# PREA Audit: PREA AUDITOR'S SUMMARY REPORT

## Community Confinement Facilities

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| **Name of facility:** | **Northwest Community Corrections Center** |
| **Physical address:** | **1740 East Gypsy Lane Rd, Bowling Green, OH 43402** |
| **Date report submitted:** | **September 17, 2014** |
| **Auditor Information** | |
| **Name:** | **Michelle Bonner** |
| **Address:** | **1629 K St NW, Suite 300, Washington, DC 20006** |
| **Email:** | michelle@michellebonner.com |
| **Telephone number:** | **202-489-7184** |
| **Date of facility visit:** | **July 21-22, 2014** |
| **Facility Information** | |
| **Facility mailing address:** (if different from above) | **same** |
| **Telephone number:** | **419-354-7444** |
| **The facility is:** | **State** |
| **Facility Type** | **Other Community Correctional Facility** |
| **Name of Facility Head:** | **Cary Williams** |
| **Title:** | **Executive Director** |
| **Email address:** | **cwilliams@co.wood.oh.us** |
| **Telephone number:** | **419-373-4977** |
| **Name of Facility PREA Coordinator: Charlie Hughes** | |
| **Title:** | **Program Manager** |

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|---|---|
| **Email address:** | **chughes@co.wood.oh.us** |
| **Telephone number:** | **419-373-4979** |
| **Agency Information** | |
| **Name of Agency:** | |
| **Governing authority or parent agency:** (if different from above) | |
| **Ohio Department of Rehabilitation and Correction (ODRC)** | |
| **Telephone number:** | |
| **Agency Chief Executive Officer** | |
| **Name:** | **Gary C. Mohr** |
| **Title:** | **Director** |
| **Email address:** | **Gary.Mohr@odrc.state.oh.us** |
| **Telephone number:** | **614-752-1164** |
| **Agency-Wide PREA Coordinator** | |
| **Name:** | **Andrew Albright** |
| **Title:** | **Chief, Bureau of Agency Policy and Operational Compliance** |
| **Email address:** | **Andrew.Albright@odrc.state.oh.us** |
| **Telephone number:** | **614-752-1708** |

## AUDIT FINDINGS

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

Michelle Bonner, an independent contractor certified by the United States Department of Justice (DOJ) to conduct audits of community confinement facilities to assess their compliance with the DOJ-adopted standards of the Prison Rape Elimination Act of 2003 (PREA), conducted an onsite audit of Northwest Community Corrections Center (hereinafter, "NWCCC"), 1740 E. Gypsy Lane Road, Bowling Green, Ohio 43402, on July 21-22, 2014. NWCCC serves five surrounding counties in northwestern Ohio, and is located in Wood County, Ohio. During the audit, 61 residents were present at this male only facility; and the facility employed 33 staff members who worked with the residential program.

NWCCC is one of nineteen community based correctional facilities (CBCF's) in the state of Ohio. Ohio's Bureau of Community Sanctions, Ohio Department of Rehabilitation and Corrections (ODRC), defines CBCF's as "residential sanctions that provide local Courts of Common Pleas a sanctioning alternative to prison. Each program is highly structured with assessment, treatment, and follow-up services for offenders. CBCFs provide intensive substance abuse treatment/education, educational services, job training, mental health and transitional services to the community."[1] The CBCF's employ cognitive behavioral techniques (CBT) in their programming.[2] "NWCCC utilizes a cognitive behavioral approach to reducing criminal thinking and activities and increasing pro-social skills. Our behavioral modification system involves immediate reinforcements and sanctions related to certain behaviors."[3]

NWCCC is the sixth of nine CBCF's for which Auditor Bonner conducted audits in July 2014, through a memorandum of understanding (MOU) between the auditor and CorJus, a nonprofit coalition of many of the CBCF's in the state of Ohio. While ODRC provides partial to complete funding of these CBCF's to serve multi-county regions of the state, the CBCF's each stand alone as distinct agencies, with their own facility governing boards, staff, policies and procedures, and their individual PREA policies and implementation. Auditor Bonner is providing separate reports for each of the nine facilities, according to their individual audits.

Auditor Bonner arrived at NWCCC at 8:40am on Monday, July 21, 2014. There she was greeted by PREA Coordinator Charlie Hughes. In the administration area's conference room Auditor Bonner was also met by Facility Director Cary Williams, Operations Manager Brandon Will, Business Manager Amy Willhelm, and Correctional Healthcare Companies Operations Manager Betty Christen, RN. The brief opening meeting started with introductions, a description and history of the facility, and a description of the onsite audit process. Then Auditor, PREA Coordinator, and Operations Manager conducted a complete and thorough tour of the entire facility. The tour consisted of examining all dorms, rooms, offices, closets, restrooms, programming area, intake area, segregation cells, operations center, kitchen and dining areas, recreation area, utility rooms, maintenance and administration areas.

During the course of the two days, in addition to speaking with staff and residents during the tour, Auditor Bonner conducted one-on-one interviews with the following 14 staff for specialized staff and general staff inquiries:

- Facility Director
- PREA Coordinator/Accreditations Manager
- Business Manager
- Operations Manager
- Contract Nurse
- Contract Medical Operations Manager
- 2 Case Managers

[1] Annual Report 2014, Bureau of Community Sanctions, Christopher Galli, Chief, Ohio Department of Rehabilitation and Correction, p. 3.
[2] *Id.*, p. 8.
[3] Description of facility by NWCCC for PREA Auditor binder, July 22, 2014.

- Intake Specialist
- 3 Resident Specialists
- Resident Specialist Coordinator
- Volunteer

Auditor Bonner also met individually with 10 residents. Residents were chosen by dorm, age, and length of stay at the facility. During the two-day audit, Auditor Bonner conducted document review which included review of employee files (including new hires, terminations, spot check of five year background checks and promotions), security logs, PREA assessments/reassessments, PREA investigation documents, staff and volunteer training acknowledgements, employee training records, resident acknowledgements, PREA forms and data logs. Auditor was onsite for 12 hours on July 21 and 10 hours on July 22. Near the end of the second day, Auditor held a closeout session with management staff, during which she shared some of her immediate observations.

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

NWCCC is a one level facility built in 1998, with a similar layout to West Central Community Corrections Facility (WCCCF) that was also built in the 1990's (except for WCCCF's small mezzanine level above the male dayroom). Despite its age, NWCCC facility is in the condition of a relatively new facility. The first door to the lobby remains unlocked, but there are two cameras along the walkway to the door; and one cannot get any farther than the Operations Center which is right in front and staffed 24 hours a day. There are lockers and PREA signage for visitors. The facility requires electronic key entry or entry through Operations Center.

To the right of the Operations Center is the hall to the visitation room. This hall is monitored by Operations Center staff; and there is camera coverage in the visitation room. (There will be audio recording in this room by the end of the year.) After visitation area is the clinical area, which includes a small room with no audio recording for legal visits. Other classrooms along this hall have been slated to have cameras and audio recording devices installed. Clinical and other staff offices have doors with windows through which one can see residents when present. There are cameras along the halls in this programming area.

A male only facility with capacity for 64 residents, the facility has only one large dayroom and four dorms that each contains 8 bunk beds with the heads along the walls. The dorms are labeled A through D. Each dorm has a pan/tilt/zoom camera (with plans to get one more stationary camera in each) and an audio recorder. Dorms A and B are for low to medium risk residents (through Ohio Risk Assessment Screening, or "ORAS"); C and D, high to very high-risk residents. There are also two restrooms, one for each side of the dayroom, which each contain toilet stalls with doors and shower curtains cut short to see number of feet in each. The facility has ordered and installed shower curtains with clear tops for better monitoring of the showers. There are no cameras or microphones in the restrooms themselves; however, NWCCC has proposed microphones right out side of each restroom for increased monitoring.

The dayroom itself is expansive and is referred to in three sections with no dividers. All three sections have camera coverage,

and the Operations Center looks out onto the dayroom. Pay phones are located on both sides, with PREA signs with telephone numbers for ODRC hotline and rape crisis center hotline provided. Although the dorms and restrooms are separate, the resident lockers were all in one place. Per Auditor's suggestion, the facility separated the high risk residents' lockers from the low risk residents' lockers. Beyond the dayroom is the dining area/classroom, which has two cameras, microphone, and a glass wall between it and the dayroom. The recreation yard is off the dining area; and it has three cameras (including one pan/tilt/zoom).

The kitchen, which is staffed by employees and residents, has at least four cameras and at least three mirrors to cover serving line, dishwashing area, office and cooler entrances, and the sally port area. Residents were allowed to enter a blind spot area to retrieve hairnets before their shifts; but during the audit, kitchen staff moved hairnets out of blind spot and made that area restricted to staff only.

Intake area has a door to Operations Center; and it is covered by two cameras and a microphone near the segregation cells. Pat-downs are performed on camera. Maintenance is locked in this area. There is a camera on the sally port door where residents enter and exit the building. Medical examination room is also in this area, behind the intake desk. PREA signage is on the shower room door where strip searches are conducted.

The Operations Center is referred to as the "fish bowl"; it has practically 360-degree views to various areas of the facility, including the computer lab as well. There are no cameras in the administration area. There are external cameras around the entire building; and security walk the perimeter of the building during rounds, checking utility closets that open from the outside of the building. Outdoor trash and garden areas frequented by residents are covered by cameras.

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

NWCCC is an all male facility in Bowling Green, OH, tucked away between corn and soybean fields, away from all of the distractions of more suburban or urban areas. Although built in the late 1990's, the facility looks to be in new condition. The front door is unlocked; and there are cameras outside, but not immediately apparent. One gets the feeling of safety and security without the overtly correctional feel or appearance.

Auditor was impressed by the level of security monitoring at NWCCC. There are already pan/tilt/zoom cameras in each dorm; and there are plans to add additional stationary cameras in each. NWCCC also employs audio monitoring of residents. The facility has an electronic key system with sensors located in the restrooms, in utility closets, and other strategic places around the building. As resident specialists make their rounds every 30 minutes, they are required to register their key fob at these sensors, to verify that they have checked each area. Even in winter, resident specialists are required to do perimeter checks and enter multiple utility closets to achieve this purpose. The space is very open, with Operations Center having a 360-degree view of the facility areas

where residents frequent. There is a dress policy for the dorms. Proposals for more camera coverage in the dorms and in programming area will greatly enhance security monitoring.

During the onsite audit, the facility made immediate corrective action based on suggestions of the Auditor, which was also very impressive. Until then, the facility employed contract medical staff to conduct PREA risk assessment screenings. While medical staff were able to ask questions confidentially and within 72 hours, the screening is not medical, and medical staff had little to no further interaction with residents or facility staff. At the suggestion of Auditor, the facility quickly investigated changing risk screening protocol to employ intake specialist to conduct the screening. Maintenance changed the office door to one with a window for monitoring but with privacy during the screening process. Staff immediately adjusted camera angles and resolved PREA hotline calling issues to enable free calling while Auditor was present. PREA Coordinator also modified forms, ordered rearrangement of office furniture, enlarged and modified posters to add hotline information, hung additional PREA signage, and strengthened staff training curriculum.

Residents who complained to staff regarding inappropriate sexual comments by other residents expressed that NWCCC's swift action against isolated comments reduces the chance of these evolving into sexual harassment. The facility imposes sanctions consistent with its treatment modality for minor infractions. NWCCC does not conduct PREA investigations, but, instead, reports allegations of PREA violations to the Wood County Sheriff's Office across the street from the facility. NWCCC has a website, and it endeavors to make all of its PREA information and data public both onsite and through ODRC.
https://sites.google.com/site/nwcccsearch/prea

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| **Number of standards exceeded:** | **4** |
| **Number of standards met:** | **33** |
| **Number of standards not met:** | **0** |
| **Number of standards N/A:** | **2** |

**FOLLOWING INFORMATION TO BE POPULATED AUTOMATICALLY FROM AUDITOR COMPLIANCE TOOL:**

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

NWCCC P&P 14.01
(a) The facility has a written policy mandating zero tolerance toward all forms of sexual abuse and sexual harassment in facilities it operates directly or under contract. The facility has a written policy outlining how it will implement the facility's approach to preventing, detecting, and responding to sexual abuse and sexual harassment.
The policy includes definitions of prohibited behaviors regarding sexual abuse and sexual harassment.
The policy includes sanctions for those found to have participated in prohibited behaviors.
The policy includes a description of facility strategies and responses to reduce and prevent sexual abuse and sexual harassment of residents.
(b) The facility employs or designates an upper-level, facility-wide PREA coordinator.
The PREA coordinator has sufficient time and authority to develop, implement, and oversee facility efforts to comply with the PREA standards in all of its community confinement facilities. The position of the PREA coordinator in the facility's organizational structure: Program Manager, who reports directly to the Deputy Director.

| **Overall Determination:** | **§115.212 - Contracting with other entities for the confinement of residents.** |
|---|---|
| **N/A** | **Exceeds Standard** (substantially exceeds requirement of standard)<br>**Meets Standard** (substantial compliance; complies in all material ways with the standard for the relevant review period)<br>**Does Not Meet Standard** (requires corrective action)<br><br>Auditor Comments (including corrective actions needed if does not meet standard): |

| **Overall Determination:** | **§115.213 - Supervision and monitoring.** |
|---|---|
| ✔ | **Exceeds Standard** (substantially exceeds requirement of standard)<br>**Meets Standard** (substantial compliance; complies in all material ways with the standard for the relevant review period)<br>**Does Not Meet Standard** (requires corrective action)<br><br>Auditor Comments (including corrective actions needed if does not meet standard): |

NWCCC P&P 3.04
(a) The facility develops and documents a staffing plan that provides for adequate levels of staffing, and, where applicable, video monitoring to protect residents against sexual abuse.
(b) Each time the staffing plan is not complied with, the facility documents and justifies all deviations from the staffing plan.
There have been no deviations from the staffing plan in the last 12 months.

| **Overall Determination:** | **§115.215 - Limits to cross-gender viewing and searches.** |
|---|---|
| | **Exceeds Standard** (substantially exceeds requirement of standard)<br>✔ **Meets Standard** (substantial compliance; complies in all material ways with the standard for the relevant review period)<br>**Does Not Meet Standard** (requires corrective action)<br><br>Auditor Comments (including corrective actions needed if does not meet standard): |

NWCCC P&P 6.02
(a) N/A – ALL MALE FACILITY
(b) N/A
(c) N/A
(d) Facility has implemented policies and procedures that enable residents to shower, perform bodily functions, and change clothing without non-medical staff of the opposite gender viewing their breasts, buttocks, or genitalia, except in exigent circumstances or when such viewing is incidental to routine cell checks (this includes viewing via video camera).
Policies and procedures require staff of the opposite gender to announce their presence when entering a resident housing unit.
(e) Facility has a policy prohibiting staff from searching or physically examining a transgender or intersex resident for the sole purpose of determining the resident's genital status.
Such searches (described in 115.215(e)-1) occurred in the past 12 months.
(f) Fifteen of sixteen security staff received training on conducting searches of transgender and intersex residents in a professional and respectful manner, consistent with security needs.

| **Overall Determination:** | **§115.216 - Residents with disabilities and residents who are limited English proficient** |
|---|---|
| | **Exceeds Standard** (substantially exceeds requirement of standard)<br>✔ **Meets Standard** (substantial compliance; complies in all material ways with the standard for the relevant review period)<br>**Does Not Meet Standard** (requires corrective action)<br><br>Auditor Comments (including corrective actions needed if does not meet standard): |

NWCCC P&P 4.01
(a) The facility has established procedures to provide disabled residents equal opportunity to participate in or benefit from all aspects of the facility's efforts to prevent, detect, and respond to sexual abuse and sexual harassment.
(b) The facility has established procedures to provide residents with limited English proficiency equal opportunity to participate in or benefit from all aspects of the facility's efforts to prevent, detect, and respond to sexual abuse and sexual harassment. The program professes only to accept those with a working understanding of English, NWCCC P&P 5.01, but it does list access to resources for those with limited English proficiency.
(c) Facility policy prohibits use of resident interpreters, resident readers, or other types of resident assistants except in limited circumstances where an extended delay in obtaining an effective interpreter could compromise the resident's safety, the performance of first-response duties under § 115.264, or the investigation of the resident's allegations.

| **Overall Determination:** | **§115.217 - Hiring and promotion decisions.** |
|---|---|
| | **Exceeds Standard** (substantially exceeds requirement of standard)<br>✔ **Meets Standard** (substantial compliance; complies in all material ways with the standard for the relevant review period)<br>**Does Not Meet Standard** (requires corrective action)<br><br>Auditor Comments (including corrective actions needed if does not meet standard): |

NWCCC P&P 3.04 and 3.09

(a) Facility policy prohibits hiring or promoting anyone who may have contact with residents and prohibits enlisting the services of any contractor who may have contact with residents who:

- Has engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility, or other institution (as defined in 42 U.S.C. 1997);
- Has been convicted of engaging or attempting to engage in sexual activity in the community facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse; or
- Has been civilly or administratively adjudicated to have engaged in the activity described in paragraph (a)(2) of this section.

(b) Facility policy requires the consideration of any incidents of sexual harassment in determining whether to hire or promote anyone, or to enlist the services of any contractor, who may have contact with residents.

(c) Facility policy requires that before it hires any new employees who may have contact with residents, it (a) conducts criminal background record checks, and (b) consistent with federal, state, and local law, makes its best efforts to contact all prior institutional employers for information on substantiated allegations of sexual abuse or any resignation during a pending investigation of an allegation of sexual abuse.

(d) Facility policy requires that a criminal background record check be completed before enlisting the services of any contractor who may have contact with residents.

(e) Facility policy requires that either criminal background record checks be conducted at least every five years for current employees and contractors who may have contact with residents or that a system is in place for otherwise capturing such information for current employees.

(f) The facility shall ask all applicants and employees who may have contact with residents directly about previous misconduct described in paragraph (a) of this section in written applications or interviews for hiring or promotions and in any interviews or written self- evaluations conducted as part of reviews of current employees. The facility shall also impose upon employees a continuing affirmative duty to disclose any such misconduct.

(g) Facility policy states that material omissions regarding such misconduct, or the provision of materially false information, shall be grounds for termination.

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

| **Overall Determination:** | **§115.218 - Upgrades to facilities and technology.** |
|---|---|
| | ✔ **Exceeds Standard** (substantially exceeds requirement of standard)<br>**Meets Standard** (substantial compliance; complies in all material ways with the standard for the relevant review period)<br>**Does Not Meet Standard** (requires corrective action)<br><br>Auditor Comments (including corrective actions needed if does not meet standard): |

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

(b) The facility has installed or updated a video monitoring system, electronic surveillance system, or other monitoring technology since August 20, 2012. The facility bought new cameras in the dorms to make the count two each dorm, replaced one, installed a new paging system, set up additional DVRs so we can save recordings for 30 days and we will be getting a new 32" TV. The facility has audio as well as video throughout the facility.

| **RESPONSIVE PLANNING** | |
|---|---|
| **Overall Determination:** | **§115.221 - Evidence protocol and forensic medical examinations** |
| | **Exceeds Standard** (substantially exceeds requirement of standard)<br>✔ **Meets Standard** (substantial compliance; complies in all material ways with the standard for the relevant review period)<br>**Does Not Meet Standard** (requires corrective action)<br><br>Auditor Comments (including corrective actions needed if does not meet standard): |

(a) The facility is NOT responsible for conducting administrative or criminal sexual abuse investigations (including resident-on-resident sexual abuse or staff sexual misconduct). The Wood County Sheriff's Office has responsibility for conducting either administrative or criminal investigations.

(b) N/A
NWCCC P&P 14.03
(c) The facility offers to all residents who experience sexual abuse access to forensic medical examinations. Forensic medical examinations are offered without financial cost to the victim. Where possible, examinations are conducted by Sexual Assault Forensic Examiners (SAFEs) or Sexual Assault Nurse Examiners (SANEs). When SANEs or SAFEs are not available, a qualified medical practitioner performs forensic medical examinations. The facility documents efforts to provide SANEs or SAFEs.
(d) The facility attempts to make a victim advocate from a rape crisis center available to the victim, either in person or by other means. These efforts are documented. If and when a rape crisis center is not available to provide victim advocate services, the facility provides a qualified staff member from a community-based organization or a qualified facility staff member. The rape crisis center identified is the SAAFE Center.
(e) If requested by the victim, a victim advocate, qualified facility staff member, or qualified community-based organization staff member accompanies and supports the victim through the forensic medical examination process and investigatory interviews and provides emotional support, crisis intervention, information, and referrals.
(f) The facility is not responsible for investigating administrative or criminal allegations of sexual abuse and relies on Wood County Sheriff's Office to conduct these investigations, the facility has requested that this agency follow the requirements of paragraphs §115.221 (a) through (e) of the standards.

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

(a) The facility ensures that an administrative or criminal investigation is completed for all allegations of sexual abuse and sexual harassment (including resident-on-resident sexual abuse and staff sexual misconduct). In the past 12 months, there has been one allegation of sexual abuse and sexual harassment received; none resulting in an administrative investigation; one allegation was referred for criminal investigation. Referring to allegations received in the past 12 months, all administrative and/or criminal investigations were completed.

NWCCC P&P 14.03
(b) The facility has a policy that requires that allegations of sexual abuse or sexual harassment be referred for investigation to an agency with the legal authority to conduct criminal investigations, unless the allegation does not involve potentially criminal behavior.
Facility policy regarding the referral of allegations of sexual abuse or sexual harassment for criminal investigation is published on the facility website: https://sites.google.com/site/nwcccsearch/prea.
The facility documents all referrals of allegations of sexual abuse or sexual harassment for criminal investigation.
(c) A separate entity is responsible for conducting criminal investigations, and such publication shall describe the responsibilities of both the facility and the investigating entity.

| **TRAINING AND EDUCATION** | |
|---|---|
| **Overall Determination:** | **§115.231 - Employee training.**<br><br>**Exceeds Standard** (substantially exceeds requirement of standard)<br>✔ **Meets Standard** (substantial compliance; complies in all material ways with the standard for the relevant review period)<br>**Does Not Meet Standard** (requires corrective action)<br><br>Auditor Comments (including corrective actions needed if does not meet standard): |

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

(9) How to communicate effectively and professionally with residents, including lesbian, gay, bisexual, transgender, intersex, or gender nonconforming residents; and

(10) How to comply with relevant laws related to mandatory reporting of sexual abuse to outside authorities.

(b) Training is tailored to the gender of the residents at the facility.

Employees who are reassigned from facilities housing the opposite gender are given additional training.

(c) All staff employed by the facility, who may have contact with residents, were trained or retrained in PREA requirements.

Between trainings, the facility provides employees who may have contact with residents with refresher information about current policies regarding sexual abuse and sexual harassment. All policy changes or updates are emailed to staff and are accessible through a shared drive.

The frequency with which employees who may have contact with residents receive refresher training on PREA requirements is yearly.

(d) The facility documents that employees who may have contact with residents understand the training they have received through employee signature or electronic verification.

| **Overall Determination:** | **§115.232 - Volunteer and contractor training** |
|---|---|
| | **Exceeds Standard** (substantially exceeds requirement of standard) |
| | ✔ **Meets Standard** (substantial compliance; complies in all material ways with the standard for the relevant review period) |
| | **Does Not Meet Standard** (requires corrective action) |
| | Auditor Comments (including corrective actions needed if does not meet standard): |

(a) All volunteers and contractors who have contact with residents have been trained on their responsibilities under the facility's policies and procedures regarding sexual abuse/harassment prevention, detection, and response.

(b) The level and type of training provided to volunteers and contractors is based on the services they provide and level of contact they have with residents. A PREA training video for contractors and volunteers is used for those who have contact with residents. All volunteers and contractors who have contact with residents have been notified of the facility's zero-tolerance policy regarding sexual abuse and sexual harassment and informed how to report such incidents.

(c) The facility maintains documentation confirming that volunteers/contractors understand the training they have received.

| **Overall Determination:** | **§115.233 - Resident education.** |
|---|---|
| | **Exceeds Standard** (substantially exceeds requirement of standard)<br>✔ **Meets Standard** (substantial compliance; complies in all material ways with the standard for the relevant review period)<br>**Does Not Meet Standard** (requires corrective action)<br><br>Auditor Comments (including corrective actions needed if does not meet standard): |

(a) Residents receive information at time of intake about the zero-tolerance policy, how to report incidents or suspicions of sexual abuse or harassment, their rights to be free from sexual abuse and sexual harassment and to be free from retaliation for reporting such incidents, and regarding facility policies and procedures for responding to such incidents.
(b) The facility provides residents who are transferred from a different community confinement facility with refresher information referenced in 115.233(a)-1.
(c) Resident PREA education is available in accessible formats for all residents including those who are: limited English proficient, deaf, visually impaired, otherwise disabled, or limited in their reading skills.
(d) The facility maintains documentation of resident participation in PREA education sessions.
(e) The facility ensures that key information about the facility's PREA policies is continuously and readily available or visible through posters, resident handbooks, or other written formats.

| **Overall Determination:** | **§115.234 - Specialized training: Investigations.** |
|---|---|
| | **N/A** **Exceeds Standard** (substantially exceeds requirement of standard)<br>**Meets Standard** (substantial compliance; complies in all material ways with the standard for the relevant review period)<br>**Does Not Meet Standard** (requires corrective action)<br><br>Auditor Comments (including corrective actions needed if does not meet standard): |

| **Overall Determination:** | **§115.235 - Specialized training: Medical and mental health care.** |
|---|---|
| | **Exceeds Standard** (substantially exceeds requirement of standard)<br>✔ **Meets Standard** (substantial compliance; complies in all material ways with the standard for the relevant review period)<br>**Does Not Meet Standard** (requires corrective action)<br><br>Auditor Comments (including corrective actions needed if does not meet standard): |

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

| **SCREENING FOR RISK OF SEXUAL VICTIMIZATION AND ABUSIVENESS** | |
|---|---|
| **Overall Determination:** | **§115.241 - Screening for risk of victimization and abusiveness.** |
| | **Exceeds Standard** (substantially exceeds requirement of standard)<br>✔ **Meets Standard** (substantial compliance; complies in all material ways with the standard for the relevant review period)<br>**Does Not Meet Standard** (requires corrective action)<br><br>Auditor Comments (including corrective actions needed if does not meet standard): |

(a) The facility has a policy that requires screening (upon admission to a facility or transfer to another facility) for risk of sexual abuse victimization or sexual abusiveness toward other residents.
(b) The policy requires that residents be screened for risk of sexual victimization or risk of sexually abusing other residents within 72 hours of their intake.
(c) Risk assessment is conducted using an objective screening instrument.

(d) The intake screening shall consider, at a minimum, the following criteria to assess residents for risk of sexual victimization:

(1) Whether the resident has a mental, physical, or developmental disability;
(2) The age of the resident;
(3) The physical build of the resident;
(4) Whether the resident has previously been incarcerated;
(5) Whether the resident's criminal history is exclusively nonviolent;
(6) Whether the resident has prior convictions for sex offenses against an adult or child;
(7) Whether the resident is or is perceived to be gay, lesbian, bisexual, transgender, intersex, or gender nonconforming;
(8) Whether the resident has previously experienced sexual victimization; and
(9) The resident's own perception of vulnerability.

(e) The intake screening shall consider prior acts of sexual abuse, prior convictions for violent offenses, and history of prior institutional violence or sexual abuse, as known to the facility, in assessing residents for risk of being sexually abusive.

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(f) The policy requires that the facility reassess each resident's risk of victimization or abusiveness within a set time period, not to exceed 30 days after the resident's arrival at the facility, based upon any additional, relevant information received by the facility since the intake screening.

(g) The policy requires that a resident's risk level be reassessed when warranted due to a referral, request, incident of sexual abuse, or receipt of additional information that bears on the resident's risk of sexual victimization or abusiveness.

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

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

(i) The facility shall implement appropriate controls on the dissemination within the facility of responses to questions asked pursuant to this standard in order to ensure that sensitive information is not exploited to the resident's detriment by staff or other residents.

| **Overall Determination:** | **§115.242 - Use of screening information.** |
|---|---|
| | **Exceeds Standard** (substantially exceeds requirement of standard)<br>✔ **Meets Standard** (substantial compliance; complies in all material ways with the standard for the relevant review period)<br>**Does Not Meet Standard** (requires corrective action)<br><br>Auditor Comments (including corrective actions needed if does not meet standard): |

(a) The facility uses information from the risk screening required by § 115.241 to inform housing, bed, work, education, and program assignments with the goal of keeping separate those residents at high risk of being sexually victimized from those at high risk of being sexually abusive.
(b) The facility makes individualized determinations about how to ensure the safety of each resident.
(c) The facility makes housing and program assignments for transgender or intersex residents in the facility on a case-by-case basis.
(d) A transgender or intersex resident's own views with respect to his or her own safety shall be given serious consideration.
(e) Transgender and intersex residents shall be given the opportunity to shower separately from other residents.
(f) The facility shall not place lesbian, gay, bisexual, transgender, or intersex residents in dedicated facilities, units, or wings solely on the basis of such identification or status, unless such placement is in a dedicated facility, unit, or wing established in connection with a consent decree, legal settlement, or legal judgment for the purpose of protecting such residents.

| **REPORTING** | |
|---|---|
| **Overall Determination:** | **§115.251 - Resident reporting** |
| | **Exceeds Standard** (substantially exceeds requirement of standard)<br>✔ **Meets Standard** (substantial compliance; complies in all material ways with the standard for the relevant review period)<br>**Does Not Meet Standard** (requires corrective action)<br><br>Auditor Comments (including corrective actions needed if does not meet standard): |

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

- Sexual abuse or sexual harassment;
- Retaliation by other residents or staff for reporting sexual abuse and sexual harassment; AND
- Staff neglect or violation of responsibilities that may have contributed to such incidents.

(b) The facility provides at least one way for residents to report abuse or harassment to a public or private entity or office that is not part of the facility: ODRC phone number.
(c) The facility has a policy mandating that staff accept reports of sexual abuse and sexual harassment made verbally, in writing, anonymously, and from third parties.
Staff are required to document verbal reports by end of business day or no more than 24 hrs.
(d) The facility has established procedures for staff to privately report sexual abuse and sexual harassment of residents: via email, Google voice, or to Sheriff's Office. Staff are informed of these procedures in the following ways: training and emails.

| **Overall Determination:** | **§115.252 - Exhaustion of administrative remedies** |
|---|---|
| | **Exceeds Standard** (substantially exceeds requirement of standard)<br>✔ **Meets Standard** (substantial compliance; complies in all material ways with the standard for the relevant review period)<br>**Does Not Meet Standard** (requires corrective action)<br><br>Auditor Comments (including corrective actions needed if does not meet standard): |

NWCCC P&P 14.03
(a) The facility has an administrative procedure for dealing with resident grievances regarding sexual abuse.
(b) Facility policy or procedure allows a resident to submit a grievance regarding an allegation of sexual abuse at any time regardless of when the incident is alleged to have occurred.
Facility policy does not requires a resident to use an informal grievance process, or otherwise to attempt to resolve with staff, an alleged incident of sexual abuse.
(c) Facility policy and procedure allows a resident to submit a grievance alleging sexual abuse without submitting it to the staff member who is the subject of the complaint. Facility policy and procedure requires that a resident grievance alleging sexual abuse not be referred to the staff member who is the subject of the complaint.

(d) Facility policy and procedure requires that a decision on the merits of any grievance or portion of a grievance alleging sexual abuse be made within 90 days of the filing of the grievance.
(e) Facility policy and procedure permits third parties, including fellow residents, staff members, family members, attorneys, and outside advocates, to assist residents in filing requests for administrative remedies relating to allegations of sexual abuse and to file such requests on behalf of residents.
Facility policy and procedure requires that if the resident declines to have third-party assistance in filing a grievance alleging sexual abuse, the facility documents the resident's decision to decline.
(f) The facility has a policy and established procedures for filing an emergency grievance alleging that a resident is subject to a substantial risk of imminent sexual abuse.
Facility policy and procedure for emergency grievances alleging substantial risk of imminent sexual abuse requires an initial response within 48 hours. Facility policy and procedure for emergency grievances alleging substantial risk of imminent sexual abuse requires that a final facility decision be issued within five days.
(g) The facility has a written policy that limits its ability to discipline a- resident for filing a grievance alleging sexual abuse to occasions where the facility demonstrates that the resident filed the grievance in bad faith.

| **Overall Determination:** | **§115.253 - Resident access to outside confidential support services** |
|---|---|
| | **Exceeds Standard** (substantially exceeds requirement of standard)<br>✔ **Meets Standard** (substantial compliance; complies in all material ways with the standard for the relevant review period)<br>**Does Not Meet Standard** (requires corrective action)<br><br>Auditor Comments (including corrective actions needed if does not meet standard): |

(a) The facility provides residents with access to outside victim advocates for emotional support services related to sexual abuse by:
• Giving residents mailing addresses and telephone numbers (including toll-free hotline numbers where available) for local, state, or national victim advocacy or rape crisis organizations; and
• Enabling reasonable communication between residents and these organizations in as confidential a manner as possible.
(b) The facility informs residents, prior to giving them access to outside support services, of the extent to which such communications will be monitored.
The facility informs residents, prior to giving them access to outside support services, of the mandatory reporting rules governing

privacy, confidentiality, and/or privilege that apply to disclosures of sexual abuse made to outside victim advocates, including any limits to confidentiality under relevant federal, state, or local law.
(c) The facility maintains memorandum of understanding (MOU) with community service provider that is able to provide residents with emotional support services related to sexual abuse: SAAFE Center.

| **Overall Determination:** | **§115.254 - Third party reporting.** |
|---|---|
| | **Exceeds Standard** (substantially exceeds requirement of standard)<br>✔ **Meets Standard** (substantial compliance; complies in all material ways with the standard for the relevant review period)<br>**Does Not Meet Standard** (requires corrective action)<br><br>Auditor Comments (including corrective actions needed if does not meet standard): |

The facility provides a method to receive third-party reports of resident sexual abuse or sexual harassment: through Wood County Sheriff's Office, email or Google voice line.
The facility publicly distributes information on how to report resident sexual abuse or sexual harassment on behalf of residents: procedures made available upon request.

| **OFFICIAL RESPONSE FOLLOWING A RESIDENT REPORT** | |
|---|---|
| **Overall Determination:** | **§115.261 - Staff and agency reporting duties** |
| | **Exceeds Standard** (substantially exceeds requirement of standard)<br>✔ **Meets Standard** (substantial compliance; complies in all material ways with the standard for the relevant review period)<br>**Does Not Meet Standard** (requires corrective action)<br><br>Auditor Comments (including corrective actions needed if does not meet standard): |

NWCCC P&P 14.02

(a) The facility requires all staff to report immediately and according to facility policy:

- Any knowledge, suspicion, or information they receive regarding an incident of sexual abuse or sexual harassment that occurred in a facility, whether or not it is part of the facility.
- Any retaliation against residents or staff who reported such an incident.
- Any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation.

(b) Apart from reporting to designated supervisors or officials and designated state or local service agencies, facility policy prohibits staff from revealing any information related to a sexual abuse report to anyone other than to the extent necessary to make treatment, investigation, and other security and management decisions.

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

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

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

| **Overall Determination:** | **§115.262 - Agency protection duties.** |
|---|---|
| | **Exceeds Standard** (substantially exceeds requirement of standard)<br>✔ **Meets Standard** (substantial compliance; complies in all material ways with the standard for the relevant review period)<br>**Does Not Meet Standard** (requires corrective action)<br><br>Auditor Comments (including corrective actions needed if does not meet standard): |

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

| **Overall Determination:** | **§115.263 - Reporting to other confinement facilities.** |
|---|---|
| | **Exceeds Standard** (substantially exceeds requirement of standard)<br>✔ **Meets Standard** (substantial compliance; complies in all material ways with the standard for the relevant review period)<br>**Does Not Meet Standard** (requires corrective action)<br><br>Auditor Comments (including corrective actions needed if does not meet standard): |

NWCCC P&P 14.03

(a) The facility has a policy requiring that, upon receiving an allegation that a resident was sexually abused while confined at another facility, the head of the facility must notify the head of the facility or appropriate office of the agency or facility where sexual abuse is alleged to have occurred.

In the past 12 months, the facility received one allegation that a resident was abused while confined at another facility. The facility wrote a letter reporting this allegation to the other facility, but there was no response.

(b) Facility policy requires the facility head provides such notification as soon as possible, but no later than 72 hours after receiving the allegation. Facility has improved its risk assessment procedure to ensure timely notification of abuse in other facilities, to ensure that the PREA Coordinator is informed of abuse at another facility on the same day as the report is made to any facility staff.

(c) The facility documents that it has provided such notification within 72 hours of receiving the allegation.

(d) The facility policy requires that allegations received from other facilities/agencies are investigated in accordance with the PREA standards.

| **Overall Determination:** | **§115.264 – Staff first responder duties.** |
|---|---|
| | **Exceeds Standard** (substantially exceeds requirement of standard)<br>✔ **Meets Standard** (substantial compliance; complies in all material ways with the standard for the relevant review period)<br>**Does Not Meet Standard** (requires corrective action)<br><br>Auditor Comments (including corrective actions needed if does not meet standard): |

NWCCC P&P 14.03

(a) The facility has a first responder policy for allegations of sexual abuse. The facility policy requires that, upon learning of an allegation that a resident was sexually abused, the first security staff member to respond to the report shall be required to:

(1) Separate the alleged victim and abuser;

(2) Preserve and protect any crime scene until appropriate steps can be taken to collect any evidence;

(3) If the abuse occurred within a time period that still allows for the collection of physical evidence, request that the alleged victim not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating; and

(4) If the abuse occurred within a time period that still allows for the collection of physical evidence, ensure that the alleged abuser does not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating.

In the past 12 months, there was one allegation that a resident was sexually abused. This one time the first security staff member to respond to the report separated the alleged victim and abuser. Staff were not notified within a time period that still allowed for the collection of physical evidence.

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

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

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

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

| **Overall Determination:** | **§115.266 – Preservation of ability to protect residents from contact with abusers.** |
|---|---|
| | **Exceeds Standard** (substantially exceeds requirement of standard)<br>✔ **Meets Standard** (substantial compliance; complies in all material ways with the standard for the relevant review period)<br>**Does Not Meet Standard** (requires corrective action)<br><br>Auditor Comments (including corrective actions needed if does not meet standard): |

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

| **Overall Determination:** | **§115.267 – Agency protection against retaliation.** |
|---|---|
| | **Exceeds Standard** (substantially exceeds requirement of standard)<br>✔ **Meets Standard** (substantial compliance; complies in all material ways with the standard for the relevant review period)<br>**Does Not Meet Standard** (requires corrective action)<br><br>Auditor Comments (including corrective actions needed if does not meet standard): |

NWCCC P&P 14.03

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

The facility designates staff member(s) or charges department(s) with monitoring for possible retaliation. Operations Manager monitors residents; Business Manager (HR) monitors staff.

(b) The facility shall employ multiple protection measures, such as housing changes or transfers for resident victims or abusers, removal of alleged staff or resident abusers from contact with victims, and emotional support services for residents or staff who fear retaliation for reporting sexual abuse or sexual harassment or for cooperating with investigations.

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

(d) In the case of residents, such monitoring shall also include periodic status checks.

(e) If any other individual who cooperates with an investigation expresses a fear of retaliation, the facility shall take appropriate measures to protect that individual against retaliation.

(f) Facility's obligation to monitor shall terminate if the facility determines that the allegation is unfounded.

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

NWCCC P&P 14.03

(a) The facility has a policy related to criminal and administrative facility investigations.
(b) Where sexual abuse is alleged, the facility calls the Wood County Sheriff's Office.
(c) Wood County Sheriff's Office shall gather and preserve direct and circumstantial evidence, including any available physical and DNA evidence and any available electronic monitoring data; shall interview alleged victims, suspected perpetrators, and witnesses; and shall review prior complaints and reports of sexual abuse involving the suspected perpetrator.
(d) When the quality of evidence appears to support criminal prosecution, the Wood County Sheriff's Office shall conduct compelled interviews and will consult with prosecutors as to whether compelled interviews may be an obstacle for subsequent criminal prosecution.
(e) The credibility of an alleged victim, suspect, or witness shall be assessed on an individual basis and shall not be determined by the person's status as resident or staff. Wood County Sheriff's Office shall not require a resident who alleges sexual abuse to submit to a polygraph examination or other truth-telling device as a condition for proceeding with the investigation of such an allegation.
(f) Administrative investigations are not conducted at this facility.
(g) Criminal investigations shall be documented in a written report that contains a thorough description of physical, testimonial, and documentary evidence and attaches copies of all documentary evidence where feasible.
(h) Substantiated allegations of conduct that appears to be criminal shall be referred for prosecution.
(i) The facility shall retain all written reports referenced in paragraphs (f) and (g) of this section for as long as the alleged abuser is incarcerated or employed by the facility, plus five years.
(j) N/A
(k) N/A
(l) When Wood County Sheriff's Office investigates sexual abuse, the facility shall cooperate with outside investigators and shall endeavor to remain informed about the progress of the investigation.

| **Overall Determination:** | **§115.272 - Evidentiary standards for administrative investigations.** |
|---|---|
| | **Exceeds Standard** (substantially exceeds requirement of standard)<br>✔ **Meets Standard** (substantial compliance; complies in all material ways with the standard for the relevant review period)<br>**Does Not Meet Standard** (requires corrective action)<br><br>Auditor Comments (including corrective actions needed if does not meet standard): |

NWCCC P&P 14.03
The facility imposes a standard of a preponderance of the evidence or a lower standard of proof when determining whether allegations of sexual abuse or sexual harassment are substantiated.

| **Overall Determination:** | **§115.273 - Reporting to residents.** |
|---|---|
| | **Exceeds Standard** (substantially exceeds requirement of standard)<br>✔ **Meets Standard** (substantial compliance; complies in all material ways with the standard for the relevant review period)<br>**Does Not Meet Standard** (requires corrective action)<br><br>Auditor Comments (including corrective actions needed if does not meet standard): |

(a) The facility has a policy requiring that any resident who makes an allegation that he or she suffered sexual abuse in the facility is informed, verbally or in writing, as to whether the allegation has been determined to be substantiated, unsubstantiated, or unfounded following an investigation by the facility.
In the past 12 months, one resident was notified, verbally or in writing, of the results of the investigation.
(b) If an outside entity conducts such investigations, the facility requests the relevant information from the investigative entity in order to inform the resident of the outcome of the investigation.
In the past 12 months, this one investigation of alleged resident sexual abuse in the facility that was completed by an outside agency, Wood County Sheriff's Dept.
(c) Following a resident's allegation that a staff member has committed sexual abuse against the resident, the facility would

subsequently inform the resident (unless the allegation is unfounded) whenever:

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

There have been no substantiated or unsubstantiated complaint (i.e., not unfounded) of sexual abuse committed by a staff member against a resident in the facility in the past 12 months.

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

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

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

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

| **DISCIPLINE** | |
|---|---|
| **Overall Determination:** | **§115.276 - Disciplinary sanctions for staff.**<br><br>**Exceeds Standard** (substantially exceeds requirement of standard)<br>✔ **Meets Standard** (substantial compliance; complies in all material ways with the standard for the relevant review period)<br>**Does Not Meet Standard** (requires corrective action)<br><br>Auditor Comments (including corrective actions needed if does not meet standard): |

NWCCC P&P 14.04

(a) Staff is subject to disciplinary sanctions up to and including termination for violating facility sexual abuse or sexual harassment policies.

(b) Termination shall be the presumptive disciplinary sanction for staff who have engaged in sexual abuse.

(c) Disciplinary sanctions for violations of facility policies relating to sexual abuse or sexual harassment (other than actually engaging in sexual abuse) are commensurate with the nature and circumstances of the acts committed, the staff member's disciplinary history, and the sanctions imposed for comparable offenses by other staff with similar histories.

(d) All terminations for violations of facility sexual abuse or sexual harassment policies, or resignations by staff who would have been terminated if not for their resignation, are reported to law enforcement agencies, unless the activity was clearly not criminal, and to any relevant licensing bodies.

| **Overall Determination:** | **§115.277 - Corrective action for contractors and volunteers.** |
|---|---|
| | **Exceeds Standard** (substantially exceeds requirement of standard)<br>✔ **Meets Standard** (substantial compliance; complies in all material ways with the standard for the relevant review period)<br>**Does Not Meet Standard** (requires corrective action)<br><br>Auditor Comments (including corrective actions needed if does not meet standard): |

(a) Facility policy requires that any contractor or volunteer who engages in sexual abuse be reported to law enforcement agencies, unless the activity was clearly not criminal, and to relevant licensing bodies.
Facility policy requires that any contractor or volunteer who engages in sexual abuse be prohibited from contact with residents.
(b) The facility takes appropriate remedial measures and considers whether to prohibit further contact with residents in the case of any other violation of facility sexual abuse or sexual harassment policies by a contractor or volunteer.

| **Overall Determination:** | **§115.278 - Disciplinary sanctions for residents.** |
|---|---|
| | **Exceeds Standard** (substantially exceeds requirement of standard)<br>✔ **Meets Standard** (substantial compliance; complies in all material ways with the standard for the relevant review period)<br>**Does Not Meet Standard** (requires corrective action)<br><br>Auditor Comments (including corrective actions needed if does not meet standard): |

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

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.
(b) Sanctions shall be commensurate with the nature and circumstances of the abuse committed, the resident's disciplinary history, and the sanctions imposed for comparable offenses by other residents with similar histories.
(c) The disciplinary process shall consider whether a resident's mental disabilities or mental illness contributed to his or her behavior when determining what type of sanction, if any, should be imposed.
(d) The facility offers therapy, counseling, or other interventions designed to address and correct the underlying reasons or motivations for abuse; and the facility considers whether to require the offending resident to participate in such interventions as a condition of access to programming or other benefits.
(e) The facility disciplines residents for sexual conduct with staff only upon finding that the staff member did not consent to such contact.
(f) The facility prohibits disciplinary action for a report of sexual abuse made in good faith based upon a reasonable belief that the alleged conduct occurred, even if an investigation does not establish evidence sufficient to substantiate the allegation.
(g) The facility prohibits all sexual activity between residents. The facility deems such activity to constitute sexual abuse only if it determines that the activity is coerced.

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

(a) Resident victims of sexual abuse receive timely, unimpeded access to emergency medical treatment and crisis intervention services. The nature and scope of such services are determined by medical and mental health practitioners according to their professional judgment.
Medical and mental health staff maintain secondary materials (e.g., form, log) documenting the timeliness of emergency medical

treatment and crisis intervention services that were provided; the appropriate response by non-health staff in the event health staff are not present at the time the incident is reported; and the provision of appropriate and timely information and services concerning contraception and sexually transmitted infection prophylaxis.
(b) If no qualified medical or mental health practitioners are on duty at the time a report of recent abuse is made, security staff first responders shall take preliminary steps to protect the victim pursuant to § 115.262 and shall immediately notify the appropriate medical and mental health practitioners.
(c) Resident victims of sexual abuse while incarcerated are offered timely information about and timely access to emergency sexually transmitted infections prophylaxis, in accordance with professionally accepted standards of care, where medically appropriate.
(d) Treatment services are provided to every victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident.

| **Overall Determination:** | **§115.283 - Ongoing medical and mental health care for sexual abuse victims and abusers.** |
|---|---|
| | **Exceeds Standard** (substantially exceeds requirement of standard) |
| | ✔ **Meets Standard** (substantial compliance; complies in all material ways with the standard for the relevant review period) |
| | **Does Not Meet Standard** (requires corrective action) |
| | Auditor Comments (including corrective actions needed if does not meet standard): |

(a) The facility offers medical and mental health evaluation and, as appropriate, treatment to all residents who have been victimized by sexual abuse in any prison, jail, lockup, or juvenile facility.
(b) The evaluation and treatment of such victims shall include, as appropriate, follow-up services, treatment plans, and, when necessary, referrals for continued care following their transfer to, or placement in, other facilities, or their release from custody.
(c) The facility shall provide such victims with medical and mental health services consistent with the community level of care.
(d) N/A
(e) N/A
(f) Resident victims of sexual abuse while incarcerated are offered tests for sexually transmitted infections as medically appropriate.
(g) Treatment services are provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident.
(h) The facility attempts to conduct a mental health evaluation of all known resident-on-resident abusers within 60 days of learning

of such abuse history, and offers treatment when deemed appropriate by mental health practitioners.

| DATA COLLECTION AND REVIEW | |
|---|---|
| **Overall Determination:** | **§115.286 - Sexual abuse incident reviews.**<br><br>**Exceeds Standard** (substantially exceeds requirement of standard)<br>✔ **Meets Standard** (substantial compliance; complies in all material ways with the standard for the relevant review period)<br>**Does Not Meet Standard** (requires corrective action)<br><br>Auditor Comments (including corrective actions needed if does not meet standard): |

(a) The facility conducts a sexual abuse incident review at the conclusion of every criminal or administrative sexual abuse investigation, unless the allegation has been determined to be unfounded.
(b) The facility ordinarily conducts a sexual abuse incident review within 30 days of the conclusion of the criminal or administrative sexual abuse investigation.
(c) The sexual abuse incident review team includes upper-level management officials and allows for input from line supervisors, investigators, and medical or mental health practitioners.
(d) The facility prepares a report of its findings from sexual abuse incident reviews, including but not necessarily limited to determinations made pursuant to paragraphs (d)(1)-(d)(5) of this section and any recommendations for improvement, and submits such report to the facility head and PREA Coordinator.

(1) Consider whether the allegation or investigation indicates a need to change policy or practice to better prevent, detect, or respond to sexual abuse;
(2) Consider whether the incident or allegation was motivated by race; ethnicity; gender identity; lesbian, gay, bisexual, transgender, or intersex identification, status, or perceived status; or gang affiliation; or was motivated or otherwise caused by other group dynamics at the facility;
(3) Examine the area in the facility where the incident allegedly occurred to assess whether physical barriers in the area may enable abuse;

(4) Assess the adequacy of staffing levels in that area during different shifts;
(5) Assess whether monitoring technology should be deployed or augmented to supplement supervision by staff;
(e) The facility implements the recommendations for improvement or documents its reasons for not doing so.

| **Overall Determination:** | **§115.287 - Data collection.** |
|---|---|
| | **Exceeds Standard** (substantially exceeds requirement of standard)<br>✔ **Meets Standard** (substantial compliance; complies in all material ways with the standard for the relevant review period)<br>**Does Not Meet Standard** (requires corrective action)<br><br>Auditor Comments (including corrective actions needed if does not meet standard): |

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

| **Overall Determination:** | **§115.288 - Data review for corrective action.** |
|---|---|
| | ✔ **Exceeds Standard** (substantially exceeds requirement of standard)<br>**Meets Standard** (substantial compliance; complies in all material ways with the standard for the relevant review period)<br>**Does Not Meet Standard** (requires corrective action)<br><br>Auditor Comments (including corrective actions needed if does not meet standard): |

(a) The facility reviews data collected and aggregated pursuant to §115.287 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, and training, including:

- Identifying problem areas;
- Taking corrective action on an ongoing basis; and
- Preparing an annual report of its findings from its data review and any corrective actions for each facility, as well as the facility as a whole.

(b) The annual report includes a comparison of the current year's data and corrective actions with those from prior years.
The annual report provides an assessment of the facility's progress in addressing sexual abuse.
(c) The facility makes its annual report readily available to the public at least annually through a link to the website where the information is published. https://sites.google.com/site/nwcccsearch/prea
The annual reports are approved by the facility head.
(d) When the facility redacts material from an annual report for publication the redactions are limited to specific materials where publication would present a clear and specific threat to the safety and security of the facility.
The facility indicates the nature of material redacted.

| **Overall Determination:** | **§115.289 - Data storage, publication, and destruction.** |
|---|---|
| | **Exceeds Standard** (substantially exceeds requirement of standard)<br>✔ **Meets Standard** (substantial compliance; complies in all material ways with the standard for the relevant review period)<br>**Does Not Meet Standard** (requires corrective action)<br><br>Auditor Comments (including corrective actions needed if does not meet standard): |

NWCCC P&P 14.06.

(a) The facility ensures that incident-based and aggregate data are securely retained.

(b) N/A

(c) Before making aggregated sexual abuse data publicly available, the facility removes all personal identifiers.

(d) The facility maintains sexual abuse data collected pursuant to §115.287 for at least 10 years after the date of initial collection, unless federal, state, or local law requires otherwise.

| **AUDITOR CERTIFICATION:** The auditor certifies that the contents of the report are accurate to the best of his/her knowledge and no conflict of interest exists with respect to his or her ability to conduct an audit of the facility under review. | |
|---|---|
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| | |
| AUDITOR SIGNATURE | /s/ Michelle Bonner |
| | |
| DATE | September 16, 2014 |