a) The facility has a policy that requires screening (upon admission to a facility or transfer to another facility) for risk of sexual abuse victimization or sexual abusiveness toward other residents.
- (b) The policy requires that residents be screened for risk of sexual victimization or risk of sexually abusing other residents within 72 hours of their intake.
- (c) Risk assessment is conducted using an objective screening instrument.
- (d) The intake screening considers, at a minimum, the following criteria to assess residents for risk of sexual victimization:
 - (1) Whether the resident has a mental, physical, or developmental disability;
 - (2) The age of the resident;
 - (3) The physical build of the resident;
 - (4) Whether the resident has previously been incarcerated;
 - (5) Whether the resident's criminal history is exclusively nonviolent;
 - (6) Whether the resident has prior convictions for sex offenses against an adult or child;
 - (7) Whether the resident is or is perceived to be gay, lesbian, bisexual, transgender, intersex, or gender nonconforming;
 - (8) Whether the resident has previously experienced sexual victimization and
 - (9) The resident's own perception of vulnerability.
- (e) The intake screening considers prior acts of sexual abuse, prior convictions for violent offenses, and history of prior institutional violence or sexual abuse, as known to the facility, in assessing residents for risk of being sexually abusive.
- (f) The policy 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.
- (g) The policy requires that a resident's risk level be reassessed when warranted due to a referral, request, incident of sexual abuse or receipt of additional information that bears on the resident's risk of sexual victimization or abusiveness.

(h) The policy prohibits disciplining residents for refusing to answer (or for not disclosing complete information related to) questions regarding:

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

(i) The facility implements 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. Individual case managers have access to their residents' information; and PREA Coordinator and Deputy Director have access if residents are at risk of victimization or abusiveness.

<p>Overall Determination: <u>§115.242 - Use of screening information.</u></p> <p>✓ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)</p> <p>Exceeds Standard (substantially exceeds requirement of standard)</p> <p>Does Not Meet Standard (requires corrective action)</p> <p>Auditor Comments (including corrective actions needed if does not meet standard):</p>
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- (a) The facility uses information from the risk screening required by § 115.241 to inform housing, bed, work, education, and program assignments with the goal of keeping separate those residents at high risk of being sexually victimized from those at high risk of being sexually abusive.
- (b) The facility makes individualized determinations about how to ensure the safety of each resident.
- (c) The facility would make housing and program assignments for transgender or intersex residents in the facility on a case--by-case basis.
- (d) A transgender or intersex resident's own views with respect to his or her own safety shall be given serious consideration.
- (e) Transgender and intersex residents shall be given the opportunity to shower separately from other residents.
- (f) The facility does not place lesbian, gay, bisexual, transgender, or intersex residents in dedicated facilities, units, or wings solely on the basis of such identification or status, unless such 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 such residents. There are no such orders.

REPORTING

Overall Determination: §115.251 - Resident reporting

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

Auditor Comments (including corrective actions needed if does not meet standard):

(a) The facility has established procedures allowing for multiple internal ways for residents to report privately to facility 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.

Residents can report to staff, call PREA Coordinator, or call outside entity for assistance.

(b) The facility provides at least one way for residents to report abuse or harassment to a public or private entity or office that is not part of the facility. Residents can call ODRC (toll free PREA hotline) or can call local rape crisis center, Allen County Crime Victims Center.

(c) The facility 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 immediately.

(d) The facility has established procedures for staff to privately report sexual abuse and sexual harassment of residents: report to any supervisory staff. Staff are informed of these procedures in training and staff meetings.

Overall Determination: §115.252 - Exhaustion of administrative remedies

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

Auditor Comments (including corrective actions needed if does not meet standard): AUDITOR ENCOURAGES FACILITY TO INSTALL A LOCKED GRIEVANCE BOX FOR ANONYMOUS SUBMISSIONS.

- (a) The facility has an administrative procedure for dealing with resident grievances regarding sexual abuse.
- (b) Facility 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. Facility policy requires a resident to use an informal grievance process, or otherwise to attempt to resolve with staff, an alleged incident of sexual abuse.
- (c) Facility policy and procedure allows a resident to submit a grievance alleging sexual abuse without submitting it to the staff member who is the subject of the complaint. Facility policy and procedure requires that a resident grievance alleging sexual abuse not be referred to the staff member who is the subject of the complaint.
- (d) Facility policy and procedure requires that a decision on the merits of any grievance or portion of a grievance alleging sexual abuse be made within 90 days of the filing of the grievance. In cases where the facility requests an extension of the 90--day period to respond to a grievance, the facility may extend the time to respond to such grievance up to 70 days. The facility always notifies the resident in writing when the facility files for an extension, including notice of the date by which a decision will be made.
- (e) Facility policy and procedure permits third parties, including fellow residents, staff members, family members, attorneys, and outside advocates, to assist residents in filing requests for administrative remedies relating to allegations of sexual abuse and to file such requests on behalf of residents. Facility policy and procedure requires that if the resident declines to have third--party assistance in filing a grievance alleging sexual abuse, the facility documents the resident's decision to decline.
- (f) The facility 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. Facility policy and procedure for emergency grievances alleging substantial risk of imminent sexual abuse requires an initial response within 48 hours. Facility policy and procedure for emergency grievances alleging substantial risk of imminent sexual abuse requires that a final facility decision be issued within five days.

(g) The facility has a written policy that limits its ability to discipline a-- resident for filing a grievance alleging sexual abuse to occasions where the facility demonstrates that the resident filed the grievance in bad faith.

Overall Determination: **§115.253 - Resident access to outside confidential support services**

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

Auditor Comments (including corrective actions needed if does not meet standard):

- (a) The facility provides residents with access to outside victim advocates for emotional support services related to sexual abuse by:
- Giving residents mailing addresses and telephone numbers (including toll--free hotline numbers where available) for local, state, or national victim advocacy or rape crisis organizations; and
 - Enabling reasonable communication between residents and these organizations in as confidential a manner as possible.
- (b) The facility informs residents, prior to giving them access to outside support services, of the extent to which such communications will be monitored. The facility informs residents, prior to giving them access to outside support services, of the mandatory reporting rules governing privacy, confidentiality, and/or privilege that apply to disclosures of sexual abuse made to outside victim advocates, including any limits to confidentiality under relevant federal, state, or local law.
- (c) The facility maintains memoranda of understanding (MOUs) or other agreements with community service providers that are able to provide residents with emotional support services related to sexual abuse. The facility maintains copies of those agreements.

Overall Determination: §115.254 - Third party reporting.

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

Auditor Comments (including corrective actions needed if does not meet standard):

The facility provides a method to receive third--party reports of resident sexual abuse or sexual harassment: either through email or phone to facility PREA Coordinator, or by contacting Allen County Crime Victims Center. The facility publicly distributes information on how to report resident sexual abuse or sexual harassment on behalf of residents on its website, <http://www.worthcenter.org/prea.html>.

OFFICIAL RESPONSE FOLLOWING A RESIDENT REPORT

Overall Determination: §115.261 - Staff and agency reporting duties

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

Auditor Comments (including corrective actions needed if does not meet standard):

- (a) The facility requires all staff to report immediately and according to facility 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 facility.
 - Any retaliation against residents or staff who reported such an incident.
 - Any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation.
- (b) Apart from reporting to designated supervisors or officials and designated state or local service agencies, facility 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.

(c) Unless otherwise precluded by Federal, State, or local law, medical and mental health practitioners shall be required to report sexual abuse pursuant to paragraph (a) of this section and to inform residents of the practitioner's duty to report, and the limitation of confidentiality, at the initiation of services.

(d) If the alleged victim is under the age of 18 or considered a vulnerable adult under a State or local vulnerable persons statute, the facility shall report the allegation to the designated State or local services agency under applicable mandatory reporting laws.

(e) The facility shall report all allegations of sexual abuse and sexual harassment, including third-party and anonymous reports, to the facility's designated investigators.

Overall Determination: **§115.262 - Agency protection duties.**

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

Auditor Comments (including corrective actions needed if does not meet standard): AUDITOR ENCOURAGES FACILITY FIND ALTERNATIVE SAFETY MEASURES TO ADMINISTRATIVE SEGREGATION FOR THOSE WHO ARE AT RISK OF IMMINENT SEXUAL ABUSE.

When the facility learns that a resident is subject to a substantial risk of imminent sexual abuse, it takes immediate action to protect the resident (i.e., it takes some action to assess and implement appropriate protective measures without unreasonable delay).

Overall Determination: **§115.263 - Reporting to other confinement facilities.**

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

Auditor Comments (including corrective actions needed if does not meet standard):

- (a) The facility has a policy requiring that, upon receiving an allegation that a resident was sexually abused while confined at another facility, the head of the facility must notify the head of the facility or appropriate office of the agency where sexual abuse is alleged to have occurred. In the past 12 months, there was one allegation the facility received that a resident was abused while confined at another facility. The facility responded immediately by contacting the other facility's investigator the same day as the report was received. The next day the other facility called WORTH's Facility Director for more information and came to WORTH Center to interview the victim and conduct an investigation.
- (b) Facility policy requires the facility head provides such notification as soon as possible, but no later than 72 hours after receiving the allegation.
- (c) The facility documents that it has provided such notification within 72 hours of receiving the allegation.
- (d) The facility policy requires that allegations received from other facilities/agencies are investigated in accordance with the PREA standards.

Overall Determination: **§115.264 - Staff first responder duties.**

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

Auditor Comments (including corrective actions needed if does not meet standard):

(a) The facility has a first responder policy for allegations of sexual abuse.

The facility policy requires that, upon learning of an allegation that a resident was sexually abused, the first security staff member respond to the report shall be required to

- (1) Separate the alleged victim and abuser;
- (2) Preserve and protect any crime scene until appropriate steps can be taken to collect any evidence;
- (3) If the abuse occurred within a time period that still allows for the collection of physical evidence, request that the alleged victim not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating; and
- (4) If the abuse occurred within a time period that still allows for the collection of physical evidence, ensure 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.

(b) Facility policy requires that if the first staff responder is not a security staff member, that responder shall be required to:

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

Overall Determination:	§115.265 - Coordinated response.
	Exceeds Standard (substantially exceeds requirement of standard)
✓	Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
	Does Not Meet Standard (requires corrective action)
	Auditor Comments (including corrective actions needed if does not meet standard):

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

Overall Determination: §115.266 - Preservation of ability to protect residents from contact with abusers.

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

Auditor Comments (including corrective actions needed if does not meet standard):

The facility, or any other governmental entity responsible for collective bargaining on the facility's behalf has NOT entered into or renewed any collective bargaining agreement or other agreement since August 20, 2012.

Overall Determination: §115.267 - Agency protection against retaliation.

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

Auditor Comments (including corrective actions needed if does not meet standard):

(a) The facility has a policy to protect all residents and staff who report sexual abuse or sexual harassment or cooperate with sexual abuse or sexual harassment investigations from retaliation by other residents or staff.

The facility designates Clinical Director/PREA Coordinator Chuck Honigford with monitoring for possible retaliation.

(b) The facility shall 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.

(c) The facility monitors the conduct or treatment of residents or staff who reported sexual abuse and of residents who were reported to have suffered sexual abuse to see if there are any changes that may suggest possible retaliation by residents or staff for at least 90 days. The facility acts promptly to remedy any such retaliation. The facility continues such monitoring beyond 90 days if the initial monitoring indicates a continuing need.

- (d) In the case of residents, such monitoring shall also include periodic status checks.
- (e) If any other individual who cooperates with an investigation expresses a fear of retaliation, the facility shall take appropriate measures to protect that individual against retaliation.
- (f) The facility's obligation to monitor shall terminate if the facility determines that the allegation is unfounded.

INVESTIGATIONS	
Overall Determination:	<u>§115.271 - Criminal and administrative agency investigations.</u>
	<p>Exceeds Standard (substantially exceeds requirement of standard)</p> <p>✓ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)</p> <p>Does Not Meet Standard (requires corrective action)</p> <p>Auditor Comments (including corrective actions needed if does not meet standard):</p>

- (a) When the facility conducts its own investigations into allegations of sexual abuse and sexual harassment, it does so promptly, thoroughly, and objectively for all allegations, including third-party and anonymous reports. The facility has a policy related to criminal and administrative facility investigations.
- (b) Where sexual abuse is alleged, the facility uses an investigator who has received special training in sexual abuse investigations pursuant to § 115.234.
- (c) Investigator gathers and preserve direct and circumstantial evidence, including any available physical and DNA evidence and any available electronic monitoring data; interviews alleged victims, suspected perpetrators, and witnesses and reviews prior complaints and reports of sexual abuse involving the suspected perpetrator.
- (d) When the quality of evidence appears to support criminal prosecution, the facility shall conduct compelled interviews only after consulting with Allen County Sheriff's Office as to whether compelled interviews may be an obstacle for subsequent criminal prosecution.
- (e) The credibility of an alleged victim, suspect, or witness is assessed on an individual basis and is not determined by the person's status as resident or staff. The facility does not require a resident who alleges sexual abuse to submit to a polygraph examination or other truth-telling device as a condition for proceeding with the investigation of such an allegation.
- (f) Administrative investigations:
 - (1) include an effort to determine whether staff actions or failures to act contributed to the abuse and

(2) are documented in written reports that include a description of the physical and testimonial evidence, the reasoning behind credibility assessments, and investigative facts and findings.

(g) Criminal investigations are 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.

(h) Substantiated allegations of conduct that appears to be criminal shall be referred for prosecution.

(i) The facility retains all written reports referenced in paragraphs (f) and (g) of this section for as long as the alleged abuser is incarcerated or employed by the facility, plus five years.

(j) The departure of the alleged abuser or victim from the employment or control of the facility shall not provide a basis for terminating an investigation.

(k) N/A

(l) When outside agencies investigate sexual abuse, the facility shall cooperate with outside investigators and shall endeavor to remain informed about the progress of the investigation.

Overall Determination:

§115.272 - Evidentiary standards for administrative investigations.

Exceeds Standard (substantially exceeds requirement of standard)

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

Does Not Meet Standard (requires corrective action)

Auditor Comments (including corrective actions needed if does not meet standard):

The facility imposes a standard of a preponderance of the evidence or a lower standard of proof when determining whether allegations of sexual abuse or sexual harassment are substantiated.

Overall Determination: **§115.273 - Reporting to residents.**

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

Auditor Comments (including corrective actions needed if does not meet standard):

(a) The facility has a policy requiring that any resident who makes an allegation that he or she suffered sexual abuse in a 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 facility. In the past 12 months, the facility conducted two administrative investigations of alleged resident sexual abuse that were completed by the facility; and in both cases the residents were notified, verbally or in writing, of the results of the investigation.

(b) If an outside entity conducts such investigations, the facility requests the relevant information from the investigative entity in order to inform the resident of the outcome of the investigation. In the past 12 months, there have been no investigations of alleged resident sexual abuse in the facility that were completed by an outside facility.

(c) Following a resident's allegation that a staff member has committed sexual abuse against the resident, the facility subsequently informs the resident (unless the facility has determined that the allegation is unfounded) whenever:

- The staff member is no longer posted within the resident's unit;
- The staff member is no longer employed at the facility;
- The facility learns that the staff member has been indicted on a charge related to sexual abuse within the facility; or
- The facility learns that the staff member has been convicted on a charge related to sexual abuse within the facility.

There has not been any substantiated or unsubstantiated complaint (i.e., not unfounded) of sexual abuse committed by a staff member against a resident in the facility facility in the past 12 months.

(d) Following a resident's allegation that he or she has been sexually abused by another resident in the facility, the facility subsequently informs the alleged victim whenever:

- The facility learns that the alleged abuser has been indicted on a charge related to sexual abuse within the facility; or
- The facility learns that the alleged abuser has been convicted on a charge related to sexual abuse within the facility.

(e) The facility has a policy that all notifications to residents described under this standard are documented.

(f) The facility's obligation to report under this standard shall terminate if the resident is released from the facility's custody.

DISCIPLINE

Overall Determination: §115.276 - Disciplinary sanctions for staff.

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

Auditor Comments (including corrective actions needed if does not meet standard):

- (a) Staff is subject to disciplinary sanctions up to and including termination for violating facility sexual abuse or sexual harassment policies.
- (b) Termination shall be the presumptive disciplinary sanction for staff who have engaged in sexual abuse. In the past 12 months: one staff member from the facility violated facility sexual harassment policies and was terminated. Review of the employee file indicated that this staff member repeatedly sexual harassed other staff members, with no indication that this staff member sexually harassed residents.
- (c) Disciplinary sanctions for violations of facility policies relating to sexual abuse or sexual harassment (other than actually engaging in sexual abuse) are commensurate with the nature and circumstances of the acts committed, the staff member's disciplinary history, and the sanctions imposed for comparable offenses by other staff with similar histories.
- (d) All terminations for violations of facility 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.

Overall Determination: **§115.277 - Corrective action for contractors and volunteers.**

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

Auditor Comments (including corrective actions needed if does not meet standard):

(a) Facility 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. Facility policy requires that any contractor or volunteer who engages in sexual abuse be prohibited from contact with residents.

(b) If sexual harassment was suspected, appropriate remedial measures will be taken such as contacting the contractor agency.

Overall Determination: **§115.278 - Disciplinary sanctions for residents.**

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

Auditor Comments (including corrective actions needed if does not meet standard):

(a) 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.

In the past 12 months, there have been NO administrative or criminal findings of resident-on-resident sexual abuse that have occurred at the facility.

(b) Sanctions shall be 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.

(c) The disciplinary process shall consider whether a resident's mental disabilities or mental illness contributed to his or her behavior when determining what type of sanction, if any, should be imposed.

- (d) The facility offers therapy, counseling, or other interventions designed to address and correct the underlying reasons or motivations for abuse.
- (e) The facility disciplines residents for sexual conduct with staff only upon finding that the staff member did not consent to such contact.
- (f) The facility prohibits disciplinary action for a report of sexual abuse made in good faith based upon a reasonable belief that the alleged conduct occurred, even if an investigation does not establish evidence sufficient to substantiate the allegation.
- (g) The facility prohibits all sexual activity between residents and deems such activity to constitute sexual abuse only if it determines that the activity is coerced.

MEDICAL AND MENTAL CARE	
Overall Determination:	<u>§115.282 -- Access to emergency medical and mental health services.</u>
	<p>Exceeds Standard (substantially exceeds requirement of standard)</p> <p>✓ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)</p> <p>Does Not Meet Standard (requires corrective action)</p> <p>Auditor Comments (including corrective actions needed if does not meet standard):</p>

- (a) 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.
- (b) If no qualified medical or mental health practitioners are on duty at the time a report of recent abuse is made, security staff first responders shall take preliminary steps to protect the victim pursuant to § 115.262 and shall immediately notify the appropriate medical and mental health practitioners.
- (c) Resident victims of sexual abuse while incarcerated are offered timely information about and timely access to emergency contraception and sexually transmitted infections prophylaxis, in accordance with professionally accepted standards of care, where medically appropriate.
- (d) 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.

Overall Determination: **§115.283 -- Ongoing medical and mental health care for sexual abuse victims and abusers.**

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

Auditor Comments (including corrective actions needed if does not meet standard):

- (a) The facility offers medical and mental health evaluation and, as appropriate, treatment to all residents who have been victimized by sexual abuse in any prison, jail, lockup, or juvenile facility.
- (b) The evaluation and treatment of such victims shall 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.
- (c) The facility shall provide such victims with medical and mental health services consistent with the community level of care.
- (d) Female victims of sexually abusive vaginal penetration while incarcerated are offered pregnancy tests.
- (e) If pregnancy results from sexual abuse while incarcerated, victims receive timely and comprehensive information about, and timely access to, all lawful pregnancy-related medical services.
- (f) Resident victims of sexual abuse while incarcerated are offered tests for sexually transmitted infections as medically appropriate.
- (g) 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.
- (h) The facility attempts to conduct a mental health evaluation of all known resident-on-resident abusers within 60 days of learning of such abuse history, and offers treatment when deemed appropriate by mental health practitioners.

DATA COLLECTION AND REVIEW

Overall Determination: §115.286 - Sexual abuse incident reviews.

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

Auditor Comments (including corrective actions needed if does not meet standard):

- (a) The facility conducts a sexual abuse incident review at the conclusion of every criminal or administrative sexual abuse investigation, unless the allegation has been determined to be unfounded. In the past 12 months, there have been no such criminal and/or administrative investigations.
- (b) The facility would conduct a sexual abuse incident review within 30 days of the conclusion of the criminal or administrative sexual abuse investigation.
- (c) The sexual abuse incident review team includes upper--level management officials and allows for input from line supervisors, investigators, and medical or mental health practitioners.
- (d) The facility would prepare a report of its findings from sexual abuse incident reviews, including but not necessarily limited to determinations made pursuant to paragraphs (d)(1)--(d)(5) of this section and any recommendations for improvement, and submit such report to the facility head and PREA Coordinator, who are both on the sexual abuse review team.
 - (1) Consider whether the allegation or investigation indicates a need to change policy or practice to better prevent, detect, or respond to sexual abuse;
 - (2) 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;
 - (3) Examine the area in the facility where the incident allegedly occurred to assess whether physical barriers in the area may enable abuse;
 - (4) Assess the adequacy of staffing levels in that area during different shifts; and
 - (5) Assess whether monitoring technology should be deployed or augmented to supplement supervision by staff.
- (e) The facility implements the recommendations for improvement or documents its reasons for not doing so.

Overall Determination: **§115.287 - Data collection.**

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

Auditor Comments (including corrective actions needed if does not meet standard):

- (a) The facility collects accurate, uniform data for every allegation of sexual abuse at facilities under its direct control using a standardized instrument and set of definitions.
- (b) The facility aggregates the incident--based sexual abuse data at least annually.
- (c) The standardized instrument includes, at a minimum, the data necessary to answer all questions from the most recent version of the Survey of Sexual Violence conducted by the Department of Justice.
- (d) The facility maintains, reviews, and collects data as needed from all available incident--based documents, including reports, investigation files, and sexual abuse incident reviews.
- (e) N/A
- (f) N/A

Overall Determination: **§115.288 - Data review for corrective action.**

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

Auditor Comments (including corrective actions needed if does not meet standard):

- (a) The facility reviews data collected and aggregated pursuant to §115.287 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, and training, including:
- Identifying problem areas;
 - Taking corrective action on an ongoing basis; and
 - Preparing an annual report of its findings from its data review and any corrective actions for each facility, as well as the facility as a whole.
- (b) The annual report includes a comparison of the current year's data and corrective actions with those from prior years. The annual report provides an assessment of the facility's progress in addressing sexual abuse.
- (c) The facility makes its annual report readily available to the public at least annually through its website. If NO, the facility makes available through other means. The facility head approves the annual reports.
- (d) When the facility redacts material from an annual report for publication the redactions are limited to specific materials where publication would present a clear and specific threat to the safety and security of the facility. The facility indicates the nature of material redacted.

Overall Determination: **§115.289 - Data storage, publication, and destruction.**

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

Auditor Comments (including corrective actions needed if does not meet standard):

- (a) The facility ensures that incident--based and aggregate data are securely retained.
- (b) Facility policy requires that aggregated sexual abuse data from facilities under its direct control and private facilities with which contracts be made readily available to the public, at least annually, through its website. If NO, the facility makes it available through other means.
- (c) Before making aggregated sexual abuse data publicly available, the facility removes all personal identifiers.
- (d) The facility maintains sexual abuse data collected pursuant to §115.287 for at least 10 years after the date of initial collection, unless federal, state, or local law requires otherwise.

AUDITOR CERTIFICATION: The auditor certifies that the contents of the report are accurate to the best of his/her knowledge and no conflict of interest exists with respect to his or her ability to conduct an audit of the facility under review.

AUDITOR SIGNATURE	/s/ Michelle Bonner
DATE	February 11, 2015