PREA AUDIT REPORT ☐ Interim ☒ Final

COMMUNITY CONFINEMENT FACILITIES

Date of report: March 3rd, 2017

Auditor Information			
Auditor name: Kenneth VanMeveren			
Address: PO Box 88944, Sioux Falls, SD 57109			
Email: Cogent.view@gmail.com			
Telephone number: 605-368-4991			
Date of facility visit: July 12th, 13th and 14th, 2016			
Facility Information			
Facility name: Glory House			
Facility physical address: 4000 S. West Ave Sioux Falls, SD			
Facility mailing address: *(if different from above)* PO Box 88145, Sioux Falls, SD 57105			
Facility telephone number: 605-988-9100			
The facility is:	☐ Federal	☐ State	☐ County
	☐ Military	☐ Municipal	☐ Private for profit
	☒ Private not for profit		
Facility type:	☐ Community treatment center ☒ Halfway house ☐ Alcohol or drug rehabilitation center	☐ Community-based confinement facility ☐ Mental health facility ☐ Other	
Name of facility's Chief Executive Officer: Dave Johnson			
Number of staff assigned to the facility in the last 12 months: 49			
Designed facility capacity: 68 Male / 22 Female = Total 90			
Current population of facility: 55 Males / 18 females = Total 73			
Facility security levels/inmate custody levels: Medium to Low			
Age range of the population: Adults only 18 years on up.			
Name of PREA Compliance Manager: Same as Coordinator		**Title:** Click here to enter text.	
Email address: Click here to enter text.		**Telephone number:** Click here to enter text.	
Agency Information			
Name of agency: Same as facility			
Governing authority or parent agency: *(if applicable)* Click here to enter text.			
Physical address: Click here to enter text.			
Mailing address: *(if different from above)* Click here to enter text.			
Telephone number: Click here to enter text.			
Agency Chief Executive Officer			
Name: Dave Johnson		**Title:** Executive Director	
Email address: djohnson@glory-house.org		**Telephone number:** 605- 988-9102	
Agency-Wide PREA Coordinator			
Name: Nicole Dvorak		**Title:** Human Resource/Compliance Officer	
Email address: ndvorak@glory-house.org		**Telephone number:** 605-988-9113	

AUDIT FINDINGS

NARRATIVE

In February of 2016 I was contacted by Glory House PREA Coordinator Nicki Dvorak about conducting a PREA Audit of the Glory House – a halfway house in Sioux Falls, South Dakota.

After meeting with Ms. Dvorak and discussing the requirement and procedures for conducting a PREA Audit a contract was signed on March 8th, 2016. The on-site audit dates were set for July 12th through July 14th, 2016.

The Glory House posted a Notice of pending PREA Audit at its facility housing units on May 30th, 2016. This notice provided a brief explanation of the PREA Audit and how to write the PREA Auditor to report any relevant information. During the audit period, no letters were received by the auditor.

On June 14th, 2016 the PREA Coordinator provided me with a flash drive containing the Pre-Audit Questionnaire and associated documentation. After this time, a period of review, question and answers and staff/residents list compilation began.

The on-site audit began on the morning of July 12th, 2016 and started with a brief introduction and a tour of the facility. This tour included areas for initial intake, all the housing units, medical and mental health areas, other program areas, recreation areas, cafeteria, and the outside grounds.

After the tour, staff interviews began and continued for the remainder of the day.

The next day, July 13th began with inmate interviews and these went through the afternoon. The rest of the day was conclude with policy review and follow-up questions.

On the afternoon of July 14th I meet with Glory House Executive Director, Dave Johnson and PREA Coordinator, Nicki Dvorak to give an initial summary of the pre and on-site audit.

I reported my initial impressions where the Glory House will need a corrective action period, primarily dealing with policy and documentation procedures. In the close-out summary I emphasized the primary, but not all of the areas of concern.

I explained the process for a corrective action period and my willingness to work with them.

<u>Update for Final Report</u>

The 180 day corrective action period started on August 15th, 2016 and ended on February 11th, 2017.

Throughout the corrective action period I had a couple of on-site meetings with PREA Coordinator Dvorak and maintained email contact with her on the progress of updating policy and procedures.

During the corrective action period it was reported that the Glory House also prepared and underwent an ACA audit. Because of this, the staff were not able to finalize the policy and procedure changes until the latter half of the corrective action period. Staff were notified and trained on the changes to policy. Residents were informed of new procedures by postings and education.

DESCRIPTION OF FACILITY CHARACTERISTICS

The Glory House at its current location, 4000 South West Avenue was established in October 1975. The Glory House continued to expand and in 1988 the ground was broken on a 28-bed addition. The new addition housed men and the original building was remodeled into a facility for 12 women and expanded administrative offices. The woman's program began on November 15, 1989.

In March 1990, Glory House received state accreditation as a transitional program for alcohol and drug treatment. In July 1995, Glory House became a Community Sanctions Center for the Federal Bureau of Prisons.

In 1998, Glory House celebrated its 30-year anniversary in Sioux Falls, SD. In 2003, the Glory House acquired the Administrative Annex, increasing bed count from 42 to 56.

In 2008, due to continual growth and expansion the Glory House opened The Sands Freedom Center. This new unit expanded residential treatment for women and outpatient treatment for stimulant addiction. The opening of The Sands Freedom Center took the Glory House to an 80 plus bed capacity.

The Glory House employs over 50 full time and part time employees and provided services for approximately 300 residential clients this year and approximately 150 outpatient clients.

There are currently two Licensed Professional Counselors, eight certified Chemical Dependency Counselors, and five Chemical Dependency Counselor trainees. Because of the co-occurring disorders needs, some of the staff also have mental health degrees and are working towards licensure as such. In addition to the Executive Director and counseling staff, Glory House has a Social Services Director and Clinical Supervisor, an Outpatient Coordinator, Human Resource and Compliance Officer, a Facility Manager, a Resident Employment Coordinator, and three Case Managers.

The Glory House currently offers GPS Electronic Monitoring, SCRAM (Secure Continuous Remote Alcohol Monitoring), a Native American Treatment Program, a Corrective Thinking Treatment Program, Methamphetamine/Stimulant Treatment Program, Intensive Methamphetamine Treatment (IMT) Program, and Alcohol and Other Drugs (AOD) Programs.

Glory House belongs to and is accredited by the American Correctional Association. In addition, the Glory House is accredited by the South Dakota Division of Alcohol and Drug Abuse for level III.I Low Intensity Residential Treatment Program, level II.I Intensive Out-Patient Treatment, and I.0 Out-Patient Group Counseling and the Glory House belongs to the International Community Corrections Association as a partner agency.

SUMMARY OF AUDIT FINDINGS

Initial Report:

First, I want to emphasize a majority of the issues identified as not meeting the standards were documentation and policy detail issues. The staff and inmate training and knowledge of PREA issues were good. Staff attitude about working with the auditor and correcting or addressing any issues was excellent.

Of the 39 standards for community confinement facilities, Glory House exceed standards on 3% of the standards, met the standards on 54% and did not meet standards on 38%. 5% of the standards were not applicable.

Final Report:

The response for the issues pertaining to documentation and policy was very good. The Glory House implemented a more detailed approach to policy outlining the standard requirements.

Of the 39 standards for community confinement facilities, Glory House exceed standards on 3% of the standards, met the standards on 92% and did not meet standards on 0%. 5% of the standards were not applicable.

Number of standards exceeded: 1

Number of standards met: 36

Number of standards not met: 0

Number of standards not applicable: 2

Standard 115.211 Zero tolerance of sexual abuse and sexual harassment; PREA Coordinator

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The Glory House does include the Zero Tolerance standard into its policies and procedures. The facility has appointed a capable PREA Compliance Manager with sufficient time and authority to monitor PREA programs in the facility.

Standard 115.212 Contracting with other entities for the confinement of residents

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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NOT APPLICABLE: Facility does not contract with outside agencies to house residents.

Standard 115.213 Supervision and monitoring

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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The facility completes a yearly policy and budget review that includes some aspects of the Staffing Plan described in the standards, but it does not cover or document all aspects of the plan. The facility should have a specific staffing plan and review developed according to the requirements of this standard.

To be compliant on this issue the facility shall develop a staffing plan incorporating all of the items listed in this standard into one reviewable document. The staffing plan and review process should be detailed in a policy description.

Corrective Action Update: The facility developed a staffing plan that incorporates the standard requirements into the plan. A new written review was provided and meets the requirements of this standard.

Standard 115.215 Limits to cross-gender viewing and searches

☒ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The facility does not permit any type of cross-gender viewing or searches. Resident private areas are all closed with door and a 'knock and announce' procedure is in place. Staff do not conduct cavity, strip or pat searches at all. The only type of search conducted is a 'pocket' search. This is where the resident empties their own pockets on arrival to facility.

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

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The facility maintains posts, notices and PREA policy in both English and Spanish versions. In cases where an interpreter is needed the facility contracts with an outside/local interpreter service.

Standard 115.217 Hiring and promotion decisions

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The facility has been using Federal guidelines on hiring, promotions and access to residents for a number of years due to their involvement with BOP residents.

Standard 115.218 Upgrades to facilities and technologies

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The facility has not had any facility upgrades, expansions or additions since prior to 2012. They have updated their video system, adding cameras. This addition was primarily for the safety of the residents, focusing on known blindspots in prior video coverage.

It should be noted the facilities video system is primarily viewed for investigative reasons and is not used as a monitoring system.

Standard 115.221 Evidence protocol and forensic medical examinations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The facility has only a generalized policy of PREA investigations. There is no formalized uniform evidence protocol identifying what staff should or should not do, nothing based upon the National Protocol outlined in the standards. There is evidence this is covered in staff training, but not in policy or procedures. The facility is involved with the local SART team and meets the other parts of this standard.

To be compliant on this issue the facility should develop a formal policy or procedure document that identifies the criteria for response in a sexual abuse case: identifying all staff and agencies involved, their duties in such an incident, how first responders should handle evidence or crime scene (what to collect or not to collect, procedures for securing areas, how to respond to evidence on a person, etc.), medical and mental health responsibilities, types of reporting, conclusions and responses.

Corrective Action Update: The facility updated policy and procedure as outlined. Staff were trained on the new procedures.

Standard 115.222 Policies to ensure referrals of allegations for investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The facility has a policy addressing administrative and criminal referrals. This policy is posted on their website. Although the policy is very general in its approach to the subject, staff training was excellent. All staff interviewed were able to detail the process on reporting to staff, PREA Investigative staff and when and who would call the police department.

Standard 115.231 Employee training

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Staff training is completed using National PREA Resource Center training materials and carried out for new staff and reviewed annually. All staff interviewed displayed a very good knowledge of the PREA training subjects. When the training is complete staff sign an 'Acknowledgement of Understanding' form indicating they have received and understand the training.

Standard 115.232 Volunteer and contractor training

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Training procedures and materials are the same as the employee training procedures listed above and do meet requirements. The issue is that one volunteer had not been trained prior to service.

To be compliant on this standard the facility should provide training and documentation for the volunteer.

Corrective Action Update: Since the audit the facility has provided PREA training and Mental Health specialized training to the contractor. The contracted staff signed an acknowledgement and understanding of the training form.

Standard 115.233 Resident education

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Policy and procedures state residents shall receive this training. All residents interviewed reported knowledge of the the training and were able to identify training subjects.

Standard 115.234 Specialized training: Investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

For a majority of the 12 month reporting period the facility did not have a PREA investigator who had the specialized training. At the start of the audit process the single PREA administrative investigator did complete the NIC E-learning course for this. Documentation provided.

Standard 115.235 Specialized training: Medical and mental health care

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

For a majority of the 12 month reporting period the facilities medical/mental health staff did not have the specialized training. During the after audit review period all of the medical/mental health staff did complete the NIC E-learning course for this. Documentation provided.

Standard 115.241 Screening for risk of victimization and abusiveness

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The facility uses an objective risk screen for risk of being sexually abused or sexually abusive on residents. This risk screen is based upon the criteria in this standard. It is initially administered within 72 hours and reviewed again at 30 days. Residents have the option of answering the screen or not and the information is confidential.

Standard 115.242 Use of screening information

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The facility meets all sections of this standard except 115.242 (d). This section deals with a transgender or intersex residents own views on the safety of their placement and are given serious consideration. Policy states the overriding authority on this determination will be medical and legal determination only. A residents own concerns is not mentioned.

For compliance on this standard the facility needs to develop a process for determination of a transgender or intersex resident's gender and placement based upon the requirements of this standard.

Corrective Action Update: The facility has developed a procedure for residents that identify as transgender or intersex. Consideration is based upon resident safety needs, medical and mental health needs and resident concerns.

Standard 115.251 Resident reporting

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Staff and residents can go to any staff to report an incident. Additionally staff accept third party and anonymous reports of incidents. Notices have been posted containing contact information for outside agencies and resources. During interviews both staff and residents were aware of these options.

Standard 115.252 Exhaustion of administrative remedies

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The facility does have a 'Client Grievance' policy/procedure. This policy does not cover all of the required criteria mentioned in the standard and the wording in very general. Residents are supposed to know when an incident and accompanying procedures are 'appropriate'. There are no guidelines established for the residents to follow.

To achieve compliance on this standard the facility should review and update its existing Client Grievance' policy/procedures to match or exceed all of the criteria outlined in this standard. The facility should then post or make available to the residents the new policy/procedure.

Corrective Action Update: The facility updated its policy to detail the criteria as outlined in this standard. Staff have been trained on the updated policy and a new posting for inmates outlining the changes is displayed in the facility.

Standard 115.253 Resident access to outside confidential support services

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion

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

The facility has notices and postings, with contact phone numbers, displayed on the units. The local rape crisis center - Compass Center has brochures posted on the units. Residents also have full access to the outside community for any confidential communications.

Standard 115.254 Third-party reporting

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Facility has set up a link on its website with a link for third-parties to report violations. The link goes to a Glory House Report form. This form cannot be filled out electronically, there is not a link to send the report back nor is there any instructions on who to send it to.

To be compliant on this standard the facility should have a reporting form that can be returned immediately to a Glory House staff member who has the authority to initiate an investigation. The facility should also consider having a reporting phone number available. This can be a phone connection to any staff with the authority to report the incident for investigation. Clear instructions and expectations on this reporting procedure should be included on the website with the link.

Corrective Action Update: The facility has kept the website form as a printable form to be filled out manually and returned. The website also provides phone contact numbers for immediate reporting.

Standard 115.261 Staff and agency reporting duties

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Facility policy outlines staff reporting duties and staffing training reinforces this. The staff interviewed were all able to describe their reporting duties including:

- reporting any knowledge,
- suspicion or information,
- confidentiality,
- reports from third party,

- anonymous and
- All other types of reports.

Standard 115.262 Agency protection duties

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Facility policy outlines immediate responses to any risk of sexual abuse. In interviews staff reported that their response to any threat or risk of sexual abuse is immediate.

Standard 115.263 Reporting to other confinement facilities

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Procedure is outlined in policy. In addition, the facility provided a documented case where they notified an outside facility of a resident reporting an allegation of sexual harassment.

Standard 115.264 Staff first responder duties

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Facility policies outline the first responder duties detailed in the standard. The policy was disorganized, but all of the required points were covered. Suggest an update that is tied in with the 115.221 Evidence Protocol update. All staff interviewed were aware of the first responder's duties and who to contact next.

Standard 115.265 Coordinated response

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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Facility has developed a plan to respond to reports of sexual abuse that coordinates all departments.

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

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

NOT APPLICABLE: Facility does not have a collective bargaining agreement.

Standard 115.267 Agency protection against retaliation

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Facility has a policy and procedure in place to protect/respond to retaliation. The PREA Coordinator / Investigator also is in charge of monitoring for any possible retaliation. No sexual abuse or retaliation cases have been reported to date.

Standard 115.271 Criminal and administrative agency investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The facility's policy 'Investigations' does not cover all of the criteria identified in the standard. There was no form or procedures produced that would address this. Current policy only covers 'client reporting' and other items such as credibility, polygraphs, report of staff actions or inactions and required summary information is not included or demonstrated in any report. In absence of any examples a policy or procedure is needed.

For compliance on this issue the facility should review and update the Investigation policy to comply with the criteria in this standard. I would also suggest coordinating with the updates in 115.221 Evidence Protocol and 115.264 First Responders.

Corrective Action Update: The facility has updated its Investigative & Reporting policies to include the criteria outlined in this standard. Staff have been trained on these updates.

Standard 115.272 Evidentiary standard for administrative investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

This standard is not covered in policy or procedure. There is no documentation to demonstrate its use. Investigative staff were aware of the standard, but in absence of any examples a policy or procedure is needed.

For compliance on this standard, the preponderance of evidence standard should be included in any update of your investigative policy.

Corrective Action Update: This criteria was included in the policy update for Investigations & Reporting.

Standard 115.273 Reporting to residents

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Facility policy and procedures do not cover all of the criteria listed in the standard. Currently procedure provides a general summarization of the investigation but does not list or cover the required criteria. In absence of any documentation, policy and procedure should identify the exact criteria needed. These are covered in 115.273 parts (a), (c) and (d).

For compliance on this standard the facility should review all of the criteria needed for this standard and update their investigative policy.

Corrective Action Update: The facility developed a new policy: Reporting Investigative Status. This policy covers the criteria outlined in this standard.

Standard 115.276 Disciplinary sanctions for staff

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Facility policy meets the criteria on this standard. There have been no staff abuse/harassment incidents for this reporting period.

Standard 115.277 Corrective action for contractors and volunteers

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Facility policy meets the criteria on this standard. There has been no contractor or volunteer abuse/harassment incidents for this reporting period.

Standard 115.278 Disciplinary sanctions for residents

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Facilities current resident disciplinary sanctions do not use the PREA definitions as a base for violations in this category. An example of this is the No-Contact rule. The facility only has two disciplinary sanctions available for disciplining residents for involvement in a sexual incident: Harassment and No Contact. If a resident is involved with a staff member, PREA would describe this resident as a victim. The facility could still 'punish' the victim for violating the no contact rule. There are no rules for sexual harassment or sexual abuse.

For compliance on this standard the facility should review and update its resident disciplinary sanctions to meet the criteria of this standard and use in standardized PREA reporting.

Corrective Action Update: The facility added a new policy – Disciplinary Sanctions for Clients under PREA Violation. This policy details PREA definitions and outlines disciplinary responses meeting the criteria outlined in this standard.

Standard 115.282 Access to emergency medical and mental health services

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The facility meets all requirements of this standard except for one item. 115.282 (a) states victims of sexual shall receive…intervention services, the nature and scope determined by medical and mental health …according to their professional judgement.

In both the Pre-Audit Questionnaire and staff interviews stated 'No' this is determined by the facility unit supervisor or would need approval through facility supervisor.

For compliance on this standard facility policy and practice would need to be updated to meet the criteria of this standard.

Corrective Action Update: Procedure has been clarified on this issue. Any physical or sexual assault would be considered a medical emergency and would not need prior management approval for response.

Standard 115.283 Ongoing medical and mental health care for sexual abuse victims and abusers

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The facility has documented relationships with the community SART program and outside medical and mental health providers in addition to their own programs.

Standard 115.286 Sexual abuse incident reviews

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The facility recently updated its investigation policy to have any investigations reviewed in its weekly management meeting. This management meeting is to be identified as Sexual Incident Review Team. No additional standard criteria on who makes up the team, the specific items for review, or the facilities approval process is included in the policy. Without any examples or documentation to demonstrate this is being covered; the procedure should be identified in policy.

For compliance on this standard the facility should review the policy on investigations: Administrative and update this to match the criteria outlined in the standard.

Corrective Action Update: The facility developed a review team for a number of emergency situations, including a Sexual Incident Review Team. The team includes the Executive Director, senior staff and incorporates the criteria outlined in this standard.

Standard 115.287 Data collection

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance

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

The facility collects data only for the SSV or BOP reporting process. For compliance on this standard the facility should collect accurate uniform (based upon the PREA Standards) data on every sexual incident allegation. The data should at a 'minimum' include information necessary to answer the SSV questionnaire. This information needs to be collected for the 2015 reporting year.

Important: this data should use the PREA Standards definitions as a basis for arranging and categorizing the data.

Corrective Action Update: The facility has collected data based upon the standards outlined in this standard for the years 2014, 2015 and 2016.

Standard 115.288 Data review for corrective action

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The facility has not produced an annual data review of the aggregate data for any of the previous years.

For compliance on this standard the facility will need to prepare a report for the 2015 reporting year using the criteria required in this standard. This report will need to be approved by the agency head and made available on your website – PREA section.

Corrective Action Update: The facility used the data collected per 115.287 for review of the 2015 and 2016 years. This review included the criteria outlined in this standard, approved by the agency head and published on the agency website.

Standard 115.289 Data storage, publication, and destruction

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Facility meets all sections of this standard except for 115.289 (d): This section requires the sexual abuse data be kept for at least 10 years unless Federal, State or local law requires otherwise.

There is no mention of this in your policy or procedure. Absent of any other documentation, this should be noted in policy for compliance on this issue.

Corrective Action Update: This information was provided, but not identified in the original data packet. Once identified and reviewed the current practice was found to be compliant.

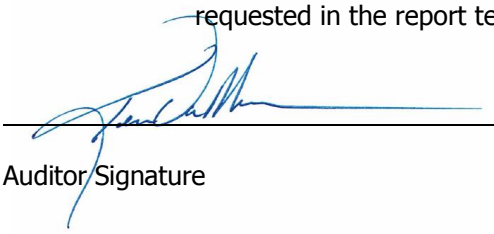
AUDITOR CERTIFICATION

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



March 4th, 2017

Auditor Signature Date