PREA AUDIT REPORT ☐ Interim ☒ Final

COMMUNITY CONFINEMENT FACILITIES

Date of report: 7/27/17

Auditor Information			
Auditor name: Bridgette M. Collins			
Address: PO Box 811, Danville, In 46122			
Email: confinementsafety@gmail.com			
Telephone number: 3176790879			
Date of facility visit: 6/28/17			
Facility Information			
Facility name: Allen County Work Release			
Facility physical address: 12103 Lima Road, Fort Wayne, In 46818			
Facility mailing address: *(if different from above)* Click here to enter text.			
Facility telephone number: 260-449-7453			
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: Michael Biltz			
Number of staff assigned to the facility in the last 12 months: 2			
Designed facility capacity: 104			
Current population of facility: 83			
Facility security levels/inmate custody levels: Minimum			
Age range of the population: 18-99			
Name of PREA Compliance Manager: N/A		**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: Allen County Work Release			
Governing authority or parent agency: *(if applicable)* Allen County Sheriff Department			
Physical address: 715 South Calhoun Street, Room 101 Courthouse, Fort Wayne, In 46802			
Mailing address: *(if different from above)* Click here to enter text.			
Telephone number: 260-449-7535			
Agency Chief Executive Officer			
Name: David Gladieux		**Title:** Allen County Sheriff	
Email address: david.gladieux@allencounty.us		**Telephone number:** 260-449-7535	
Agency-Wide PREA Coordinator			
Name: N/A		**Title:** Click here to enter text.	
Email address: Click here to enter text.		**Telephone number:** Click here to enter text.	

AUDIT FINDINGS

NARRATIVE

The Mission of Allen County Government is, “To effectively and efficiently serve the needs of our citizens. We take this responsibility very seriously. Please take satisfaction from knowing your position contributes to the overall success of local government.” The Jail Mission statement states, “The mission of the Allen County Jail is to securely detain persons arrested by the law enforcement agencies, securely detain persons sentenced to serve time, to keep inmates safe and healthy while incarcerated, and to guarantee the availability of suspects for legal proceedings while contributing to the safety of Allen County.”

The Allen County Work Release is an entity of the Sheriffs Department and therefore follows the policies and procedures as set forth by the Sheriff in conjunction with Allen County Government.

The initial on-site Prison Rape Elimination Act (PREA) Audit was conducted on Allen County Work Release Facility on 11/14/16 and 11/15/16.

The Allen County Work Release facility employed 18 staff members for a 24 hour/7 day a week operation. The facility doesn’t employ medical or mental health professionals as those services are provided by outside agencies. The eighteen (18) staff are comprised of a Director, case management staff, custody staff and a bookkeeper.

Meals are prepared in the jail and transported to the work release for the residents. They also have access to vending machines for additional food options.

Residents are sentenced from the Federal Bureau of Prisons (BOP) or local county courts. There is a contract with BOP in place that requires that the facility be PREA compliant.

Upon completion of the initial on-site audit, it was determined that the standards were not met as expected and thus began the 180 day corrective action period. A secondary on-site audit was conducted on 6/28/17 for the purpose of re-interviewing staff and residents and doing a final walk-through of the facility to see if policies were put into place and implemented.

DESCRIPTION OF FACILITY CHARACTERISTICS

The Allen County Work Release is a minimum security community confinement facility located in the Byron Health Center Complex in Fort Wayne, Indiana. It was moved to that location on 11/20/99. It is a coed, adult facility with a capacity for 104 residents (16 female and 88 males). The work release is a wing of the complex and has separate living quarters for the males and females. There are five (5) rooms for the females and thirty-eight (38) rooms for the males.

The work release was not built to be a correctional facility and therefore doesn't have all of the security equipment that would aid in ensuring the facility is PREA compliant. The dorm rooms had large doors that do no have window slats and could be closed for the residents privacy. There also were no cameras in that space. Because of this, visual obstruction was a daily occurrence.

Because the work release has outgrown its current housing and is need of updates, a new facility was proposed to be ready for operation in spring/summer of 2017.

Since the initial audit, the timeline for the change in location has been delayed. Originally, it was assumed that by the end of the 180 day corrective action period that the facility would have already moved to the new location. Currently, there is no definitive move date into the new facility.

Therefore, changes had to be made to the current building to address some of the concerns that may not have been if they were able to move into the new facility. The dorm room doors have been completed removed so that staff can easily view the area without alerting residents to their presence. No cameras were installed as it was not fiscally feasible. Staff of the opposite sex no longer have to announce themselves when walking down the hallways because the residents are not allowed to be in a state of undress any place other than the restrooms.

SUMMARY OF AUDIT FINDINGS

The initial on-site audit was conducted on Monday and Tuesday, November 14-15, 2016. The Director provided a space for interviews, filled out pre-audit paperwork and gave a tour of the facility. Flyers were hung throughout the facility that notified residents, staff and the public of the upcoming audit. An address was provided in the event someone wanted to send anonymous notifications of concerns. It should be noted that no correspondence was received by the auditor.

The auditor staggered the hours of the audit to ensure that staff and residents not available during typical business hours were given a chance to be interviewed and speak to the Auditor.

On the day of the audit, there were 91 residents assigned to the facility. There were 9 female residents and 82 male residents (not including those assigned to home detention). Residents were interviewed randomly with an attempt to meet with both genders, ethnicities, age groups, length of sentence, types of offenses and sentencing authorities. Eight (8) males and four (4) females were interviewed.

There was no education being provided to the residents at intake. The majority of the residents interviewed admitted to knowing about PREA from their incarcerations at previous institutions prior to their arrival to Allen County Work Release. No Sexual Abusiveness/Victimization Risk Assessment was being conducted on residents upon arrival with a follow up assessment within 30 days.

At that time, there were 18 staff employed by the facility. There was no designated PREA Auditor as the facility had not yet begun the process of being PREA compliant. The following staff were interviewed, Resident Advisor (3), Confinement Officers (6)(full and part-time), Confinement Sgt (1), Unit Supervisor (1) and the Director.

There was no training provided to employees of the work release. Of the twelve (12) staff interviewed, only the Director was able to provide proof of training. Because most of the staff were transplants from other Allen County Departments or other correctional institutions, they had received PREA training in previous employment.

Staff knew that sexual abuse and sexual harassment were not permitted and had an idea of what should happen in the event of an occurrence but there was no written protocal or expectations provided.

Because Allen County was starting from the beginning, the majority of the corrective action period would be spent creating the policies and procedures as well as the training/educational materials. Once that was completed and approved by Department Heads, it would then be implemented from that point forward for all new residents and staff alike. The Director will be the PREA Coordinator initially and then may be the duties of someone else once it is implemented and all of the decisions have been made.

Upon completion of the interim report on 12/28/16, the 180 day corrective action period began. Allen County was given the report with information on how to proceed and what needed to be in place in order to gain compliance. At that time, they were notified that the Auditor would need to return for a final review of the facility and its policies.

On 6/28/17, the final on-site audit was conducted. Six weeks prior to the arrival of the auditor, flyers of the impending audit were hung a secondary time for staff and residents to send anonymous documentation. Be advised that no mail was received. There were 83 residents assigned to the facility the day of the audit, 9 females and 74 males. Residents were randomly interviewed based on who was available at the time. Eight (8) males and four (4) females were interviewed. All of them reported feeling safe in the facility and believed that if they reported PREA allegations to specified staff, that an investigation would be launched. They were able to communicate that education had been provided and knew different methods for reporting abuse including both inside and outside of the facility.

Sexual Abusiveness/Victimization Risk Assessments had been instituted and the auditor was provided copies of them for the current residents. Follow-up assessments within 30 days of arrival were beginning to occur.

There were seventeen (17) staff employed during the time of the secondary on-site audit. The PREA Coordinator and Retaliation Monitor had been identified and processes for carrying out those duties had been assigned. Two (2) confinement officers, one (1) case manager and one(1) resident advisor were interviewed. The Director was on vacation at this time but several work release and jail staff were assigned to aid in the process in his absence.

Staff had since received training and had protocals to follow in the event of an allegation. Due to the low number of staff, the jail staff were now helping cover during periods of shortages for safety and security reasons. A law enforcement agency had been designated to conduct investigations. Other previous processes have since been corrected to the degree that could be done in 6 months knowing that a secondary facility is being constructed to increase safety and security.

One of the concerns was the ratio of female staff to male staff in a male dominated facility. Jail staff are able to do lateral moves to the work release when there are openings and in the past, female staff have been the ones to do so. The Director is planning to meet with the Sheriff concerning the potential to correct this issue by having gender specific positions so that the ratio of staff mimics that of the residents or the addition of new positions to increase the numbers overall.

Below each titled standard, information will be provided based on what the conclusion was at the interim phase of the audit as well as the final. All of the standards previously not met have since been corrected and new practices are in place. Allen County Work Release is aware of the expectation to continue to follow the policy as it has been written and continue perfecting the practices in anticipation of allegations and future audits.

The Director is aware that some processes may require additional change once moved into the new facility as it may warrant so. The PREA policy and its procedures are meant to be living document that is updated and reviewed regularly.

Number of standards exceeded: 0

Number of standards met: 36

Number of standards not met: 0

Number of standards not applicable: 3

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.

There was an Allen County Policy from 2011 that addressed anti-harassment, but wasn't all encompassing and didn't specifically address sexual assault and sexual harassment. There was no facility specific policy or one that provided an outline as to the agency's approach to preventing, detecting and responding to sexual abuse and sexual harassment. No definitions of prohibited behaviors or sanctions for those who have been found to have participated were listed. There was no description of the agency's strategy and response to reduce sexual abuse and sexual harassment of inmates. There was no assigned PREA Coordinator in this facility.

On 5/18/17, Allen County Work Release instituted a written Prison Rape Elimination Act (PREA) policy that provided information on the agencies stance on mandating zero tolerance towards all forms of sexual abuse and sexual harassment. It outlines the agency's approach to prevention, detection and response to such conduct.

There is now a designated PREA Coordinator as well as a Retaliation Monitor in the event of allegations requiring the need for an investigation.

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)

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.

In June of 2016, a contract was entered into with the US Department of Justice, United States Marshals Service Prisoner Operations Division. The 14 page contract specifically states that the facility must post the Prison Rape Elimination Act brochure/bulletin in each housing unit of the Facility as well as must abide by all relevant PREA regulations. The final two pages of the contract provide definitions for sexual assault awareness, detainee-on-detainee sexual abuse/assault, staff-on-detainee sexual abuse/assault and staff sexual misconduct. Prohibited Acts, detention as a safe environment, confidentiality and the requirement to report all assaults is also outlined in the contract.

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 had a staffing plan in place that would require that there are at least two Confinement Officers on duty at all times. This plan states that there are part time employees as well as those who stagger the shifts for extra coverage in the event of a vacancy or the use of paid time off. There are 31 cameras that are recording up to 19 days of footage at a time. The cameras are motion censored so they are only in operation when there is movement.

The facility capacity at the initial on-site audit was 104 inmates (both male and female). The average daily population was 87. The day of the audit the total population was 91.

The staffing plan stated that there are times when it had to be deviated from due to staff illness, planned vacations, medical transports and training. It also stated that there are times when the facility is manned by one staff member only for the monitoring of up to 104 inmates.

The staffing plan was not reviewed annually to see if staffing patterns, video monitoring equipment or the allocation of facility resources to commit to the staffing plan were ensured.

Based on interviews with staff, the staffing plan was deviated from quite frequently. There were multiple times wherein female staff were left to monitor the entire facility alone for an 8 hour period. Sometimes there were two female staff but definitely there are times that is it was only one. This not only compromised the safety and security of the institution, staff and inmates, but was also not indicative of being PREA compliant as there should be same-sex staff on duty at all times in a co-ed facility.

There have been changes considering staffing patterns since the initial audit. If there is not more than one staff member scheduled for work, jail staff are sent to the facility to aid with coverage. Also there are two part-time positions being advertised for the purpose of covering vacancies and shortages. Female staff are no longer left to man the facility alone and there is always a male officer present.

During interviews of both staff and residents, it was confirmed that staffing at night and on the weekends looks different than it did in December of 2016 with more persons present.

As previously stated, once the facility is moved to the new location, because of its structure, this issue may no longer be of concern, therefore Allen County is cautious to spend money that may only be necessary temporarily.

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.

It is understood by staff and inmates that cross-gender strip or cross-gender visual body cavity searches are prohibited. Cavity Searches are only to be conducted by same-sex medical personnel not work release staff. This can be done by medical professionals in the jail as well as in a hospital or treatment facility.

The facility doesn't permit cross-gender pat-down searches. If an resident returns and a member of the opposite sex is responsible for the pat-down, the use of a wand is employed for these purposes. Staff also have the option of contacting police dispatch and asking for a road deputy to come and perform the search if there is reason to suspect that items are concealed.

The facility is co-ed however from interviews with both staff and inmates, it is not the practice to restrict inmate movement and access to regularly available programming because there may not be a same-sex confinement officer on duty to conduct a pat-down search upon return.

There was a contradiction regarding resident's ability to shower, perform bodily functions and change clothing without a non-medical staff of the opposite gender viewing their breasts, buttocks or genitalia except in exigent circumstances during the initial on-site audit.

The 2013 inmate rules and regulations manual stated that there is a "no-knock policy" in place for their sleeping quarters and that they are subject to search at any time. Staff of the opposite sex are not required to announce themselves when completing visual inspection rounds except when they are conducting a formal head count which happens three times per day. The residents are housed in individual rooms that may contain up to 4 residents per separate dorm. Each dorm had a door without a window that they were allowed to close.

Staff interviews provided feedback that residents may be in a state of undress in the restrooms and their dorm rooms. This means that a staff of the opposite sex could potentially view an inmate in a state of undress due to the no-knock policy that was in place.

Staff are expected to announce themselves prior to entering the restrooms of the opposite sex residents. Most of the staff interviewed admitted that they do announce themselves when entering the dorms despite it not being a policy requirement, however there were also staff who do not announce themselves unless entering the restroom.

There was no policy that specifically spelled out the requirements of this standard, although it was the unwritten expectation. There was no policy that addressed transgender or intersex resident searches or cross-gender pat-down searches. There had been no specific training on this standard.

The "no-knock policy" is no longer in effect. The resident doors have been removed from the dorms, thus providing 24 hour visual access to the space. The residents are required to change clothing in the restrooms as they are no longer allowed to do so in the dorms. Both of these changes remove the threat of potential opposite sex viewing in a state of undress.

There is an individual room with a window for viewing that could be used for a person who identifies as transgender as well as medical and disciplinary purposes. This room is closest to central control, therefore the ease of monitoring is greatly increased due to the location.

Training has been provided regarding the expectations of pat-down searches for transgender or intersex residents. All searches shall be conducted in a professional and respectful manner and with the least intrusive manner possible consistent with security needs.

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.

There had been no procedures established to provide disabled inmates or those with limited English proficiency equal opportunity to participate in or benefit from PREA expectations.

There was no policy that prohibited the use of inmate interpreters except in limited circumstances that could compromise the safety and security of the inmate or delay the performance of first-responders duties.

Staff interviews provided different responses as to how inmates of limited English proficiency are addressed. A few staff mentioned having access to a list that would provide an interpreter if needed. Others stated that they used other inmates to communicate on their behalf or used a language conversion application on their cellular phones. None of the circumstances discussed were described as being emergent in nature.

A Memorandum of Understanding was provided in regards to interpreter services being provided by the Office of Evangelization of the Diocese of Fort Wayne—South Bend. It discloses the rates, contact person and how to arrange interpreter services when needed. This information was verified by the auditor.

Staff were able to communicate that interpreter services were readily available and they knew where to locate the information if needed after hours or on the weekend. It is now the understanding that residents are not to be used as interpreters unless it is an emergency wherein a lapse in time may be a threat of danger.

Spanish PREA documentation was also provided to the auditor for review.

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)

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Agency Policy required that criminal background checks were conducted but not to the extent to which the PREA standards

require. There was no written policy that gave in-depth specifics as to the hiring or promoting procedures that checks both civil and criminal prosecutions for sexual abuse related convictions. There was no policy that required that these processes be conducted on contractors who may have access to residents. It had not been practice that criminal background checks be completed no less than every 5 years on all current employees.

All current staff have since had criminal background checks conducted with the expectation that they will continue at that rate no less than every 5 years, beyond at hire and promotion. Documentation was provided verifying that this had been completed as expected. This includes contractors as well.

Some questions regarding previous sexual deviance were in the original hiring packets, but has been revamped to include more standard specific questioning prior to offering a position to an applicant. Material omissions reagarding such misconduct, or the provision of materially false information are grounds for termination.

Unless prohibited by law, the agency shall provide information on substantiated allegations of sexual abuse or sexual harassment involving former employees upon receiving a request from an institutional employer for whom such employee has applied to work.

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)

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This standard is non-applicable as there has been no substantial expansions or modifications of the existing facility since 8/20/12, nor has there been an addition or update to video monitoring systems.

Currently a secondary building has been purchased and is in the process of being renovated for the purpose of the work release changing locations. The completion date was originally Spring/Summer 2017 but that is no longer the case. No definitive move date has been provided as of this time.

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)

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corrective actions taken by the facility.

Residents are provided access to forensic medical examinations through the use of St. Joseph Hospital at no financial cost to the victim. There has been no reported cases of sexual abuse that would require the need for a medical examination and thus the documentation of efforts to provide Sexual Assault Nurse Examiners (SANE) or Sexual Assault Forensic Examiners (SAFE).

St Joseph Hospital confirmed that they are equipped with SANE or SAFE examiners in the event of a current allegation of abuse. They have the ability to make referrals to community agencies for aftercare through victim advocates and other community-based organizations.

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)

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It was the expectation that an administrative or criminal investigation is completed for all allegations of sexual abuse and sexual harassment, however there was no specific policy.

There had been no allegations received at the facility level within the past 12 months. However there was a PREA situation that took place with a male and female inmate who were engaging in oral sex while being transported to/from work in a contracted vehicle by the employer. Once the information was relayed, both inmates were remanded to the Allen County Jail. To date no charges have been filed as both inmates reported that the sexual contact was consensual. Because this took place while in the custody of the employer, there was no obligation to conduct an investigation, however Allen County followed protocol which lead to disciplinary action.

There is now a policy that ensures the expectation of an administrative or criminal investigation for all allegations of sexual abuse and sexual harassment. Allen County Sheriff's Department is the designated law enforcement agency responsible for conducting the investigation and working towards prosecution if warranted. Any training requirements will be the responsibility of the Sheriff to be in compliance for sex crime investigations.

This policy can be found on the facilities website.

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.

All staff interviewed admitted to having PREA training but it was completed while employed with the Allen County Jail or previous criminal justice employers during the initial audit. There had been no refresher or training since their employment with the work release. Staff were asked if they felt that a refresher course would be advantageous and most responded that it would not be. They felt that PREA is common-sense and that special training wasn't necessary. It should be noted that during the questioning of the protocol in the event of a PREA assault, the responses were vague and uncertain. There was no clear indication of what their expectations were, how to follow the chain of command, securing the crime scene or the collection of evidence.

Since that time, staff have been formally trained on PREA and their specific duties in the event of an allegation. Signed staff training acknowledgements along with the training curriculum table of content were provided to the auditor. The PREA policy states that training shall be provided upon hire and every 2 years thereafter. It also states that refresher trainings will be provided as needed in the interim.

Because the facility is co-ed, the training is not gender specific, it applies to all populations. The main topics of the training were being professional, staff responsibility, victim characteristics, being aware, policies and the law and creating a safe environment.

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)

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No volunteers or contractors had been trained on their responsibilities concerning the prevention, detection and response to sexual abuse and/or harassment. They had not been notified of the agency's zero-tolerance policy regarding sexual abuse or sexual harassment.

Staff interviews expressed concerns about co-ed groups being provided by contractors or volunteers who may be the opposite sex of the participants. The feeling is that the contractors or volunteers have no knowledge of manipulation tactics, residents causing diversions and overall the safety provided during these interactions.

There was also a concern about the vending contractor having keys to enter the building through entrances that don't require him to sign in/out and make Confinement Officers aware of his presence. He was also allowed to walk freely throughout the facility (including the female side) without an escort and had had no training.

Current volunteers and contractors have since been trained on PREA. Because of this the concerns of vulnerability on the part of the volunteer/contractor, PREA training provided an opportunity to be addressed. Copies of the signed contractor/volunteer training documents were provided to the auditor.

The vending contractor no longer has keys to enter the facility at his leisure without checking in with central control first. He must now enter and exit through the doors that everyone else uses so that his presence is known.

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)

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No information, education or notification was being made to the residents at intake concerning PREA. There were posters hung throughout the facility that provided information on how to report but nothing more in-depth was communicated. There was no refresher information provided to those who have transferred from other confinement facilities. PREA education was not available in any form.

Residents are now being given PREA education within 72 hours of arrival during intake. An information brochure that provides facility specific feedback on what PREA is, how to avoid being a victim and how to report if necessary is provided at intake. This brochure was available in Spanish as well.

The process is the same for all intakes whether it is the first time they are exposed to PREA or if it is a refresher. Interviews with the residents supported that the education training was now being provided. Some of them received the information within the 72 hour window while others did not. Those that did not receive it within the required time frame were those who entered the facility prior to the implementation of the new policies and procedures. Allen County Work Release provided information to anyone in their custody once the policy was approved for use.

Posters were still hung throughout the facility with specific reporting methods and other information necessary to be PREA compliant. Some PREA literature can be found on the facilities website.

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)

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Agency policy stated that the Criminal Investigations Division would conduct investigations for serious criminal offenses such as rape, gross sexual misconduct, deviate sexual conduct or any sex act by force. This is a function of the jail and not the work release. There was no documentation provided showing that investigators have completed the required training.

While the work release is under the jurisdiction of the Sheriff, since the initial audit, it has been explained that some functions will need to be separate based on the agency as it may not be a viable option for the both. It has been determined that the Allen County Sheriff's Department will conduct all investigations of sexual abuse from the work release. It is the responsibility of the Sheriff to ensure that only detectives trained in sex crimes be assigned to the case.

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.

This standard is non-applicable. There is no medical or mental health practitioners who work regularly in its facilities.

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.

There was no policy nor sexual abuse victimization or sexual abusiveness tool used at intake to the facility. Orientation was taking place within 72 hours of arrival however no PREA procedures existed. There was no requirement to reassess a resident within 30 days of arrival, when warranted due to a referral, request, and incident of sexual abuse or receipt of additional information that bears on the resident's risk of sexual victimization or abusiveness. There was no policy that prohibited disciplining residents for refusing to answer or disclose information regarding sexual orientation, disability status, previous sexual trauma or the resident's perception of vulnerability.

The new policy that was instituted in May 2017 takes into account all the previous deficiencies. PREA education and an abuse victimization or abusiveness tool is being completed within 72 hours of arrival with the understanding that a reassessment shall be done within 30 days. The policy specifically states that a resident cannot be disciplined for refusing to answer or disclose information regarding sexual orientation, disability status, precious sexual trauma or the residents

perception of vulnerability.

Copies of this documentation was provided for the portion of the population to which this applies since the inception of the policy in May 2017.

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.

There was no risk screening completed to be used when making decisions in regards to housing, bed, work, education, and program assignments. The agency did make individualized decisions about how to ensure the safety and security of each resident however PREA standards were not a part of that process. The agency stated that housing and programming assignments for transgender or intersex residents are made on a case-by-case basis but nothing in writing was available.

The current policy states that information from the risk assessment shall be used to make informed decisions with the goal of keeping separate those residents at high risk of being sexually victimized from those at high risk of being sexually abusive. They have continued the practice of making individualized determinations about how to ensure the safety of each resident.

A special room has been designated as a housing space for a transgender or intersex resident in the event that being in the general population is not an option or best for their safety. Residents views in respect to their own safety will be taken into consideration to the degree that it doesn't compromise the safety and security of the institution and all those it inhabits. They will be given the option to shower separately from other residents if requested.

Housing was not assigned based on the persons sexual orientation or gender assignment. A male resident who identified as being a part of the Lesbian, Bi-sexual, Gay, Transgender and Intersex (LBGTI) community was housed in the general population. He confirmed that he had been provided education on PREA and was frequently asked about his perception of safety in the institution. He didn't feel that he was being treated differently than any other resident and felt staff were respectful.

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.

The agency had flyers hung throughout the facility that provides four (4) ways to report sexual abuse. It could be reported to any staff, volunteer or contractor verbally. Residents had the option to submit a grievance form. Outside family and friends could make a report on the resident's behalf by calling the facility main line phone number. It also provided the option for a resident to report on behalf of another resident.

There was no specific PREA policy that explained how to address retaliation specifically in these types of instances. There was no process to address staff neglect or violation of responsibilities that may have contributed to such incidents.

Staff interviews during the initial audit would suggest that there was no uniform method for addressing PREA violations. Any reports of sexual abuse or harassment would be treated like any other violation within the facility as there were no specific expectations that have been communicated to the staff at this facility level.

Of the staff that reported having PREA training, it all took place prior to employment with the work release. There had been no refresher training since they began employment.

The flyer now includes an Allen County Work Release PREA confidential hotline as well as the Allen County Sexual Assault Treatment Center. Residents can also contact the National PREA Hotline. All of these numbers were verified as accurate and valid by the auditor. Information on how to access emotional support services for survivors of sexual abuse was provided as well. Both a phone number and address were given.

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.

Agency policy allowed PREA violations to be reported through the use of the grievance policy, however there was no specific standards as to how this type of violation should be handled differently than any other grievance. There are no special mandates, deadlines and expectations for staff responsibilities concerning grievances on PREA situations.

Agency policy no longer lists grievances as a method to which PREA allegations can be reported. Therefore this portion of the standard is not-applicable.

There have been no PREA related grievances filed in the past 12 months.

The new PREA policy provides feedback and expectations to address all the previous concerns with third party reporting. It states that all allegations will be treated equally and investigated every time.

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 does allow the residents to have access to outside victim advocates for emotional support services. There was no Memorandum of Understanding (MOU) with the outside agencies, nor is it communicated to the resident the extent to which communication with those agencies will be monitored. No attempts to enter into an MOU had been provided. There was no specific agency that is used by this facility as staff interviews provided names of multiple organizations that could be used if necessary.

The facility flyers now provide specified contact information to the residents depending on their individual choice for aftercare.

The Rape Crisis Center of Fort Wayne was contacted and information was provided that supports use by anyone in the local jurisdiction in need of services. There are six (6) Sexual Assault Nurse Examiners on staff that are trained to do medical evaluations following an assault if the person is medically stable. If they are not stable, they would be escorted to a local hospital for stabilization and an examination. This agency has office hours Monday – Friday from 8a-5p but have staff on call 24/7. Law Enforcement referrals are made based on where the assault took place. Third party reporting is not allowed as their primary purpose is to provide care for the victim. Once stabilized, the victim can be referred to other agencies for aftercare including Phoenix Associates, Oak Tree Counseling and Fort Wayne Women's Bureau.

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.

The flyer hung throughout the facility provided the main line phone number as an option to call and do third party reporting. There was no specific mechanism in place to ensure that all third party reports go to the same source and are addressed based on policy and procedure. Calls to the facility main line will send the call to any person employed instead of a specific line to the PREA Coordinator. There was no public distribution of information as to how to report resident sexual assault and sexual harassment.

Since the initial audit there has been the creation of the PREA confidential hotline that is a voicemail specifically for PREA reports only. The new policy states that all allegations will be addressed and investigated regardless of the method used for 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.

The immediate reporting of PREA incidents is the expectation however there was no policy or procedure that provided a specific outline of the requirements.

During staff interviews, many staff stated that reporting a PREA incident is common sense and that a policy or training wasn't necessary. They work under the guise that anything that is a threat or harm to a human should be reported. There was no policy on prohibition of staff from revealing any information related to a sexual abuse report to anyone other than to the extent necessary for treatment, investigation and other security or management decisions.

The new PREA policy now has written expectations of the chain of events following a report of allegations. Staff have received formal training and have a better idea of each incident is to be handled and is no longer left for their own interpretation. Staff know that information is on a "need to know basis" and that during an investigation, no information is to be shared with anyone other than to the extent necessary.

Allen County doesn't house anyone under the age of 18 therefore no special circumstances had to be set for the juvenile population.

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.

The agency and staff interviews suggested that a resident who reports being in imminent risk of abuse would be addressed

immediately, however there is no policy to support or require such.

In May 2017, the PREA policy was put into place that addressed risk of imminent danger and that protocals should be followed to protect the resident. All allegations or threats thereof are to be treated seriously and investigated to the degree necessary to ensure the safety and security of the institution and all of its inhabitants.

The agency stated that no risk of imminent danger has been reported in the past 12 months.

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.

There was no policy that addressed a report regarding sexual abuse at intake from a resident that occurred at a previous facility. There also was no policy that required an investigation be conducted upon being notified of a sexual abuse allegations of a resident no longer in custody.

The new PREA policy addresses reports of allegations in previous institutions. It states that the information will immediately be forwarded to the PREA Coordinator. Within 72 hours of awareness, the head of the other agency will be notified in writing of the allegations. It is also the expectation that if notified by a secondary agency of allegations within Allen County Work Release that an investigation will be launched.

The PREA Coordinator is aware of his duties regarding allegations involving secondary institutions.

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.

The agency had a training curriculum that provided first responder duties for allegations of sexual abuse but no policy. While the curriculum exists, no proof of staff training was provided. Staff interviews were a recall of training from previous employers and the expectations for that agency. There was no uniform expectations upon being notified of sexual abuse or

harassment.

A Field Training Officer (FTO) Performance Checklist was provided that discussed crime scene control, but no proof of staff training accompanied it.

Training documentation supportive of the new policy was provided as proof that the staff have formally been instructed as to their responsibilities regarding allegations and crime scene control. Interviews of staff provided a more uniform understanding of the expectations and consistent responses. They were able to verbalize the importance of procuring biological evidence from both the alledged perpetrator and victim as well as maintaining the integrity of physical evidence if the event took place within the institution.

The agency reports no PREA allegations within the last 12 months.

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)

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.

There was no 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 at the initial on-site audit.

Allen County Work Release doesn't have medical staff or mental health practicitionsers on duty and they share jail custodial staff. The PREA policy states that an incident review team comprised of middle management, case managers, Director and the PREA Coordinator will meet within 30 days after the conclusion of any investigation that is either substantiated or unsubstantiated. They will not meet if the findings were unfounded. A report of the findings and recommendations for improvement shall be typed and submitted to the Community Corrections Advisory Board (if additional funding is necessary). If no additional funding is required, then it will be forwarded to Human Resources. If a need cannot be met, it shall be documented as to why.

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.

This standard is non-applicable. There has been no new or renewed collective bargaining agreement since August 20, 2012.

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.

There was no policy to address the protection of resident's and staff who report sexual abuse or sexual harassment or cooperate with investigations from retaliation by other residents or staff. No staff member had been designated to monitor possible retaliation.

It was common practice to monitor conduct or treatment of staff or residents who reported sexual abuse to see if there were any changes that may suggest possible retaliation by residents and staff. It was the expectation for monitoring to last for the remainder of that residents stay. These expectations were conveyed during staff interviews although there was no policy with specific instructions as to how it is to be carried out.

During the corrective action period, the retaliation monitor position was created and is in place. The Director and the assigned Resident Advisor shall monitor retaliation for any resident that reports or is the alleged victim of sexual abuse or sexual harassment for a period of at least 90 days. Signs of potential retaliation that will be monitored include excessive disciplinary action, dormitory changes, restriction in privileges without cause, decrease in employment hours, down phasing, expressing concern for safety, home pass suspension and behavioral changes.

Staff who may have reported or been the victim of a PREA incident will also be monitored for retaliation. Some specific signs that will be monitored include excessive disciplinary actions, undo shift changes, rejection of vacation days, unfair post assignment rotations, absence of overtime offering, excessive call-ins, requests to work different shift due to being uncomfortable, expressing concern for safety and behavioral changes.

There have been no PREA related incidents in the past 12 months.

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.

There is a policy for the Sheriff's Department that is related to criminal and administrative agency investigations. The work release is operated and supervised under the Sheriff's Department. Substantiated allegations of conduct that appear to be criminal are referred for prosecution. There have been no substantiated allegations of conduct that appear criminal that were referred for prosecution since August 20, 2012.

If the evidence supports criminal prosecution, Allen County Work Release will do whatever is required per the investigating entity or the Prosecutor to aid in a conviction. The credibility of the alleged victim, suspect or witness shall not be a determined by the persons status as a resident or staff. No residents shall be subjected to spolygraph examiniation or other truth-telling devices as a condition for proceeding with the investigation of such an allegation.

Both administrative and criminal investigations shall be documented with written reports that contain thorough descriptions of physical, testimonial and documentary evidence. There will be an effort to determine whether staffs actions or negligence contributed to the abuse.

The departure of the alleged abuser or victim from the employment or incarceration shall not provide a basis for terminating the investigation.

The new policy specifically states that all written reports pertaining to the administrative or criminal investigation of alleged sexual abuse or sexual harassment be retained for as long as the alleged abuser is incarcerated or employed by the agency, plus five years.

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.

The agency originally didn't have in writing that it would impose a standard of a preponderance of evidence or a lower standard of proof when determining whether allegations of sexual abuse or sexual harassment can be substantiated. The new policy does in fact state that this is the expectation.

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.

The agency didn't have a policy that required that any resident who makes an allegation be informed either verbally or in writing as to whether the allegations were determined to be substantiated, unsubstantiated or unfounded following an investigation by the agency.

There have been no criminal and or administrative investigations of alleged resident sexual abuse completed by the facility within the last 12 months.

There were no requirements to inform a resident about the employment status of an employee who has committed sexual abuse against a resident. There were no requirements to inform a resident on the outcomes for another resident who has been indicted or convicted on a charges related to the sexual abuse within the facility.
There was no policy that required all notifications to residents described in this standard were to be documented.

All of this has since been implemented during the 180 days corrective action period. However the agency's obligation to report under this standard shall terminate if the resident is released from the agency's custody.

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.

Staff is subject to disciplinary sanctions up to and including termination for violating agency sexual abuse or sexual harassment policies. There have been no staff terminated for violating this policy in the past 12 months.

Policy didn't specifically state that sanctions for violations of policy relating to sexual abuse or sexual harassment are commensurate with the nature and circumstances of the acts committed, the staff members disciplinary history and the sanctions imposed or comparable offenses by other staff with similar histories. It also didn't speak on reporting to law enforcement and any relevant licensing bodies for staff terminated due to violations of agency sexual abuse or harassment policy.

The implementation of the new policy now addresses all of the required duties per this standard. Termination shall be the presumptive disciplinary sanction for staff who have engaged in sexual abuse.

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.

There was no policy requiring that any contractor or volunteer who engages in sexual abuse be reported to law enforcement and relevant licensing bodies, nor were they prohibited from contact with the residents.

In the past 12 months, there have been no contractors or volunteers that have been reported to law enforcement.

The PREA policy specifically addresses the disciplinary action to occur involving a contractor or volunteer who violates the policy.

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.

Per the List of Prohibited Acts, residents are subject to disciplinary sanctions only pursuant to a formal disciplinary process following an administrative finding that a resident engaged in resident-on-resident sexual abuse. Residents are subject to disciplinary sanctions only pursuant to a formal disciplinary process following a criminal finding of guilt for resident-on-resident sexual abuse.

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. A resident may only be disciplined for sexual contact with a staff upon a finding tha the staff member did not consent to such contact.

A report of sexual abuse made in good faith based upon a reasonable belief shat the alleged conduct occurred shall not constitute false reporting or lying, even if there isn't sufficient evidence to substantiate the allegation.

There have been zero administrative or criminal findings of guilt for resident-on-resident sexual abuse in the past 12 months.

The facility offers therapy, counseling and other interventions designed to address and correct the reasons or motivations for abuse per interviews with staff, per policy. Consideration as to whether to require the offending resident to participate in such interventions as a condition of access to programming or other benefits is the expectation.

The agency prohibits all sexual activity between residents as it is listed as a prohibited act.

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.

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 judgement. There are no medical and mental health practitioners employed by the facility, therefore all decisions will be made by an outside agency.

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. 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.

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 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. Pregnancy tests are made available for victims of sexually abusive vaginal penetration. If found to be pregnant, the victim will receive timely and comprehensive information about and timely access to all lawful pregnancy-related medical services. Testing for sexually transmitted diseases as deemed medically appropriate would be provided.

Confirmation of all of the above being performed once a person has been referred to outside rape crisis centers suggested that the expectations will be met. Mental health evaluations will be provided immediately or within 60 days of learning of such abuse history and offer treatment.

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.

There is a sexual abuse incident review at the conclusion of criminal or administrative investigations of sexual abuse with either substantiated or unsubstantiated findings. Unfounded findings will not require an incident review. The review shall be conducted within 30 days of the conclusion of the investigation. The review team will consiste of middle management, case managers, the Director and the PREA Coordinator.

The review team shall consider the need to change policy, whether the incident was motivated by race, ethnicity, gender identity, gang affiliation, or sexual orientation. The area in which the incident occurred will be examined to see if physical changes need to take place. Staffing levels and the need to increase technological equipment shall also be considered.

The findings of the meeting shall be made into a report and presented to either Human Resources and or the Community Corrections Advisory Board. Recommendations for improvement shall be documented and implemented. If unable to do so, the reason for not doing so shall be documented.

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 will annually collect accurate, uniform data for every allegation of sexual abuse using a standardized instrument and set of definitions. At a minimum, it shall include the answers to all questions found on the most recent version of the Survey of Sexual Violence conducted by the Department of Justice. Data shall be maintained, reviewed and collected as needed from all available documentation, investigation files and sexual abuse incident reviews.

All of this information will be made available to the Department of Justive no later than June 30th for the previous calendar year.

Because this is the first year that they have been required to be PREA compliant, the expectation is that the first annual report will be completed for calendar year 2017.

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.

Data will be collected or reviewed to assess and improve the effectiveness of its sexual abuse prevention, detection, response policies and training. Identifying problem areas and taking corrective action on an ongoing basis is the expectation. The annual report shall be made readily available to the public through its website. A comparison of the current year's data and corrective actions with those from prior years shall be provided for the purpose of assessing the agenc's progress in addressing sexual abuse.

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.

The agency does ensure that incident-based and aggregate data are securely retained per policy. All aggregated sexual abuse data shall be made readily available to the public at least annually through its website. However any personal identifiers shall be removed All sexual abuse data collected shall be maintained for at least 10 years after the date of the initial collection unless Federal, State or local law requires otherwise.

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.

Bridgette M. Collins 7/27/17

Auditor Signature Date