

Prison Rape Elimination Act (PREA) Audit Report Community Confinement Facilities

Interim Final

Date of Report September 6, 2018

Auditor Information

Name: Dwight L. Fondren	Email: fondu714@hotmail.com
Company Name: Self-Employed	
Mailing Address: 6208 NW 78th Street	City, State, Zip: Kansas City, MO. 64151
Telephone: 816-699-0244	Date of Facility Visit: August 7, 2018

Agency Information

Name of Agency: Heartland Center For Behavioral Change		Governing Authority or Parent Agency (If Applicable): Click or tap here to enter text.	
Physical Address: 1514 Campbell St.		City, State, Zip: Kansas City, MO 64108	
Mailing Address: Click or tap here to enter text.		City, State, Zip: Click or tap here to enter text.	
Telephone: (816)421-2045		Is Agency accredited by any organization? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
The Agency Is:	<input type="checkbox"/> Military	<input type="checkbox"/> Private for Profit	<input checked="" type="checkbox"/> Private not for Profit
<input type="checkbox"/> Municipal	<input type="checkbox"/> County	<input type="checkbox"/> State	<input type="checkbox"/> Federal
Agency mission: The HCBC mission is to provide behavioral healthcare and substance abuse services to help individuals lead healthier, happier, more productive lives.			
Agency Website with PREA Information: http://heartlandcbc.org			

Agency Chief Executive Officer

Name: Carolyn Ross	Title: President
Email: cross@heartlandcbc.org	Telephone: 816-421-6670

Agency-Wide PREA Coordinator

Name: Debra Monday	Title: PREA Coordinator
Email: dmonday@heartlandcbc.org	Telephone: 816-421-6670 ext. 1862
PREA Coordinator Reports to: Shawn Wicklund	Number of Compliance Managers who report to the PREA Coordinator Click or tap here to enter text.

Facility Information

Name of Facility: Heartland Center for Behavioral Change

Physical Address: 1514 Campbell, Kansas City, Missouri 64108

Mailing Address (if different than above): Click or tap here to enter text.

Telephone Number: 816-421-6670

The Facility Is:	<input type="checkbox"/> Military	<input type="checkbox"/> Private for Profit	<input checked="" type="checkbox"/> Private not for Profit
<input type="checkbox"/> Municipal	<input type="checkbox"/> County	<input type="checkbox"/> State	<input type="checkbox"/> Federal

Facility Type:	<input type="checkbox"/> Community treatment center	<input checked="" type="checkbox"/> Halfway house	<input type="checkbox"/> Restitution center
	<input type="checkbox"/> Mental health facility	<input type="checkbox"/> Alcohol or drug rehabilitation center	
	<input type="checkbox"/> Other community correctional facility		

Facility Mission: The HCBC mission is to provide behavioral healthcare and substance abuse services to help individuals lead healthier, happier, more productive lives.

Facility Website with PREA Information: <http://heartlandcbc.org>.

Have there been any internal or external audits of and/or accreditations by any other organization? Yes No

Director

Name: Helen Hurley	Title: Vice President Community Re-Entry Services
Email: hhurley@heartlandcbc.org	Telephone: 816-421-6670 ext. 1241

Facility PREA Compliance Manager

Name: Debra Monday	Title: PREA Coordinator
Email: dmonday@heartlandcbc.org	Telephone: 816-421-6670 x 1862

Facility Health Service Administrator

Name: N/A	Title: N/A
Email: N/A	Telephone: N/A

Facility Characteristics

Designated Facility Capacity: 104	Current Population of Facility: 84
Number of residents admitted to facility during the past 12 months	404
Number of residents admitted to facility during the past 12 months who were transferred from a different community confinement facility:	0
Number of residents admitted to facility during the past 12 months whose length of stay in the facility was for 30 days or more:	316

Number of residents admitted to facility during the past 12 months whose length of stay in the facility was for 72 hours or more:			382
Number of residents on date of audit who were admitted to facility prior to August 20, 2012:			0
Age Range of Population:	<input checked="" type="checkbox"/> Adults 18 +	<input type="checkbox"/> Juveniles Click or tap here to enter text.	<input type="checkbox"/> Youthful residents Click or tap here to enter text.
Average length of stay or time under supervision:			120
Facility Security Level:			Minimum
Resident Custody Levels:			Minimum
Number of staff currently employed by the facility who may have contact with residents:			30
Number of staff hired by the facility during the past 12 months who may have contact with residents:			10
Number of contracts in the past 12 months for services with contractors who may have contact with residents:			10
Physical Plant			
Number of Buildings: 1		Number of Single Cell Housing Units: 0	
Number of Multiple Occupancy Cell Housing Units:		0	
Number of Open Bay/Dorm Housing Units:		7	
Description of any video or electronic monitoring technology (including any relevant information about where cameras are placed, where the control room is, retention of video, etc.): The camera monitoring system is located in the central control area which is situated among the living units. The system is constantly monitored by a HCBC staff member. Cameras are located in strategic areas including living units, gymnasium, outside recreation area, and administration area. The system has the capability to store data up to 90 days. No cameras are located in the restrooms.			
Medical			
Type of Medical Facility:		Refer to local Hospital: Truman Medical Center	
Forensic sexual assault medical exams are conducted at:		Truman Medical Center	
Other			
Number of volunteers and individual contractors, who may have contact with residents, currently authorized to enter the facility:			10
Number of investigators the agency currently employs to investigate allegations of sexual abuse:			1

Audit Findings

Audit Narrative

The auditor's description of the audit methodology should include a detailed description of the following processes during the pre-onsite audit, onsite audit, and post-audit phases: documents and files reviewed, discussions and types of interviews conducted, number of days spent on-site, observations made during the site-review, and a detailed description of any follow-up work conducted during the post-audit phase. The narrative should describe the techniques the auditor used to sample documentation and select interviewees, and the auditor's process for the site review.

The Heartland Center for Behavioral Change (HCBC) Facility is located in an urban area of Kansas City, MO and is one building that houses male and female state offenders. The HCBC is a private, not for profit, 501(c)(3) charitable organization dedicated to providing substance abuse and other behavioral healthcare services to Missouri residents. Founded in 1982 as the Kansas City Community Center, they deliver hope, healing and recovery to people who are struggling with addiction and other life problems. Their comprehensive services have helped tens of thousands of people begin a new life — free of alcohol and drugs.

Audit Methodology

Pre-Onsite Audit Phase

The HCBC Agency PREA Coordinator (APC) and the Auditor had discussions concerning access to the facility and staff, the audit process, logistics for the onsite phase of the audit, and goals and expectations prior to the site visit. The PREA Auditor was in communication with the President and Facility Administrator directly. The APC serves as the facility's PREA Compliance Manager. The APC and the Director of the facility were very receptive to the audit process and were well informed of the role of the Auditor and the expectations during each stage of the PREA audit. The facility staff has participated in a mock PREA audit facilitated by the APC and other team members from outside of the facility. The Facility Director is new in her position and was not responsible for the oversight of the PREA compliance initiatives when the last audit was conducted in 2015.

The notification of the on-site audit at Heartland Center for Behavioral Change (HCBC)) was posted on June 22, 2018, six weeks prior to the date of the onsite audit. The posting of the notices was verified by photographs received electronically from the facility's APC. The photographs provided with the Pre-Audit information indicated notices were posted strategically throughout the facility, accessible to residents, staff, visitors, contractors, and volunteers. The notice was posted in English and Spanish and at eye levels easy for a person to see either standing or sitting. All residents in the facility during the time of the site visit spoke and read English. The Auditor noticed that the notifications were placed in the lobby, hallways, living units, and common areas. The posted audit notices contained the Auditor's contact information and included information regarding confidentiality. No correspondence was received during any phase of the audit.

Approximately 6 to 8 weeks prior to the Auditor's onsite visit to the facility, the Auditor worked with the HCBC APC in developing and completing the Pre-Audit Questionnaire (PAQ). This document identified the minimum information and supporting documents that the facility should submit to the Auditor before the onsite audit begins. The HCBC PAQ was received on July 27, 2018, and included policies, procedures and supporting documentation which was within an adequate timeframe for review. The completed PREA Pre-Audit Questionnaire, policies and procedures, and supporting documentation were uploaded to a flash drive and mailed to the Auditor. This flash drive was received by the Auditor well over a month before the site visit. An initial assessment was conducted of the information provided and it was determined the information was provided in detail on the flash drive. The documentation on the flash drive was well organized by each standard, including the identified provisions of each standard. Additional information requested during the site visit was provided or explained by the Quality Assurance Manager/APC.

The APC had been previously provided a document by the Auditor titled, "Information Requested to Determine Staff and Residents to be interviewed during the On-site PREA Audit." The document was completed and provided to the Auditor onsite. The document requested the identification of the staff members who served and performed in specific PREA-related specialized roles within the facility, including volunteers and contractors who have contact with residents. The document requested a list of security staff and their shift assignments and a resident population roster. Additionally, the request included information regarding residents who may be in vulnerable categories such as disabled; limited English proficient; intersex, gay, lesbian, bisexual and/or transgender residents; and residents housed in isolation.

The Auditor communicated with the APC and the Director to confirm schedules and to clarify specialized PREA roles. A current resident roster was also provided to the Auditor. As a result of the information

received, the Auditor developed an interview schedule of specialized and random staff and residents, including targeted resident interviews.

The facility provided the lists and information before or during the site visit that assisted with the following determinations and interview selections:

Lists/Information	Comments
Complete Resident Roster	An up-to-date roster was provided prior to the site visit
Youthful inmates/detainees	Youthful inmates/detainees are not housed in this facility
Residents with disabilities	Two were identified
Residents who are Limited English Proficient	None were identified
LGBTI Residents	Four were identified
Residents who identified as Transgender/Intersex	One was identified
Residents in segregated housing	There is no segregated housing
Residents in Isolation	No residents were in isolation
Residents with Cognitive disabilities	Three residents were identified
Residents who reported sexual abuse	None were Identified
Residents who reported sexual victimization during risk screening	One was identified
Staff roster for the time of the site visit	The roster was provided during the pre-onsite phase of the audit
Specialized Staff	Specialized staff was identified and interviewed
Contractors who have contact with the residents	Contractors were identified on interview document sent to the facility and on flash drive
Volunteer who has contact with the residents	Volunteers identified on interview document sent to the facility and on flash drive
All grievances/allegations made in the 12 months preceding the audit	None
All allegations of sexual abuse and sexual harassment reported for investigation in the 12 months preceding the audit	None
Hotline calls made during the 12 months preceding the audit	None
Detailed list of number of sexual abuse and sexual harassment allegations in the 12 months preceding the audit	The facility reported there were no allegations of sexual abuse or sexual harassment in the 12 months preceding the audit

The Auditor reviewed the lists/documents provided and conferred with the APC and Director in development of the interview schedule to ensure clarity regarding specialized PREA roles among staff.

Internet research of the facility revealed no indication of litigation, U. S. Department of Justice involvement, or federal consent decrees. General and specific information about the facility and the programs and services provided are detailed on the facility's website. An array of information, pictures of the facility and contact information may be accessed from the informative page. The facility's website also contains PREA information including but not limited to the zero-tolerance and coordinated response policies. The PREA audit report for the initial audit in 2017 is located on the website and it also contains the third-party reporting form.

Onsite Audit Phase

The onsite visit was conducted August 7, 2018 by Dwight L. Fondren (Auditor). The Auditor arrived onsite during the early morning hours in order to interview some staff members on the overnight shift and observe early morning operations. HCBC random staff members working the overnight shift were interviewed

immediately upon the Auditors' arrival to the facility to reduce the accrual of overtime hours. Once the interviews were completed, an entrance conference was conducted. In addition to the Auditor, the entrance conference included the facility Director; APC; and the HCBC President to discuss the information contained in the PAQ. Formal introductions were made and a review of the audit process, site visit activities and the itinerary were reviewed. Site review Instructions were reviewed to include a description of the areas of the facility to be toured; operations and practices to be observed; and questions that should be asked of staff and residents to conduct a thorough site review. Additionally, interview protocols to be used by the auditor to interview staff and residents as part of the audit were discussed. Required documentation, relevant observations, the interview protocols, and the audit compliance tool were used to establish evidence of standard compliance. At the time of this audit, the facility employed 59 staff. The resident population was 84 adult male and females.

Upon completion of the entrance conference, a comprehensive site review of the facility was conducted and led by the APC. The tour included all areas of the facility. The staff was observed providing direct supervision to the residents. During the pre-audit phase, the Auditor was provided a diagram of the physical plant which provided familiarity with the layout of the facility. The program is housed in one building which includes seven housing units; gymnasium; conference room; staff offices; a kitchen and storage rooms. Resident files were observed to be maintained securely in locked file cabinets in an office which is kept locked when unoccupied. The file cabinets located in the APC's office have limited and identified key access. The resident population on the first day of the onsite audit was 84.

During the comprehensive site review, the printed notifications of the PREA site visit were observed posted in the areas previously identified in the pictures sent to the Auditor, such as living units, lobby and common areas for residents and staff. The notices contained large enough print to make them accessible and easy to see and read and in English and Spanish. Posted signs were observed regarding general PREA information including emergency and non-emergency numbers for assistance. The posted information included instructions on accessing the 24/7 hotline for reporting allegations and requesting advocacy services.

Questions were answered by staff during informal interviews regarding resident activities and program services as the site review progressed throughout the facility. The site visit also included the outside grounds. During the comprehensive site review, the intake process was described and the daily scheduled activities and staff supervision were discussed by the Director and the APC. There were no new admissions during the site visit. Staff readily explained activities as different facility areas were visited.

Residents were observed in the dayrooms of their living units preparing for the daily programming or work assignments. In addition to security staff members providing direct supervision to residents, another staff member was monitoring the camera system in the central control area/staff workstation. Telephones were observed in each living unit for reporting allegations of sexual abuse and sexual harassment; the telephones were in working order. The reporting process was discussed during the site review. Directions for accessing the crisis hotline are posted and include the limitations of confidentiality.

Male and Female staff were observed knocking on entrance doors to alert the residents that opposite gender staff were entering the unit. All residents interviewed stated staff members knock or announce their presence when entering the living unit. This practice was experienced and observed during the comprehensive site review. Visibility is enhanced with the strategic use of cameras, mirrors and windows in doors. There are no cameras in bathrooms and reasonable privacy is provided to residents when they use the toilet, change clothes and shower. The shower procedures are printed and posted at the entrance of the bathroom on each unit. In addition, procedures were posted in the Laundry Rooms indicating that all doors will remain opened when in use.

Medical Request Forms, grievance forms, and the locked boxes for each are posted in the common area, accessible to all residents, staff and visitors. All residents have access to writing utensils needed for completing the forms. Signage was posted which indicated where residents were not allowed or only allowed with staff supervision. The doors to closets and storage rooms are kept locked.

A Memorandum of Understanding (MOU) exists with The Metropolitan Organization to Counter Sexual Assault (MOCSA) to receive allegations of sexual abuse and sexual harassment and for the provision of advocacy services upon request. The APC was interviewed by phone and confirmed the advocacy services to be provided in accordance with the MOU. Documentation and interviews with medical providers at Truman Medical Center confirmed forensic medical examinations will be performed at Truman Hospital located in Kansas City, MO. The hospital's Sexual Assault Policy provides that a Sexual Assault Nurse Examiner (SANE) will conduct the examinations.

Interviews

Thirty-four staff members are currently employed at the facility that may have contact with residents. A total of 44 residents were in the facility during the site visit. A total of 16 residents were interviewed which included three with Cognitive Disabilities, two residents identified with Physical Disability; four residents who identified as Gay or Bisexual; one resident who identified as Transgender; one inmate who reported an allegation of sexual abuse during intake, and six random residents from the general population roster. No residents refused. A previous inquiry was made regarding vulnerable categories within the resident population related to the selection of targeted interviews. All targeted resident interviews were conducted because of requested lists/documents and conferring with a Counselor.

Several HCBC staff provided dual services and roles in the management of the PREA Programs. Thirty staff were interviewed; twelve security staff (from all three 8-hour shifts); three administrative staff; one contract staff and 14 specialized and random staff. The random staff members interviewed covered all shifts and specialized staff members interviewed based on their job duties and PREA roles, including a volunteer and two contractors. The President, the Director and the APC were interviewed, however, they are not counted as specialized staff. Although 14 individuals were identified for specialized interviews, the specialized interviews conducted totaled 16 due to staff members in this category serving in more than one PREA related specialized role.

Volunteers conduct religious services at the facility and coordinate the group of religious volunteers. One contractor provides clinical services. The interviews with residents, staff and contractor indicated their receipt of PREA training which was also verified by a review of documentation, including training materials. Staff and resident interviews were conducted by the Auditor and the interviews conducted onsite were done in the privacy of two different offices.

During this process the Auditor did not limit the interview questions to only those included in the protocols; rather, additional site-specific questions were asked to use as a starting point for eliciting information about the facility's compliance with the PREA Standards. All Responses to the interview questions were part of the auditor's compliance assessment. There are no on-site medical providers at the center. Resident interviews support staff's compliance with the facility's prohibition of cross-gender viewing and pat searches. This Auditor was provided evidence to ensure compliance to the PREA, as documented in this report.

The Auditor conducted 16 resident interviews in the following categories during the onsite phase of the audit:

Category of Residents	Number of Interviews
Random Residents	6
Residents who Identify as Gay or Bisexual	3
Residents with a Cognitive Disability	3
Residents with Physical Disability	2
Residents Report of Sexual Abuse During Intake	1
Residents who Identify as Transgender or Intersex	1

The Auditor conducted the following number of specialized staff interviews during the onsite phase of the audit:

Category of Staff	Number of Interviews
Medical Staff	0

Mental Health Staff	1
Administrative (Human Resources) Staff	1
Intermediate or Higher-level Facility Staff (unannounced rounds)	1
Volunteers who have Contact with Residents	0
Contractors who have Contact with Residents	1
Investigative Staff	2
Staff who Perform Screening for Risk of Victimization and Abusiveness	3
Staff on the Incident Review Team	2
Designated Staff Member Charged with Monitoring Retaliation	1
Non-Security Staff First Responders	1
Intake Staff	3
Number of Specialized Staff Interviews	16
Number of Random Staff Interviews	12
Total Random and Specialized Interviews	28
Total Interviews plus PREA Coordinator and Director	30

Onsite Documentation Review

The Auditor received many examples of documentation from resident and staff files as part of the Pre-Onsite Audit Phase. During the Pre-Onsite Audit Phase and the Onsite Audit Phase the Auditor reviewed a sample of personnel files of the staff selected to be interviewed, including documentation of criminal background checks occurring. The PREA Pre-Audit Questionnaire and facility policies, procedures and supporting documentation were reviewed prior to the site visit and while onsite for interviewees and persons not interviewed. The secondary documentation reviewed included but was not limited to Vulnerability Assessments; Grievance Form; Medical Request Form; PREA education and training acknowledgement forms; training records; checklists; sexual abuse coordinated response plan; annual staffing plan assessment; staff schedules; unannounced rounds reports; retaliation monitoring form; organization chart; and other documentation. The facility reports there were no allegations of sexual abuse or sexual harassment in the past 12 months.

After the completion of the site visit process, an exit briefing was held in the conference room. The attendees were the facility Director and the APC. The exit briefing served to review the onsite process and review program strengths. The facility and HCBC staff members were given the opportunity to ask additional questions about the activities of the day and the shared information. The timelines for the submission of PREA reports were reviewed.

Facility Characteristics

The auditor's description of the audited facility should include details about the facility type, demographics and size of the inmate, resident or detainee population, numbers and type of staff positions, configuration and layout of the facility, numbers of housing units, description of housing units including any special housing units, a description of programs and services, including food service and recreation. The auditor should describe how these details are relevant to PREA implementation and compliance.

The HCBC is a private, not for profit, 501(c)(3) charitable organization dedicated to providing substance abuse and other behavioral healthcare services to Missouri residents. Founded in 1982 as the Kansas City Community Center, they deliver hope, healing and recovery to people who are struggling with addiction and other life problems. Their comprehensive services have helped tens of thousands of people begin a new life — free of alcohol and drugs.

The HCBC Facility is in an urban area of Kansas City, MO and is one building that houses both male and female state offenders. The State of Missouri Department of Corrections began housing female offenders in the portion of the building previously used by the Federal Program in July 2015. The federal program

housed both male and female offenders in separate housing wings. State residents were returned to the facility on July 1, 2015. All HCBC staff are authorized to work with the state inmate population. The state housing unit of the facility is referred to as the Community Transition Unit (CTU). The building itself is an old building that has been converted for its current use. The inmate housing areas are dormitory style and there is a shared dining room and gym for units. The showers are in common-use areas based on housing unit and gender.

Beyond the front entrance of the building is the elevator and stairs to the administration area, a common area which is also used for visitation and group activities. The Director and APC, Case Managers offices and the control center or staff workstation are located on the second level area. Recreation activities in the gymnasium are scheduled in advance for the two groups of residents to remain separate. Each housing unit has dorm occupancy rooms and a day room area for group, recreation and leisure activities. Bathrooms including showers are in the living units, Laundry rooms are located in the large common areas or in the bathrooms of the female dorms. Only one resident at a time is allowed in the bathrooms as indicated by procedures and explained by staff during the site review. There is no camera access to the restrooms. Residents are able to change clothes, shower and use the toilet with a reasonable amount of privacy.

Summary of Audit Findings

The summary should include the number of standards exceeded, number of standards met, and number of standards not met, along with a list of each of the standards in each category. If relevant, provide a summarized description of the corrective action plan, including deficiencies observed, recommendations made, actions taken by the agency, relevant timelines, and methods used by the auditor to reassess compliance.

Auditor Note: No standard should be found to be "Not Applicable" or "NA". A compliance determination must be made for each standard.

Number of Standards Exceeded: 0

Click or tap here to enter text.

Number of Standards Met: 41

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Number of Standards Not Met: 0

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Summary of Corrective Action (if any)

No Corrective Actions Required.

PREVENTION PLANNING

Standard 115.211: Zero tolerance of sexual abuse and sexual harassment; PREA coordinator

All Yes/No Questions Must Be Answered by The Auditor to Complete the Report

115.211 (a)

- Does the agency have a written policy mandating zero tolerance toward all forms of sexual abuse and sexual harassment? Yes No
- Does the written policy outline the agency's approach to preventing, detecting, and responding to sexual abuse and sexual harassment? Yes No

115.211 (b)

- Has the agency employed or designated an agency-wide PREA Coordinator? Yes No
- Is the PREA Coordinator position in the upper-level of the agency hierarchy? Yes No
- Does the PREA Coordinator have sufficient time and authority to develop, implement, and oversee agency efforts to comply with the PREA standards in all of its facilities?
 Yes No

Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documentation Reviewed:

PREA Pre-Audit Questionnaire
Facility Policy 13.1-Prevention Planning Procedures
Organizational Chart
PREA Coordinator's Job Description
National Institute of Corrections (NIC) Training Certificate
2016 Annual Report

Interviews:

President
Director of Programs
PREA Coordinator
Random Staff
Residents

Provision (a):

An agency shall have a written policy mandating zero tolerance toward all forms of sexual abuse and sexual harassment and outlining the agency's approach to preventing, detecting, and responding to such conduct.

The facility Policy mandates a zero-tolerance policy toward all forms of sexual abuse and sexual harassment. The policy outlines the facility's approach to preventing, detecting, and responding to such conduct. The policy includes definitions of prohibited behaviors regarding sexual abuse and sexual harassment and includes sanctions for those found to have participated in prohibited behaviors. The Policy provides for the appointment of a PREA Coordinator by the facility Director.

The Policy addresses detection of sexual abuse and sexual harassment through resident education, staff training, and intake screening for risk of sexual victimization and abusiveness. The Policy includes but is not limited to responding to sexual abuse and sexual harassment through reporting, investigations, assessments, crisis intervention, and disciplinary sanctions for residents and staff.

Provision (b):

An agency shall employ or designate an upper-level, agency-wide PREA Coordinator with sufficient time and authority to develop, implement, and oversee agency efforts to comply with the PREA standards in all of its facilities.

The 2017 Annual Report indicated a designated position, Agency PREA Coordinator (APC) and the responsibilities include serving as the Facilities PREA Coordinator. The organization chart shows the APC reports directly to the facility Director as confirmed by staff interviews. The interview with the APC and observations revealed that she has the time and authority to perform her PREA duties.

The evidence shows the facility has designated an upper-level position of PREA Coordinator as verified through the organization chart; Policy; Job Description; review of the PREA Pre-Audit Questionnaire; and the interviews with the Director and random staff. The PREA Coordinator has demonstrated she has sufficient time and authority to accomplish her PREA related responsibilities.

Provision (c):

Where an agency operates more than one facility, each facility shall designate a PREA compliance manager with sufficient time and authority to coordinate the facility's efforts to comply with the PREA standards.

HCBC does not contract with another facility to house its residents, according to the Policy and interview with the Director who fills the role of the contract administrator.

Conclusion:

Based upon the review and analysis of the available documentation, the Auditor has determined the facility is compliant with this standard requiring a zero-tolerance policy toward sexual abuse and sexual harassment and the designation of a PREA Coordinator.

The HCBC Policy 13.1-Prevention Planning Procedures meet the mandates of this standard. The Agency's zero-tolerance against sexual abuse is clearly established and the policy also outlines the agency's approach to preventing, detecting and responding to sexual abuse and sexual harassment allegations. Zero-tolerance posters are displayed throughout the facility. The APC and Manager were interviewed and advised that they have sufficient time and authority to coordinate efforts to comply with PREA standards. Both staff and residents are provided with a variety of opportunities to become aware of the PREA. The review of

training records and staff interviews confirmed that staff, volunteers, and contractors, who have regular or frequent contact with residents, receive PREA-related training during initial orientation and annually.

Standard 115.212: Contracting with other entities for the confinement of residents

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.212 (a)

- If this agency is public and it contracts for the confinement of its residents with private agencies or other entities including other government agencies, has the agency included the entity's obligation to comply with the PREA standards in any new contract or contract renewal signed on or after August 20, 2012? (N/A if the agency does not contract with private agencies or other entities for the confinement of residents.) Yes No NA

115.212 (b)

- Does any new contract or contract renewal signed on or after August 20, 2012 provide for agency contract monitoring to ensure that the contractor is complying with the PREA standards? (N/A if the agency does not contract with private agencies or other entities for the confinement of residents OR the response to 115.212(a)-1 is "NO".) Yes No NA

115.212 (c)

- If the agency has entered into a contract with an entity that fails to comply with the PREA standards, did the agency do so only in emergency circumstances after making all reasonable attempts to find a PREA compliant private agency or other entity to confine residents? (N/A if the agency has not entered into a contract with an entity that fails to comply with the PREA standards.) Yes No NA
- In such a case, does the agency document its unsuccessful attempts to find an entity in compliance with the standards? (N/A if the agency has not entered into a contract with an entity that fails to comply with the PREA standards.) Yes No NA

Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documents Reviewed:

PREA Pre-Audit Questionnaire
Facility Policy 3.1-Prevention Planning Procedures

Interview:

Director
APC

Provision (a):

A public agency that contracts for the confinement of its residents with private agencies or other entities, including other government agencies, shall include in any new contract or contract renewal the entity's obligation to adopt and comply with the PREA standards.

HCBC does not contract for the confinement of its residents, according to Facility Policy 3.1 and statements from Director and APC.

Provision (b):

Any new contract or contract renewal shall provide for agency contract monitoring to ensure that the contractor is complying with the PREA standards.

Conclusion:

This Standard is not applicable as HCBC does not contract with other entities for housing of residents. Based upon the review and analysis of the documentation, the Auditor has determined the facility does not contract for the confinement of its residents.

Standard 115.213: Supervision and Monitoring

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.213 (a)

- Does the agency develop for each facility a staffing plan that provides for adequate levels of staffing and, where applicable, video monitoring, to protect residents against sexual abuse?
 Yes No
- Does the agency document for each facility a staffing plan that provides for adequate levels of staffing and, where applicable, video monitoring, to protect residents against sexual abuse?
 Yes No
- Does the agency ensure that each facility's staffing plan takes into consideration the physical layout of each facility in calculating adequate staffing levels and determining the need for video monitoring? Yes No
- Does the agency ensure that each facility's staffing plan takes into consideration the composition of the resident population in calculating adequate staffing levels and determining the need for video monitoring? Yes No

- Does the agency ensure that each facility's staffing plan takes into consideration the prevalence of substantiated and unsubstantiated incidents of sexual abuse in calculating adequate staffing levels and determining the need for video monitoring? Yes No
- Does the agency ensure that each facility's staffing plan takes into consideration any other relevant factors in calculating adequate staffing levels and determining the need for video monitoring? Yes No

115.213 (b)

- In circumstances where the staffing plan is not complied with, does the facility document and justify all deviations from the plan? (N/A if no deviations from staffing plan.)
 Yes No NA

115.213 (c)

- In the past 12 months, has the facility assessed, determined, and documented whether adjustments are needed to the staffing plan established pursuant to paragraph (a) of this section? Yes No
- In the past 12 months, has the facility assessed, determined, and documented whether adjustments are needed to prevailing staffing patterns? Yes No
- In the past 12 months, has the facility assessed, determined, and documented whether adjustments are needed to the facility's deployment of video monitoring systems and other monitoring technologies? Yes No
- In the past 12 months, has the facility assessed, determined, and documented whether adjustments are needed to the resources the facility has available to commit to ensure adequate staffing levels? Yes No

Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documents Reviewed:

Facility Policy 13.1 PREA Prevention Planning Procedures
 Facility Management and Official Counts

Facility Design and Technology Charts
Staffing Plan
2017 Staffing Plan Assessment for CTU
Monthly Schedule
Resident Daily Rosters
PREA Pre-Audit Questionnaire

Interviews:

Agency President
Facility Director
PREA Coordinator

Provision (a):

The agency shall ensure that each facility it operates shall develop, implement, and document a staffing plan that provides for adequate levels of staffing, and, where applicable, video monitoring, to protect residents against sexual abuse. In calculating adequate staffing levels and determining the need for video monitoring, facilities shall take into consideration:

- (1) Generally accepted detention and correctional/secure residential practices;
- (2) Any judicial findings of inadequacy;
- (3) Any findings of inadequacy from Federal investigative agencies;
- (4) Any findings of inadequacy from internal or external oversight bodies;
- (5) All components of the facility's physical plant (including "blind spots" or areas where staff or residents may be isolated);
- (6) The composition of the resident population;
- (7) The number and placement of supervisory staff;
- (8) Institution programs occurring on a particular shift;
- (9) Any applicable State or local laws, regulations, or standards;
- (10) The prevalence of substantiated and unsubstantiated incidents of sexual abuse; and
- (11) Any other relevant factors.

Facility Policy 13.1 provides details for maintaining the staffing ratios. In 2017, the maintenance department closed off a doorway and installed an additional entrance leading into the CTU unit to better ensure resident safety. The staffing plan for HCBC mandate 3 staff members per shift with one being a female. The 1st shift has 3 to 4 staff members, 2nd shift has 3 to 5 staff members, and 3rd shift has 3 to 4 staff members. An additional surveillance camera was placed in the entrance. PREA training is required of all new hires, as well as PREA refresher courses provided throughout the year to better ensure resident safety. The camera system is monitored constantly and the provisions of the standard are taken into consideration regarding adequate staffing levels as confirmed through the interview with the Director, review of staffing plan and observations. The work schedules are based on the staffing plan and facility policy.

Provision (b):

The agency shall comply with the staffing plan except during limited and discrete exigent circumstances, and shall fully document deviations from the plan during such circumstances.

The Facility Policy 13.1 states in the event that the staffing ratio is unable to be maintained during exigent circumstances, the deviation must be documented. The facility documents there have been no deviations to the staffing plan in the past 12 months. The facility is prepared to document any deviations from the staffing plan. Each secure facility shall maintain staff ratios of a minimum of 1:8 during resident waking hours and 1:16 during resident sleeping hours, except during limited and discrete exigent circumstances, which shall be fully documented. Only security staff shall be included in these ratios.

Policy 13.1 provides for a staff-to-resident ratio of 1:8 during the waking hours and 1:14 during the sleeping hours. The ratio during the sleeping hours may increase but will not be beyond the required ratio of 1:16 during the sleeping hours as indicated by the Policy and the interview with the Director. The staff-to-resident ratio was in compliance during the site visit as observed during the comprehensive site review. Since the

last PREA audit the average daily number of residents is 84. The average daily number of residents on which the staffing plan is predicated is 104.

Provision (c):

Whenever necessary, but no less frequently than once each year, for each facility the agency operates, in consultation with the APC required by § 115.311, the agency shall assess, determine, and document whether adjustments are needed to:

- (1) The staffing plan established pursuant to paragraph (a) of this section;
- (2) Prevailing staffing patterns;
- (3) The facility's deployment of video monitoring systems and other monitoring technologies; and
- (4) The resources the facility has available to commit to ensure adherence to the staffing plan.

Policy 13.1 provides at the least; an annual assessment of the staffing plan is conducted. The Staffing Plan Assessment is conducted annually with the latest being conducted on January 9, 2018 and is signed by the Director and the APC. The document reviews but is not limited to the following areas prevailing staffing patterns; deployment of video monitoring system; and occurrence of unannounced rounds. The APC assess the video monitoring system at least annually and document the assessment.

HCBC has implemented a policy and practice of having intermediate-level or higher-level supervisors conduct and document unannounced rounds to identify and deter staff sexual abuse and sexual harassment. Such policy and practice shall be implemented for night shifts as well as day shifts. The policy prohibits staff from alerting other staff members that these supervisory rounds are occurring, unless such announcement is related to the legitimate operational functions of the facility. A review of a sample of documented unannounced rounds support unannounced rounds are conducted by intermediate level and higher-level staff and by Supervisors for each shift at the various times as determined by a review of documentation and interviews. The unannounced rounds conducted by administrative staff are documented on the Unannounced PREA Rounds checklist and the Unannounced Supervisor Rounds checklist is used by shift Supervisors. Areas assessed during the unannounced rounds by the administrative staff includes all areas of the facility such as all living units; common area; staff break room; loading dock; gymnasium; and classrooms. The Supervisors' unannounced rounds include all living units and provides for comments regarding mood, demeanor and interactions. The interview with the APC indicated how she ensures that staff does not alert other staff when she is conducting unannounced rounds. Staff members are not informed of the unannounced rounds and there is not a routine schedule regarding the rounds. Staff members are encouraged not to alert other staff members regarding the unannounced visits.

Conclusion:

Based upon the review and analysis of the available evidence, the Auditor has determined the facility follows this standard regarding supervision and monitoring.

Standard 115.215: Limits to cross-gender viewing and searches

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.215 (a)

- Does the facility always refrain from conducting any cross-gender strip or cross-gender visual body cavity searches, except in exigent circumstances or by medical practitioners?
 Yes No

115.215 (b)

- Does the facility always refrain from conducting cross-gender pat-down searches of female residents, except in exigent circumstances? (N/A if less than 50 residents)
 Yes No NA
- Does the facility always refrain from restricting female residents' access to regularly available programming or other outside opportunities in order to comply with this provision? (N/A if less than 50 residents) Yes No NA

115.215 (c)

- Does the facility document all cross-gender strip searches and cross-gender visual body cavity searches? Yes No
- Does the facility document all cross-gender pat-down searches of female residents?
 Yes No

115.215 (d)

- Does the facility implement policies and procedures that enable residents to shower, perform bodily functions, and change clothing without nonmedical 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? Yes No
- Does the facility require staff of the opposite gender to announce their presence when entering an area where residents are likely to be showering, performing bodily functions, or changing clothing? Yes No

115.215 (e)

- Does the facility always refrain from searching or physically examining transgender or intersex residents for the sole purpose of determining the resident's genital status? Yes No
- If a resident's genital status is unknown, does the facility determine genital status during conversations with the resident, by reviewing medical records, or, if necessary, by learning that information as part of a broader medical examination conducted in private by a medical practitioner?
 Yes No

115.215 (f)

- Does the facility/agency train security staff in how to conduct cross-gender pat down searches in a professional and respectful manner, and in the least intrusive manner possible, consistent with security needs? Yes No
- Does the facility/agency train security staff in how to conduct searches of transgender and intersex residents in a professional and respectful manner, and in the least intrusive manner possible, consistent with security needs? Yes No

Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documents Reviewed:

Facility Policy 13.1, Prevention Planning
Facility Policy 8.12, Resident Searches
PREA Pre-Audit Questionnaire
Training Acknowledgement Statements
Training Sign-in Sheet
Resident Pat Down Searches & Control of Contraband Accountability Form
Resident Handbook
Posted Signs

Interviews:

Random Staff
Residents

Provision (a):

The facility shall not conduct cross-gender strip searches or cross-gender visual body cavity searches (meaning a search of the anal or genital opening) except in exigent circumstances or when performed by medical practitioners. Facility Policy 8.12, Resident Searches, prohibit cross-gender strip searches and cross-gender visual body cavity searches. There is no evidence of cross-gender strip searches or cross-gender visual body cavity searches occurring at the facility. Based on the review of the Pre-audit questionnaire and according to the Director, no such searches have been conducted.

Provision (b):

The agency always refrains from conducting cross-gender pat-down searches of female residents, except in exigent circumstances. In addition, the agency shall always refrain from restricting female residents' access to regularly available programming or other outside opportunities in order to comply with this provision.

HCBC Policy 13.1 provides that staff will only conduct cross-gender pat-down searches of females only in exigent circumstances. Additionally, the search must be approved by the Director and the justification for the search must be documented. The facility provides training on how to conduct these searches in exigent circumstances using training curricula. Staff participation in the training is recorded with training sign-in sheets and training acknowledgement statements. Staff interviews confirmed they are aware of the restriction of conducting cross-gender pat-down searches except in exigent circumstances.

No female residents interviewed reported a male staff member conducted a pat-down search of their body. The evidence shows cross-gender pat-down searches have not occurred at the facility, but the facility is

prepared for them to be conducted in exigent circumstances. Based on the review of the Pre-audit questionnaire; letter of non-occurrence by the Director; staff and resident interviews; training sign-in sheets; and training acknowledgement statements, the facility follows this provision of the standard.

Provision (c):

The facility shall document and justify all cross-gender strip searches, cross-gender visual body cavity searches, and cross-gender pat-down searches.

The Policy prohibits cross-gender strip searches and cross-gender visual body cavity searches. Cross-gender pat-down searches may be conducted only in exigent circumstances which random staff interviews summarized as an extreme emergency. HCBC Policy 8.12 indicates that in the event a cross-gender search is warranted pursuant to an emergency circumstance, it must be approved by the Director and the justification for the search documented. Such searches will be documented on a form currently used for all searches which have been used for same sex searches. The form requires the staff to record the reason for the search. The evidence shows the facility is prepared to document and justify all cross-gender pat-down searches. Based on the review of the Pre-audit questionnaire and the Resident Pat Down Searches & Control of Contraband Accountability Form, staff and resident interviews, and staff training materials, the facility follows this provision of the standard.

Provision (d):

The facility shall implement 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. Such policies and procedures shall require staff of the opposite gender to announce their presence when entering a resident housing unit. In facilities (such as group homes) that do not contain discrete housing units, staff of the opposite gender shall be required to announce their presence when entering an area where residents are likely to be showering, performing bodily functions, or changing clothing.

HCBC Policy 13.1 states the facility will enable residents to shower, perform bodily functions, and change clothes without non-medical staff of the opposite gender viewing them except in exigent circumstances or during routine room checks. Staff members of the opposite gender are required to knock and/or announce themselves upon entering the unit. This practice was confirmed through observation of signage indicating such, observations and interviews with residents and staff. No residents interviewed reported ever having been naked in full view of female staff while showering, changing clothing, and performing bodily functions. The evidence shows residents shower, perform bodily functions, and change clothing without non-medical staff of the opposite gender viewing their breasts, buttocks, or genitalia. Based on the review of the documentation, staff and resident interviews, and observations, the facility follows this provision of the standard. Additionally, viewing of the cameras and staff and resident interviews confirmed that residents are not directly viewed by staff when showering, using the toilet or changing clothes.

Provision (e):

The facility shall not search or physically examine a transgender or intersex resident for the sole purpose of determining the resident's genital status. If the resident's genital status is unknown, it may be determined during conversations with the resident, by reviewing medical records, or, if necessary, by learning that information as part of a broader medical examination conducted in private by a medical practitioner.

HCBC Policy 8.12 prohibits the search of transgender or intersex residents solely for the purpose of determining the residents' genital status and staff interviews verified no such searches have occurred in the past 12 months. According to the Policy, if the resident's genital status is unknown, it may be determined during conversations with the resident, by reviewing medical records, or by learning that information as part of a broader medical examination conducted in private by a medical practitioner. One hundred percent of HCBC staff received the training on conducting cross-gender pat-down searches and searches of transgender and intersex residents. Staff interviews confirmed they are aware facility policy prohibits them from conducting a physical examination of transgender or intersex resident solely for the purpose of

determining the resident's genital status. Based on the documentation reviewed and staff interviews, the facility meets this provision of the standard.

Provision (f):

The agency shall train security staff in how to conduct cross-gender pat-down searches, and searches of transgender and intersex residents, in a professional and respectful manner, and in the least intrusive manner possible, consistent with security needs.

HCBC Policy 13.1 states that staff shall be trained in how to conduct cross-gender pat-down searches, and searches of transgender and intersex residents, in a professional and respectful manner, and in the least intrusive manner possible, consistent with security needs. The documentation and staff interviews support the training is conducted at least annually. Training participation is documented with sign-in sheets and training acknowledgement forms. The evidence shows staff are trained in how to conduct cross-gender pat-down searches, and searches of transgender and intersex residents, in a professional and respectful manner, and in the least intrusive manner possible, consistent with security needs.

Conclusion:

Based on the reviewed documentation and interviews, the facility follows this provision of the standard.

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

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.216 (a)

- Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Residents who are deaf or hard of hearing? Yes No
- Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Residents who are blind or have low vision? Yes No
- Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Residents who have intellectual disabilities? Yes No
- Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Residents who have psychiatric disabilities? Yes No
- Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Residents who have speech disabilities? Yes No

- Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Other? (if "other," please explain in overall determination notes.) Yes No
- Do such steps include, when necessary, ensuring effective communication with residents who are deaf or hard of hearing? Yes No
- Do such steps include, when necessary, providing access to interpreters who can interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary? Yes No
- Does the agency ensure that written materials are provided in formats or through methods that ensure effective communication with residents with disabilities including residents who: Have intellectual disabilities? Yes No
- Does the agency ensure that written materials are provided in formats or through methods that ensure effective communication with residents with disabilities including residents who: Have limited reading skills? Yes No
- Does the agency ensure that written materials are provided in formats or through methods that ensure effective communication with residents with disabilities including residents who: Are blind or have low vision? Yes No

115.216 (b)

- Does the agency take reasonable steps to ensure meaningful access to all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment to residents who are limited English proficient? Yes No
- Do these steps include providing interpreters who can interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary? Yes No

115.216 (c)

- Does the agency always refrain from relying on 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? Yes No

Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documents Reviewed:

Facility Policy 13.1 Prevention Planning, Offenders with Disabilities and Offenders Who are Limited English Proficient.

Memorandum of Understanding (MOU), with Center for Braille and Narration Production (CBNP)

Memorandum of Understanding (MOU), Interpreting and Translation Agreement, Jewish Vocational Service Interpreter Services (JVSIS)

Admission Summary Overview forms

Resident Handbook in English and Spanish

Interviews:

Targeted Residents (11)

Random Staff

PREA Coordinator

Contractor

Provision (a):

The agency shall take appropriate steps to ensure that residents with disabilities (including, for example, residents who are deaf or hard of hearing, those who are blind or have low vision, or those who have intellectual, psychiatric, or speech disabilities), have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment. Such steps shall include, when necessary to ensure effective communication with residents who are deaf or hard of hearing, providing access to interpreters who can interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary. In addition, the agency shall ensure that written materials are provided in formats or through methods that ensure effective communication with residents with disabilities, including residents who have intellectual disabilities, limited reading skills, or who are blind or have low vision. An agency is not required to take actions that it can demonstrate would result in a fundamental alteration in the nature of a service, program, or activity, or in undue financial and administrative burdens, as those terms are used in regulations promulgated under Title II of the Americans With Disabilities Act, 28 *CFR* 35.164.

The Facility Policy addresses the provision of support services for disabled residents by providing these residents the 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 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, performance of first responder duties, or the investigation of the allegations. Staff interviews and an interview with a contractor confirmed this information. The facility has a MOU with the JVC for supportive services to residents with disabilities or who may be limited English proficient which was verified through review of the document and interview with the APC.

A resident with low vision was interviewed and the accommodations of transcribed and narrated educational material, particularly, textbooks for visually impaired resident were discussed. During the interview, the resident revealed his condition and the accommodations he receives including how he is provided information in large print and a magnifying glass to assist with reading and other activities. The interview revealed his understanding of the PREA information. Two residents with cognitive disabilities were

interviewed and their interviews revealed and understanding of the information covered in the PREA education sessions.

Provision (b):

The agency shall take reasonable steps to ensure meaningful access to all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment to residents who are limited English proficient, including steps to provide interpreters who can interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary.

An Interpreting and Translation Agreement is documented with JVSIS for services to residents. Additionally, the Resident Handbook is in English and Spanish. The evidence shows residents with disabilities and who may be limited English proficient are provided equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment. All staff interviewed confirmed residents are not used as interpreters and understand prior arrangements have been made regarding language interpreters. The Resident Handbook is printed in English and Spanish. The PREA audit notice was printed in English and Spanish. The evidence shows the facility ensures access to all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment to residents who are limited English proficient, including taking steps to provide interpreters who can interpret effectively, accurately, and impartially, using any necessary specialized vocabulary.

Provision (c):

The agency shall not rely on 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 § 115.364, or the investigation of the resident's allegations.

According to Policy 13.1, the facility prohibits the use of resident interpreters, resident readers or any kind of resident assistants except when a delay in obtaining interpreter services could jeopardize a resident's safety, performance of the first responder duties, or the investigation of the allegation. Staff interviews confirmed residents have not been used to relate PREA information to or from other residents in the past 12 months. There were no residents in need of an interpreter during the site visit.

Conclusion:

Based upon the review and analysis of the evidence, the Auditor has determined the facility is compliant with this standard regarding residents with disabilities and residents who are limited English Proficient. Residents with disabilities and who are limited English Proficient are provided equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment.

Standard 115.217: Hiring and promotion decisions

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.217 (a)

- Does the agency prohibit the hiring or promotion of anyone 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)? Yes No
- Does the agency prohibit the hiring or promotion of anyone who may have contact with residents who: 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? Yes No

- Does the agency prohibit the hiring or promotion of anyone who may have contact with residents who: Has been civilly or administratively adjudicated to have engaged in the activity described in the question immediately above? Yes No
- Does the agency prohibit the enlistment of 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)? Yes No
- Does the agency prohibit the enlistment of services of any contractor who may have contact with residents who: 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? Yes No
- Does the agency prohibit the enlistment of services of any contractor who may have contact with residents who: Has been civilly or administratively adjudicated to have engaged in the activity described in the question immediately above? Yes No

115.217 (b)

- Does the agency consider 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? Yes No

115.217 (c)

- Before hiring new employees, who may have contact with residents, does the agency: Perform a criminal background records check? Yes No
- Before hiring new employees, who may have contact with residents, does the agency: Consistent with Federal, State, and local law, make 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? Yes No

115.217 (d)

- Does the agency perform a criminal background records check before enlisting the services of any contractor who may have contact with residents? Yes No

115.217 (e)

- Does the agency either conduct criminal background records checks at least every five years of current employees and contractors who may have contact with residents or have in place a system for otherwise capturing such information for current employees? Yes No

115.217 (f)

- Does the agency 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? Yes No
- Does the agency ask all applicants and employees who may have contact with residents directly about previous misconduct described in paragraph (a) of this section in any interviews or written self-evaluations conducted as part of reviews of current employees? Yes No
- Does the agency impose upon employees a continuing affirmative duty to disclose any such misconduct? Yes No

115.217 (g)

- Does the agency consider material omissions regarding such misconduct, or the provision of materially false information, grounds for termination? Yes No

115.217 (h)

- Unless prohibited by law, does the agency 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? (N/A if providing information on substantiated allegations of sexual abuse or sexual harassment involving a former employee is prohibited by law.) Yes No NA

Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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Documentation Reviewed:

Facility Policy 13.1 Prevention Planning
Personnel Files

Interviews:

Administrative (Human Resources) Staff/Director

Provision (a) & (f):

(a) The agency shall not hire or promote anyone who may have contact with residents, and shall not enlist the services of any contractor who may have contact with residents, who—

- (1) 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);
 - (2) 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
 - (3) has been civilly or administratively adjudicated to have engaged in the activity described in paragraph (a)(2) of this section.
- (f) The agency shall also 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 agency shall also impose upon employees a continuing affirmative duty to disclose any such misconduct.

Facility Policy 13.1 addresses hiring and promotion processes and decisions and background checks. The Policy is aligned with the requirements of the provisions of the standard and provides background checks occur prior to employment and every five years thereafter. Initial background checks and five-year checks were reviewed while on site. Additional personnel information reviewed during the pre-audit and the onsite audit phases included: Offender Watch Registry checks; Pre-Hire Interview Questions and New Hire Application Packet Applications. The interview with the Director and a review of Policy provide details about the hiring process, completion of background checks, and the grounds for termination in accordance with the PREA standard. According to the interview, staff has a continuing duty to report related misconduct and omission of sexual misconduct or providing false information will be grounds for termination. The forms completed and included in the personnel files are in response to the above provisions of this standard.

According to Facility Policy 13.1, all applicants are asked about any prior misconduct involving any sexual activity. In addition, HCBC shall not hire or promote anyone who has been civilly or administratively adjudicated to have been convicted of engaging in or attempted to engage in sexual activity by any means. Also, HCBC does not hire anyone who has engaged in sexual abuse in a prison, jail, community confinement facility, or anyone, who has used or attempted to use force in the community to engage in sexual abuse.

Provision (b):

The agency shall consider 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.

The Facility Policy 13.1 states any incidents of sexual harassment by a staff member will be taken into consideration if the staff member is eligible for promotion. The interview with the Director who also serves as personnel officer was aligned with the standard. The interview questions for employment also address previous misconduct. The evidence shows the facility considers 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. Based on the review of the personnel files, records provided during the pre-audit phase, and the interview with the Director, the facility follows this provision of the standard.

Provisions (c) & (d):

- (c) Before hiring new employees or (d) contractors who may have contact with residents, the agency shall:
- (1) Perform a criminal background records check;
 - (2) Consult any child abuse registry maintained by the State or locality in which the employee would work; and
 - (3) Consistent with Federal, State, and local law, make 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.

The policy requires background checks to occur prior to residents receiving services from contractors and volunteers and confirmed by the Director's interview. Additionally, best efforts should be made 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. Based on the review of documentation and interview with the Director, the facility follows this provision of the standard.

Provision (e):

The agency shall either conduct criminal background records checks at least every five years of current employees and contractors who may have contact with residents or have in place a system for otherwise capturing such information for current employees.

The Policy is aligned with the requirements of the provisions of the standard and provides background checks to occur prior to employment and every five years thereafter. Initial background checks and five-year checks were reviewed while onsite and during the pre-audit phase. This was also confirmed during the Director's interview. Based on the review of documentation and the interview, the evidence shows the facility practices are aligned with the provisions of this standard.

Provision (g):

Material omissions regarding such misconduct, or the provision of materially false information, shall be grounds for termination.

Facility Policy states material omissions regarding such misconduct, or the provision of materially false information, shall be grounds for termination. Based on the review of the documentation and the interview with the Director, the evidence shows the facility follows this provision of the standard.

Provision (h):

Unless prohibited by law, the agency 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.

The interview with the Director confirmed the facility would provide this information if requested to do so. Facility Policy states the information would be provided when requested unless it is prohibited by law to provide the information.

Conclusion:

Based upon the review and analysis of the available evidence, the Auditor has determined the facility is compliant with the provisions of the standard regarding hiring and promotion decisions.

Standard 115.218: Upgrades to facilities and technologies

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.218 (a)

- If the agency designed or acquired any new facility or planned any substantial expansion or modification of existing facilities, did the agency consider the effect of the design, acquisition, expansion, or modification upon the agency's ability to protect residents from sexual abuse? (N/A if agency/facility has not acquired a new facility or made a substantial expansion to existing facilities since August 20, 2012, or since the last PREA audit, whichever is later.)
 Yes No NA

115.218 (b)

- If the agency installed or updated a video monitoring system, electronic surveillance system, or other monitoring technology, did the agency consider how such technology may enhance the agency's ability to protect residents from sexual abuse? (N/A if agency/facility has not installed

or updated a video monitoring system, electronic surveillance system, or other monitoring technology since August 20, 2012, or since the last PREA audit, whichever is later.)

Yes No NA

Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The interview with the Director and according to the Pre-Audit Questionnaire, no substantial modification to the facility or upgrades to the camera system occurred since the last PREA audit in 2015. Facility Policy 10.12, Facility Design and Technology, states that when there is substantial expansion to the facility, the ability to protect residents and staff from sexual abuse will be reviewed and ensured.

HCBC has not made any substantial changes to their facility but are in the process of upgrading their electronic surveillance. A review of current camera placements and proposed changes was completed and an interview with the facility executive staff indicates that considerable thought has been given to protecting residents from sexual abuse; 38 cameras of which three are PTZ cameras. These cameras are located in various locations of the building including the outside. Cameras are located in common areas such as day rooms, TV rooms, hallways, stairways, control desks, elevator and including our medication rooms. There is one centralized DVR room that houses all four of their DVR's.

The HCBC has had a video monitoring system (54 cameras) installed prior to August 20, 2012. This equipment provides coverage throughout most of the facility. PREA compliance was considered when this equipment was installed.

RESPONSIVE PLANNING

Standard 115.221: Evidence protocol and forensic medical examinations

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.221 (a)

- If the agency is responsible for investigating allegations of sexual abuse, does the agency follow a uniform evidence protocol that maximizes the potential for obtaining usable physical evidence for administrative proceedings and criminal prosecutions? (N/A if the agency/facility is not

responsible for conducting any form of criminal OR administrative sexual abuse investigations.)
 Yes No NA

115.221 (b)

- Is this protocol developmentally appropriate for youth where applicable? (N/A if the agency/facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations.) Yes No NA
- Is this protocol, as appropriate, adapted from or otherwise based on the most recent edition of the U.S. Department of Justice's Office on Violence Against Women publication, "A National Protocol for Sexual Assault Medical Forensic Examinations, Adults/Adolescents," or similarly comprehensive and authoritative protocols developed after 2011? (N/A if the agency/facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations.) Yes No NA

115.221 (c)

- Does the agency offer all residents who experience sexual abuse access to forensic medical examinations, whether on-site or at an outside facility, without financial cost, where evidentiarily or medically appropriate? Yes No
- Are such examinations performed by Sexual Assault Forensic Examiners (SAFEs) or Sexual Assault Nurse Examiners (SANEs) where possible? Yes No
- If SAFEs or SANEs cannot be made available, is the examination performed by other qualified medical practitioners (they must have been specifically trained to conduct sexual assault forensic exams)? Yes No
- Has the agency documented its efforts to provide SAFEs or SANEs? Yes No

115.221 (d)

- Does the agency attempt to make available to the victim a victim advocate from a rape crisis center? Yes No
- If a rape crisis center is not available to provide victim advocate services, does the agency make available to provide these services a qualified staff member from a community-based organization, or a qualified agency staff member? Yes No
- Has the agency documented its efforts to secure services from rape crisis centers? Yes No

115.221 (e)

- As requested by the victim, does the victim advocate, qualified agency staff member, or qualified community-based organization staff member accompany and support the victim through the forensic medical examination process and investigatory interviews? Yes No

- As requested by the victim, does this person provide emotional support, crisis intervention, information, and referrals? Yes No

115.221 (f)

- If the agency itself is not responsible for investigating allegations of sexual abuse, has the agency requested that the investigating entity follow the requirements of paragraphs (a) through (e) of this section? (N/A if the agency/facility is responsible for conducting criminal AND administrative sexual abuse investigations.) Yes No NA

115.221 (g)

- Auditor is not required to audit this provision.

115.221 (h)

- If the agency uses a qualified agency staff member or a qualified community-based staff member for the purposes of this section, has the individual been screened for appropriateness to serve in this role and received education concerning sexual assault and forensic examination issues in general? (Check N/A if agency attempts to make a victim advocate from a rape crisis center available to victims per 115.221(d) above.) Yes No NA

Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documents Reviewed:

Facility Policy 13.1 Prevention and Planning Procedures
 Memorandum of Understanding (MOU), Metropolitan Organization to Counter Sexual Assault (MOCSA)
 Staff Training Certificate
 Resident Handbook

Interviews:

HCBC Staff
 Investigative Staff
 Director
 PREA Coordinator

Provisions (a) & (b):

(a) To the extent the agency is responsible for investigating allegations of sexual abuse, the agency shall follow a uniform evidence protocol that maximizes the potential for obtaining usable physical evidence for administrative proceedings and criminal prosecutions.

(b) The protocol shall be developmentally appropriate for youth and, as appropriate, shall be adapted from or otherwise based on the most recent edition of the U.S. Department of Justice's Office on Violence Against Women publication, "A National Protocol for Sexual Assault Medical Forensic Examinations, Adults/Adolescents," or similarly comprehensive and authoritative protocols developed after 2011.

The MOU with the Metropolitan Organization to Counter Sexual Assault (MOCSA) Protocols is to be followed. The Protocol is outlined regarding appropriateness for the residents of the HCBC. The MOCSA Protocol, developed by related professionals, addresses but is not limited to interviewing; evidence collection; victim services; notifications; and prosecution of sexual assault cases. The HCBC facility-based investigators conduct administrative investigations and the Kansas City Missouri Police Division investigate sexual abuse allegations that are criminal in nature. The APC stated that an agreement exists between the facility and Kansas City Missouri Police Division regarding criminal investigations for the allegations of sexual abuse. The Police Division agrees to follow the PREA Protocol. The APC stated that documentation was provided to verify the training of the Police Division's investigators and their professional ability to conduct sexual abuse investigations. Staff interviews confirmed an understanding of the facility's protocol for obtaining usable physical evidence if a resident alleges sexual abuse and knowledge of the entities responsible for conducting investigations.

Provision (c):

The agency shall offer all residents who experience sexual abuse access to forensic medical examinations whether on-site or at an outside facility, without financial cost, where evidentiarily or medically appropriate. Such examinations shall be performed by Sexual Assault Forensic Examiners (SAFEs) or Sexual Assault Nurse Examiners (SANEs) where possible. If SAFEs or SANEs cannot be made available, the examination can be performed by other qualified medical practitioners. The agency shall document its efforts to provide SAFEs or SANEs.

The Policy states forensic medical examinations will be conducted at Truman Medical Center in Kansas City, Missouri who employs Sexual Assault Nurse Examiners (SANE) and Sexual Assault Forensic Examiners. The Sexual Assault Policy of the Hospital states that the medical forensic examination will be conducted by a SANE or SAFE. The Facility Policy states that the services will be provided at no cost to the victim. The Nurse's interview was aligned with the facility Policy.

Provisions (d) & (e):

(d) The agency shall attempt to make available to the victim a victim advocate from a rape crisis center. If a rape crisis center is not available to provide victim advocate services, the agency shall make available to provide these services a qualified staff member from a community-based organization or a qualified agency staff member. Agencies shall document efforts to secure services from rape crisis centers. For the purpose of this standard, a rape crisis center refers to an entity that provides intervention and related assistance, such as the services specified in 42 U.S.C. 14043g(b)(2)(C), to victims of sexual assault of all ages. The agency may utilize a rape crisis center that is part of a governmental unit as long as the center is not part of the criminal justice system (such as a law enforcement agency) and offers a comparable level of confidentiality as a nongovernmental entity that provides similar victim services. (e) As requested by the victim, the victim advocate, qualified agency staff member, or qualified community-based organization staff member shall accompany and support the victim through the forensic medical examination process and investigatory interviews and shall provide emotional support, crisis intervention, information, and referrals.

The facility has a MOU with MOCSA for victim advocacy services. According to the MOU, the supportive services to victims include access to 24-hour reporting and contact for advocacy service; emotional support; accompaniment through forensic examination and investigative interview upon request; and provision of information and resources. The Program Manager confirmed that advocacy services will be provided in

accordance with the MOU. The interview with the APC confirmed the resident and/or facility staff members are able to utilize the hotline to request a victim advocate.

Provisions (f) & (g):

(f) To the extent the agency itself is not responsible for investigating allegations of sexual abuse, the agency shall request that the investigating agency follow the requirements of paragraphs (a) through (f) of this section.

(g) The requirements of paragraphs (a) through (f) of this section shall also apply to:

(1) Any State entity outside of the agency that is responsible for investigating allegations of sexual abuse in juvenile facilities; and

(2) Any Department of Justice component that is responsible for investigating allegations of sexual abuse in juvenile facilities.

Allegations of sexual abuse that are criminal in nature are conducted by the Kansas City Missouri Police Division. The Police Division follows the HCBC Protocol regarding sexual abuse/assault investigations.

Provision (h):

For the purposes of this standard, a qualified agency staff member or a qualified community-based staff member shall be an individual who has been screened for appropriateness to serve in this role and has received education concerning sexual assault and forensic examination issues in general.

The facility has a MOU with MOCSA for victim advocacy services. According to the MOU, the supportive services to victims include access to 24-hour reporting and contact for advocacy service; emotional support; accompaniment through forensic examination and investigative interview upon request; and provision of information and resources. The APC stated that the agency has qualified community-based staff members who has been screened for appropriateness to serve in this role and has received education concerning sexual assault and forensic examination issues in general.

Conclusion:

Based upon the review and analysis of the available evidence, the Auditor has determined the facility is in compliance with the provisions of this standard.

Standard 115.222: Policies to ensure referrals of allegations for investigations

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.222 (a)

- Does the agency ensure an administrative or criminal investigation is completed for all allegations of sexual abuse? Yes No
- Does the agency ensure an administrative or criminal investigation is completed for all allegations of sexual harassment? Yes No

115.222 (b)

- Does the agency have a policy and practice in place to ensure that allegations of sexual abuse or sexual harassment are referred for investigation to an agency with the legal authority to conduct criminal investigations, unless the allegation does not involve potentially criminal behavior? Yes No

- Has the agency published such policy on its website or, if it does not have one, made the policy available through other means? Yes No
- Does the agency document all such referrals? Yes No

115.222 (c)

- If a separate entity is responsible for conducting criminal investigations, does such publication describe the responsibilities of both the agency and the investigating entity? [N/A if the agency/facility is responsible for conducting criminal investigations. See 115.221(a).]
 Yes No NA

115.222 (d)

- Auditor is not required to audit this provision.

115.222 (e)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documents Reviewed:

Facility Policy 13.1, Prevention and Planning Procedures
 PREA Pre-Audit Questionnaire
 Investigation Reports

Interviews:

Random Staff
 Investigative Staff
 Director/Superintendent
 PREA Coordinator

Provision (a):

The agency shall ensure that an administrative or criminal investigation is completed for all allegations of sexual abuse and sexual harassment.

The Policy directs staff to report all allegations of sexual abuse and sexual harassment and to document the reports. Staff members are aware of the Policy requirements as verified through their interviews. The facility reports no allegations of sexual abuse and one allegation of sexual harassment. During a conversation with Kansas City Police Investigator we discussed the training and experience of investigators that may be assigned to conduct investigations for HCBC.

Provision (b) and (c):

The agency shall have in place a policy to ensure that allegations of sexual abuse or sexual harassment are referred for investigation to an agency with the legal authority to conduct criminal investigations, unless the allegation does not involve potentially criminal behavior. The agency shall publish such policy on its website or, if it does not have one, make the policy available through other means. The agency shall document all such referrals. Provision (c): If a separate entity is responsible for conducting criminal investigations, such publication shall describe the responsibilities of both the agency and the investigating entity.

The facility's website provides the information and related policies for reporting allegations of sexual abuse. A third-party reporting form is also on the website. Reporting information is also posted in various areas of the facility including but not limited to living units. The posted information is accessible to residents, staff, contractors and visitors. The Policy and interviews confirmed allegations of sexual abuse and sexual harassment are investigated. Administrative investigations are conducted by the trained facility investigators and sexual abuse allegations that are criminal in nature are investigated by the Kansas City Missouri Police Division.

Provision (d):

Any State entity responsible for conducting administrative or criminal investigations of sexual abuse or sexual harassment in juvenile facilities shall have in place a policy governing the conduct of such investigations.

The HCBC works with the Kansas City Missouri Police Division to ensure compliance with their policies governing investigations.

Provision (e):

Any Department of Justice component responsible for conducting administrative or criminal investigations of sexual abuse or sexual harassment in juvenile facilities shall have in place a policy governing the conduct of such investigations.

The Department of Justice is not responsible for conducting administrative or criminal investigations of sexual abuse or sexual harassment at HCBC.

Conclusion:

Based upon the review and analysis of the available evidence, the Auditor has determined the facility is compliant with this standard regarding policies to ensure referrals of allegations for investigations.

TRAINING AND EDUCATION

Standard 115.231: Employee training

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.231 (a)

- Does the agency train all employees who may have contact with residents on: Its zero-tolerance policy for sexual abuse and sexual harassment? Yes No
- Does the agency train all employees who may have contact with residents on: How to fulfill their responsibilities under agency sexual abuse and sexual harassment prevention, detection, reporting, and response policies and procedures? Yes No
- Does the agency train all employees who may have contact with residents on: Residents' right to be free from sexual abuse and sexual harassment? Yes No
- Does the agency train all employees who may have contact with residents on: The right of residents and employees to be free from retaliation for reporting sexual abuse and sexual harassment? Yes No
- Does the agency train all employees who may have contact with residents on: The dynamics of sexual abuse and sexual harassment in confinement? Yes No
- Does the agency train all employees who may have contact with residents on: The common reactions of sexual abuse and sexual harassment victims? Yes No
- Does the agency train all employees who may have contact with residents on: How to detect and respond to signs of threatened and actual sexual abuse? Yes No
- Does the agency train all employees who may have contact with residents on: How to avoid inappropriate relationships with residents? Yes No
- Does the agency train all employees who may have contact with residents on: How to communicate effectively and professionally with residents, including lesbian, gay, bisexual, transgender, intersex, or gender nonconforming residents? Yes No
- Does the agency train all employees who may have contact with residents on: How to comply with relevant laws related to mandatory reporting of sexual abuse to outside authorities? Yes No

115.231 (b)

- Is such training tailored to the gender of the residents at the employee's facility? Yes No
- Have employees received additional training if reassigned from a facility that houses only male residents to a facility that houses only female residents, or vice versa? Yes No

115.231 (c)

- Have all current employees who may have contact with residents received such training? Yes No
- Does the agency provide each employee with refresher training every two years to ensure that all employees know the agency's current sexual abuse and sexual harassment policies and procedures? Yes No

- In years in which an employee does not receive refresher training, does the agency provide refresher information on current sexual abuse and sexual harassment policies? Yes No

115.231 (d)

- Does the agency document, through employee signature or electronic verification, that employees understand the training they have received? Yes No

Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documents Reviewed:

Facility Policy 13.1 Prevention and Planning Procedures
 Employee PREA Training Outline
 Training Attendance Record (Sign-in Sheets)
 Training Acknowledgement Statements

Interviews:

Random Staff
 APC

Provisions (a) and (c):

All HCBC Division of Correctional Services (DCS) employees shall be provided an HCBC brochure that describes PREA, HCBC's zero-tolerance of sexual abuse and sexual harassment of offenders and an overview of staff duties to meet PREA requirements. Documentation of receipt of the brochure shall be maintained in the employee training file.

The agency shall train all employees who may have contact with residents on:

- (1) Its zero-tolerance policy for sexual abuse and sexual harassment;
- (2) How to fulfill their responsibilities under agency sexual abuse and sexual harassment prevention, detection, reporting, and response policies and procedures;
- (3) Residents' right 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 juvenile facilities;
- (6) The common reactions of juvenile victims of sexual abuse and sexual harassment;
- (7) How to detect and respond to signs of threatened and actual sexual abuse and how to distinguish between consensual sexual contact and sexual abuse between residents;
- (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;
 - (10) How to comply with relevant laws related to mandatory reporting of sexual abuse to outside authorities;
 - (11) Relevant laws regarding the applicable age of consent.
- (c) All current employees who have not received such training shall be trained within one year of the effective date of the PREA standards, and the agency shall provide each employee with refresher training every two years to ensure that all employees know the agency's current sexual abuse and sexual harassment policies and procedures. In years in which an employee does not receive refresher training, the agency shall provide refresher information on current sexual abuse and sexual harassment policies.

The Facility Policy addresses PREA-related training for staff. All interviewed staff members were familiar with the PREA information regarding primary components of preventing, detecting and responding to sexual abuse or sexual harassment. PREA training is provided to staff, as indicated by a review of Policy and training documents. The documents and staff interviews support refresher training is also conducted and is documented.

The HCBC staff interviewed and the APC reported the training is provided as required. All HCBC staff members interviewed and document review verified the general topics below were included in the training:

1. Zero-tolerance PREA related policies.
2. Staff responsibilities and how to fulfill them regarding allegations or incidents of sexual abuse or sexual harassment.
3. Residents' right to be free from sexual abuse and sexual harassment.
4. The right for staff and residents to be free from retaliation for reporting allegations or cooperating in an investigation.
5. Dynamics of sexual abuse and sexual harassment in juvenile facilities.
6. Residents and employees rights to be free from retaliation for reporting sexual abuse and sexual harassment.
7. How to avoid inappropriate relationships with residents.
8. Common reactions of sexual abuse and sexual harassment by juvenile victims.
9. Communicating effectively and professionally with residents, including lesbian, gay, bisexual, transgender, intersex, or gender non-conforming residents.
10. Mandatory reporting.
11. Relevant laws regarding the applicable age of consent.

The Policy, training materials, staff interviews, review of the trainings log and acknowledgement statements verify the staff training occurs. Training is conducted annually and refresher training is provided as needed. Staff interviews confirmed they have received training on the 11 required topics.

The evidence shows staff members are provided all of the required training topics. Based on the review of the Pre-audit questionnaire, training curriculum, associated training materials and records, and staff interviews, the facility complies with the provisions of the standard.

Provision (b):

Such training shall be tailored to the unique needs and attributes of residents of juvenile facilities and to the gender of the residents at the employee's facility. The employee shall receive additional training if the employee is reassigned from a facility that houses only male residents to a facility that houses only female residents, or vice versa.

The facility houses males and females and the training consider the needs of the population as determined by a review of training curricula and interviews with random staff. The Policy state the training shall be tailored to the needs and attributes to the population served.

Provision (d):

The agency shall document, through employee signature or electronic verification that employees understand the training they have received.

The Policy provides all training be documented. Staff members sign training rosters and training acknowledgement statements. A checklist is utilized for orientation training for all new employees and contains the elements of PREA training. The facility provided the Auditor with several examples for verification of the training occurring and the training was verified through staff interviews. The facility follows this provision of the standard.

Conclusion:

Based upon the review and analysis of the available evidence, the Auditor has determined the facility is following the provisions of this standard.

Standard 115.232: Volunteer and contractor training

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.232 (a)

- Has the agency ensured that all volunteers and contractors who have contact with residents have been trained on their responsibilities under the agency's sexual abuse and sexual harassment prevention, detection, and response policies and procedures? Yes No

115.232 (b)

- Have all volunteers and contractors who have contact with residents been notified of the agency's zero-tolerance policy regarding sexual abuse and sexual harassment and informed how to report such incidents (the level and type of training provided to volunteers and contractors shall be based on the services they provide and level of contact they have with residents)? Yes No

115.232 (c)

- Does the agency maintain documentation confirming that volunteers and contractors understand the training they have received? Yes No

Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documents Reviewed:

HCBC Policy 13.3-Training and Education Volunteer and Contractor Training
Contractor and Volunteer PREA Master Training Summary Log
PREA Notification/Acknowledgement Statement

Interviews:

PREA Coordinator
Contractor

Provision (a):

The agency shall ensure that all volunteers and contractors who have contact with residents have been trained on their responsibilities under the agency's sexual abuse and sexual harassment prevention, detection, and response policies and procedures.

The Policies require volunteers and contractors who have contact with residents, be trained on PREA and their responsibilities regarding sexual assault prevention, detection, and response to allegations of sexual abuse and sexual harassment. A review of training records and interviews document the training occurs.

Provision (b):

The level and type of training provided to volunteers and contractors shall be based on the services they provide and level of contact they have with residents, but all volunteers and contractors who have contact with residents shall be notified of the agency's zero-tolerance policy regarding sexual abuse and sexual harassment and informed how to report such incidents.

The interviews revealed the PREA training informs the participants of their role in reporting allegations of sexual abuse and sexual harassment. The participants are informed of their responsibilities regarding sexual abuse prevention, detection, and response to a PREA allegation. The training is based on the services provided by the contractors and volunteers. The contractors and volunteers also stated the training includes a review of the zero-tolerance policy regarding sexual abuse and sexual harassment of residents.

Provision (c):

The agency shall maintain documentation confirming that volunteers and contractors understand the training they have received.

The PREA Notification document contains the information reviewed with the contractor and volunteer. The document also serves as the training acknowledgement statement containing the signature of the participant and the date, confirming their understanding of the PREA information. All HCBC Division of Correctional Services (DCS) volunteers and contractors who have contact with offenders shall be provided an HCBC brochure that describes PREA, HCBC's zero-tolerance of sexual abuse and sexual harassment of offenders, and an overview of the duties of volunteers and contractors to meet PREA requirements. Documentation of receipt of the brochure shall be maintained in the training file of volunteers and contractors.

Conclusion:

Based upon the review and analysis of the available evidence, the Auditor has determined the facility is compliant with the provisions of this standard regarding volunteer and contractor training.

Standard 115.233: Resident education**All Yes/No Questions Must Be Answered by the Auditor to Complete the Report****115.233 (a)**

- During intake, do residents receive information explaining: The agency's zero-tolerance policy regarding sexual abuse and sexual harassment? Yes No
- During intake, do residents receive information explaining: How to report incidents or suspicions of sexual abuse or sexual harassment? Yes No
- During intake, do residents receive information explaining: Their rights to be free from sexual abuse and sexual harassment? Yes No
- During intake, do residents receive information explaining: Their rights to be free from retaliation for reporting such incidents? Yes No
- During intake, do residents receive information regarding agency policies and procedures for responding to such incidents? Yes No

115.233 (b)

- Does the agency provide refresher information whenever a resident is transferred to a different facility? Yes No

115.233 (c)

- Does the agency provide resident education in formats accessible to all residents, including those who: Are limited English proficient? Yes No
- Does the agency provide resident education in formats accessible to all residents, including those who: Are deaf? Yes No
- Does the agency provide resident education in formats accessible to all residents, including those who: Are visually impaired? Yes No
- Does the agency provide resident education in formats accessible to all residents, including those who: Are otherwise disabled? Yes No
- Does the agency provide resident education in formats accessible to all residents, including those who: Have limited reading skills? Yes No

115.233 (d)

- Does the agency maintain documentation of resident participation in these education sessions? Yes No

115.233 (e)

- In addition to providing such education, does the agency ensure that key information is continuously and readily available or visible to residents through posters, resident handbooks, or other written formats? Yes No

Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documents Reviewed:

Facility Policy 13.1 Prevention and Planning Procedures
 PREA Education & Screening Log
 Orientation Schedule
 Acknowledgement Statements
 Resident Handbook
 Posters Observed

Interviews:

Residents (3 targeted interviews)
 Intake Staff
 Contractors

Provisions (a) and (b):

During the intake process, residents shall receive information explaining, in an age appropriate fashion, the agency's zero tolerance policy regarding sexual abuse and sexual harassment and how to report incidents or suspicions of sexual abuse or sexual harassment. Provision (b): Within 10 days of intake, the agency shall provide comprehensive age-appropriate education to residents either in person or through video regarding their rights to be free from sexual abuse and sexual harassment and to be free from retaliation for reporting such incidents, and regarding agency policies and procedures for responding to such incidents.

Facility Policy provides all residents admitted receive information about the facility, including PREA education. Residents receive directions on how to report allegations of sexual abuse and sexual harassment; and the right to be free from retaliation for reporting. According to the Intake Coordinator who provides PREA education to residents and the residents interviewed, an orientation is provided to residents during the intake process. Policy provides that residents receive a comprehensive age-appropriate PREA education session within 10 days of admission to the facility. The results of the staff and resident interviews indicated the information provided to the residents is comprehensive and age-appropriate.

The intake staff's interview revealed she ensures residents are educated regarding their rights to be free from sexual abuse and sexual harassment, and to be free from retaliation for reporting such incidents. The PREA education sessions include a review of the Safety Brochure. The residents sign acknowledgement statements confirming their receipt of the PREA information. A review of documentation showing dates and indicating residents' participation in PREA education sessions confirmed the PREA education sessions occur. The PREA-related information is provided to staff in policies and procedures, training and staff meetings.

Provision (c):

Current residents who have not received such education shall be educated within one year of the effective date of the PREA standards and shall receive education upon transfer to a different facility to the extent that the policies and procedures of the resident's new facility differ from those of the previous facility.

Provision (d):

The agency shall provide resident education in formats accessible to all residents, including those who are limited English proficient, deaf, visually impaired, or otherwise disabled, as well as to residents who have limited reading skills.

The facility has the capability to provide the PREA education in formats accessible to all residents including those who may be hearing impaired; Deaf; have intellectual, psychiatric and speech disabilities; low vision; blind; limited reading, limited English proficient, and based on the individual need of the resident. Documentation was reviewed of a MOU between the facility and JVS for the provision of accommodations and supportive services for residents in the aforementioned areas. The facility has an Intervention Specialist on site that will assist with support services. Posted PREA information is in English and Spanish accessible to residents, staff, contractors, volunteers, and visitors. Staff interviews confirmed residents are not used as translators or readers for other residents. A resident was interviewed who has low vision and he explained accommodations made for him to see to read by the accommodations of large print materials and a magnifying glass. In addition, residents with cognitive disabilities revealed an understanding of the PREA information provided.

Provision (e):

The agency shall maintain documentation of resident participation in these education sessions.

A sample of signed acknowledgement statements were reviewed which supported the residents' involvement in PREA orientation sessions. The residents were aware of PREA information, including their rights regarding PREA, how to report allegations and that they would not be punished for reporting allegations of sexual abuse or sexual harassment. Intake staff were interviewed regarding PREA education for residents. Staff stated that during the intake process, offenders are provided written information and education about HCBC's zero-tolerance policy regarding sexual abuse and sexual harassment.

Provision (f):

In addition to providing such education, the agency shall ensure that key information is continuously and readily available or visible to residents through posters, resident handbooks, or other written formats.

The PREA education materials provide residents information on how to report allegations of sexual harassment and sexual abuse. A brochure is provided to each resident to eliminate incidents of sexual abuse and sexual harassment. The brochure provides educational information regarding sexual abuse and victims. The residents revealed they can report allegations of sexual abuse or sexual harassment by telling a staff member; telling a family member who may report the allegation for them; access to the hotline to report allegations of sexual abuse or sexual harassment; or complete a grievance form. Each resident is provided a Handbook Brochure. Posters were observed placed throughout the facility and were easy to see and read.

Conclusion:

Based upon the review and analysis of the available evidence, the Auditor has determined the facility is compliant with the provision of this standard.

Standard 115.234: Specialized training: Investigations

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.234 (a)

- In addition to the general training provided to all employees pursuant to §115.231, does the agency ensure that, to the extent the agency itself conducts sexual abuse investigations, its investigators have received training in conducting such investigations in confinement settings? [N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.221(a).] Yes No NA

115.234 (b)

- Does this specialized training include: Techniques for interviewing sexual abuse victims? [N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.221(a).] Yes No NA
- Does this specialized training include: Proper use of Miranda and Garrity warnings? [N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.221(a).] Yes No NA
- Does this specialized training include: Sexual abuse evidence collection in confinement settings? [N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.221(a).] Yes No NA
- Does this specialized training include: The criteria and evidence required to substantiate a case for administrative action or prosecution referral? [N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.221(a).] Yes No NA

115.234 (c)

- Does the agency maintain documentation that agency investigators have completed the required specialized training in conducting sexual abuse investigations? [N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.221(a).] Yes No NA

115.234 (d)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Not applicable. "HCBC shall not conduct sexual abuse investigations and shall refer all such matters to outside law enforcement agencies."

Standard 115.235: Specialized training: Medical and mental health care

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.235 (a)

- Does the agency ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in: How to detect and assess signs of sexual abuse and sexual harassment? Yes No
- Does the agency ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in: How to preserve physical evidence of sexual abuse? Yes No
- Does the agency ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in: How to respond effectively and professionally to victims of sexual abuse and sexual harassment? Yes No
- Does the agency ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in: How and to whom to report allegations or suspicions of sexual abuse and sexual harassment? Yes No

115.235 (b)

- If medical staff employed by the agency conduct forensic examinations, do such medical staff receive appropriate training to conduct such examinations? N/A if agency medical staff at the facility do not conduct forensic exams.) Yes No NA

115.235 (c)

- Does the agency maintain documentation that medical and mental health practitioners have received the training referenced in this standard either from the agency or elsewhere? Yes No

115.235 (d)

- Do medical and mental health care practitioners employed by the agency also receive training mandated for employees by §115.231? Yes No
- Do medical and mental health care practitioners contracted by and volunteering for the agency also receive training mandated for contractors and volunteers by §115.232? [N/A for circumstances in which a particular status (employee or contractor/volunteer) does not apply.] Yes No NA

Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Not applicable. "HCBC does not rely on medical and mental health care practitioners to work regularly in the correctional facility and shall refer residents needing such services to appropriate practitioners in the community."

SCREENING FOR RISK OF SEXUAL VICTIMIZATION AND ABUSIVENESS

Standard 115.241: Screening for risk of victimization and abusiveness

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.241 (a)

- Are all residents assessed during an intake screening for their risk of being sexually abused by other residents or sexually abusive toward other residents? Yes No
- Are all residents assessed upon transfer to another facility for their risk of being sexually abused by other residents or sexually abusive toward other residents? Yes No

115.241 (b)

- Do intake screenings ordinarily take place within 72 hours of arrival at the facility?
 Yes No

115.241 (c)

- Are all PREA screening assessments conducted using an objective screening instrument?
 Yes No

115.241 (d)

- Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: Whether the resident has a mental, physical, or developmental disability? Yes No
- Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: The age of the resident? Yes No
- Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: The physical build of the resident? Yes No
- Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: Whether the resident has previously been incarcerated?
 Yes No
- Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: Whether the resident's criminal history is exclusively nonviolent?
 Yes No
- Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: Whether the resident has prior convictions for sex offenses against an adult or child? Yes No
- Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: Whether the resident is or is perceived to be gay, lesbian, bisexual, transgender, intersex, or gender nonconforming (the facility affirmatively asks the resident about his/her sexual orientation and gender identity AND makes a subjective determination based on the screener's perception whether the resident is gender non-conforming or otherwise may be perceived to be LGBTI)? Yes No
- Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: Whether the resident has previously experienced sexual victimization? Yes No
- Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: The resident's own perception of vulnerability? Yes No

115.241 (e)

- In assessing residents for risk of being sexually abusive, does the initial PREA risk screening consider, when known to the agency: prior acts of sexual abuse? Yes No
- In assessing residents for risk of being sexually abusive, does the initial PREA risk screening consider, when known to the agency: prior convictions for violent offenses? Yes No
- In assessing residents for risk of being sexually abusive, does the initial PREA risk screening consider, when known to the agency: history of prior institutional violence or sexual abuse?
 Yes No

115.241 (f)

- Within a set time period not more than 30 days from the resident's arrival at the facility, does the facility reassess the resident's risk of victimization or abusiveness based upon any additional, relevant information received by the facility since the intake screening? Yes No

115.241 (g)

- Does the facility reassess a resident's risk level when warranted due to a: Referral?
 Yes No
- Does the facility reassess a resident's risk level when warranted due to a: Request?
 Yes No
- Does the facility reassess a resident's risk level when warranted due to a: Incident of sexual abuse? Yes No
- Does the facility reassess a resident's risk level when warranted due to a: Receipt of additional information that bears on the resident's risk of sexual victimization or abusiveness?
 Yes No

115.241 (h)

- Is it the case that residents are not ever disciplined for refusing to answer, or for not disclosing complete information in response to, questions asked pursuant to paragraphs (d)(1), (d)(7), (d)(8), or (d)(9) of this section? Yes No

115.241 (i)

- Has the agency implemented 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? Yes No

Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documents Reviewed:

Facility Policy 13.1

Sample of Vulnerability Assessment: Risk of Victimization and/or Sexual Aggression

PREA Education & Screening Log

PREA Documents Summary Log

Interviews:

PREA Coordinator

Staff Responsible for Risk Screening

Residents

Provision (a):

Within 72 hours of the resident's arrival at the facility and periodically throughout a resident's confinement, the agency shall obtain and use information about each resident's personal history and behavior to reduce the risk of sexual abuse by or upon a resident. The Policy provides a risk screening occur within 72 hours upon arrival to the facility. The Intake Coordinator will interview the resident at intake to obtain information about the resident's personal history and behavior to reduce the risk of sexual abuse by or upon a resident. The resident's risk level is reassessed periodically.

HCBC Sexual Abuse and Harassment Prevention and Intervention Program addresses the requirements of this standard. The program manager reviews all referral packets for residents being considered for placement for this facility. Upon arrival at the HCBC, all residents are screened and assessed for their risk of being sexually abused or sexually harassed by other residents. Sexual abusers are precluded from being referred to a transition center. Residents are not disciplined for refusing to respond or failing to fully disclose information during screening. Controls are in place to ensure that information received during screening is only available to staff on a need-to-know basis. Case Managers review all relevant information from other facilities and continue to immediately reassess when additional information is received. The HCBC recently updated the screening form relevant to this standard, to ensure full compliance to the PREA. This form is being used by the HCBC. Interviews with staff and an examination of documentation confirm compliance to this standard. Disclosure of prior victimization or perpetrated sexual abuse is addressed during the time of disclosure. The information is related to mental health personnel following the disclosure of the information. There was one resident in the facility who had disclosed prior victimization. A review of documentation, interviews with residents and staff confirmed the Vulnerability Assessment is administered. The information for the instrument may be obtained by asking questions from the form, medical and mental health screenings and other methods. All residents interviewed could identify specific areas inquired about in the administration of the Vulnerability Assessment. Reassessments are conducted periodically. PREA Education and Screening log was reviewed and it is maintained indicating the administration of the initial assessment and the completion of the follow-up assessments.

The facility provided the Auditor with examples of the screening tool. The Intake Coordinator, responsible for risk screening, confirmed residents are screened whether a new admission or transfer from another facility for risk of sexual abuse victimization or sexual abusiveness toward the other residents. The risk screening occurs within 72 hours of intake, usually on the first day. Risk levels are reassessed periodically per the Intake Coordinator and a review of documents. All residents interviewed entered the facility within the past 12 months. They confirmed they were asked questions like the following examples at intake:

- (1) Have you ever been sexually abused?
- (2) Do you identify with being gay, bisexual or transgender?
- (3) Do you have any disabilities?
- (4) Do you think you might be in danger of sexual abuse at the facility?

Based on the review of the Pre-audit questionnaire, review of resident records, interview with the staff responsible for risk screening, and resident interviews, the evidence shows that resident's risk levels are assessed during intake, but no later than 72 hours of their arrival at the facility. Additionally, risk levels are reassessed periodically. The facility follows this provision of the standard.

Provision (b):

Such assessments shall be conducted using an objective screening instrument.

The Vulnerability Assessment is used to obtain the information required by the standard, including but not limited to prior sexual victimization or abusiveness; self-identification; current charges and offense history; intellectual or developmental disabilities; and a resident's concern regarding his own safety. The interview and review of Policy revealed how the objective instrument is administered to glean information to assist staff in keeping residents safe. The responses on the instrument garner a score and the risk level is determined by definition and the corresponding number to that definition. The Policy states residents will be screened within 72 hours of admission, however, interviews with residents indicated it is also administered earlier.

Provision (c):

At a minimum, the agency shall attempt to ascertain information about:

- (1) Prior sexual victimization or abusiveness;
- (2) Any gender nonconforming appearance or manner or identification as lesbian, gay, bisexual, transgender, or intersex, and whether the resident may therefore be vulnerable to sexual abuse;
- (3) Current charges and offense history;
- (4) Age;
- (5) Level of emotional and cognitive development;
- (6) Physical size and stature;
- (7) Mental illness or mental disabilities;
- (8) Intellectual or developmental disabilities;
- (9) Physical disabilities;
- (10) The resident's own perception of vulnerability; and
- (11) Any other specific information about individual residents that may indicate heightened needs for supervision, additional safety precautions, or separation from certain other residents.

The Auditor reviewed the Vulnerability Assessment: Risk of Victimization and/or Sexual Aggression screening instrument and determined all factors required by this provision of the standard are included. The interview with the staff involved with Intake Staff confirmed they are aware of the elements of the risk screening instrument. The resident interviews also confirmed the administration of the screening instrument.

Provision (d):

This information shall be ascertained through conversations with the resident during the intake process and medical and mental health screenings; during classification assessments; and by reviewing court records, case files, facility behavioral records, and other relevant documentation from the resident's files.

The Facility Policy states the information shall be ascertained through conversations with the resident during the intake process and medical and mental health screenings; during classification assessments; and by reviewing court records, case files, facility behavioral records, and other relevant documentation from the resident's file. The staff and resident interviews are aligned with the Policy and this provision of the standard. The review of the instrument and interview with the Intake Coordinator responsible for risk screening confirmed the information is ascertained through conversations with the residents using the Vulnerability Assessment: Risk of Victimization and/or Sexual Aggression screening instrument. Resident interviews also revealed the instrument is used. Additional screening instruments are used and based on the needs of the resident.

Provision (e):

The agency 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.

The Policy provides for appropriate controls be taken to ensure that sensitive information is protected and not exploited. The interview with the APC revealed the information is available to the Intake staff and the mental health staff. The documents are kept in the resident's file in a locked file cabinet in the locked office of the APC. The Auditor observed the files to be maintained in a secure manner. The evidence shows the facility follows this provision of the standard.

Conclusion:

Based upon the review and analysis of the available evidence, the Auditor has determined the facility is fully compliant with this standard regarding screening for risk of victimization and abusiveness.

Standard 115.242: Use of screening information

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.242 (a)

- Does the agency use information from the risk screening required by § 115.241, with the goal of keeping separate those residents at high risk of being sexually victimized from those at high risk of being sexually abusive, to inform: Housing Assignments? Yes No
- Does the agency use information from the risk screening required by § 115.241, with the goal of keeping separate those residents at high risk of being sexually victimized from those at high risk of being sexually abusive, to inform: Bed assignments? Yes No
- Does the agency use information from the risk screening required by § 115.241, with the goal of keeping separate those residents at high risk of being sexually victimized from those at high risk of being sexually abusive, to inform: Work Assignments? Yes No
- Does the agency use information from the risk screening required by § 115.241, with the goal of keeping separate those residents at high risk of being sexually victimized from those at high risk of being sexually abusive, to inform: Education Assignments? Yes No
- Does the agency use information from the risk screening required by § 115.241, with the goal of keeping separate those residents at high risk of being sexually victimized from those at high risk of being sexually abusive, to inform: Program Assignments? Yes No

115.242 (b)

- Does the agency make individualized determinations about how to ensure the safety of each resident? Yes No

115.242 (c)

- When deciding whether to assign a transgender or intersex resident to a facility for male or female residents, does the agency consider on a case-by-case basis whether a placement would ensure the resident's health and safety, and whether a placement would present management or security problems (NOTE: if an agency by policy or practice assigns residents to a male or female facility on the basis of anatomy alone, that agency is not in compliance with this standard)? Yes No
- When making housing or other program assignments for transgender or intersex residents, does the agency consider on a case-by-case basis whether a placement would ensure the resident's health and safety, and whether a placement would present management or security problems? Yes No

115.242 (d)

- Are each transgender or intersex resident's own views with respect to his or her own safety given serious consideration when making facility and housing placement decisions and programming assignments? Yes No

115.242 (e)

- Are transgender and intersex residents given the opportunity to shower separately from other residents? Yes No

115.242 (f)

- Unless 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 lesbian, gay, bisexual, transgender, or intersex residents, does the agency always refrain from placing: lesbian, gay, and bisexual residents in dedicated facilities, units, or wings solely on the basis of such identification or status? Yes No
- Unless 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 lesbian, gay, bisexual, transgender, or intersex residents, does the agency always refrain from placing: transgender residents in dedicated facilities, units, or wings solely on the basis of such identification or status? Yes No
- Unless 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 lesbian, gay, bisexual, transgender, or intersex residents, does the agency always refrain from placing: intersex residents in dedicated facilities, units, or wings solely on the basis of such identification or status? Yes No

Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)

Does Not Meet Standard (Requires Corrective Action)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documents Reviewed:

Facility Policy 13.1 Prevention Planning Procedures
Sample of Vulnerability Assessment: Risk of Victimization and/or Sexual Aggression
PREA Education & Screening Log
PREA Documents Summary Log

Interviews:

Resident (targeted interview)
PREA Coordinator
Director
Staff Responsible for Risk Screening/Intake Coordinator
Random Staff

Provision (a):

The agency shall use all information obtained pursuant to § 115.341 and subsequently to make housing, bed, program, education, and work assignments for residents with the goal of keeping all residents safe and free from sexual abuse.

The Facility Policy provides guidance to staff regarding the use of the information obtained from the Vulnerability Assessment: Risk for Victimization and/or Sexual Aggressiveness. The staff interviews and information obtained through the administration of the screening instrument assist in determining bed, education and other program assignments with the goal of keeping all residents safe and meeting the needs of each resident. This information was verified through a review of specific samples of the completed screening instrument. The facility also uses additional screening instruments. This facility uses information gathered in the screening instrument to inform housing and in-house job assignments. Most residents work offsite in the community. Housing dorms have assigned bunk areas and bathrooms to ensure that potential or known aggressors are not housed with potential or known victims.

Provision (b):

Residents may be isolated from others only as a last resort when less restrictive measures are inadequate to keep them and other residents safe, and then only until an alternative means of keeping all residents safe can be arranged. During any period of isolation, agencies shall not deny residents daily large-muscle exercise and any legally required educational programming or special education services. Residents in isolation shall receive daily visits from a medical or mental health care clinician. Residents shall also have access to other programs and work opportunities to the extent possible.

The Policy states any use of segregated housing to protect a resident who is alleged to have suffered sexual abuse shall comply with § 115.342 and the provision (a). At no time will any client be denied any legally required educational programs, special education services, daily large-muscle exercise, or medical/mental health care. At risk residents may only be placed in isolation in an emergency situation, and only as a last resort if less restrictive measures are inadequate to keep the resident safe.

No residents at risk of sexual victimization were placed in isolation in the 12 months preceding the audit. The interview with the APC confirmed the facility has not used isolation for this purpose. The policy is inclusive of

this provision if there were to be an emergency situation. The use of isolation would be documented. The residents' rights to daily large-muscle exercise and any legally required educational programming or special education services would be provided. Based on the review of the Pre-audit questionnaire, related documents and interview with the Director, the evidence shows the facility follows this provision of the standard.

Provision (c):

Lesbian, gay, bisexual, transgender, or intersex residents shall not be placed in particular housing, bed, or other assignments solely on the basis of such identification or status, nor shall agencies consider lesbian, gay, bisexual, transgender, or intersex identification or status as an indicator of likelihood of being sexually abusive.

The Policy prohibits placing lesbian, bisexual, transgender, or intersex residents in specific housing or making other assignments solely based on how the residents identify or their status. The Policy prohibits staff from considering the identification as an indicator that these residents may be more likely to be sexually abusive. During the comprehensive site review, there were no rooms observed to be reserved for transgender or intersex residents. The restroom/showers were observed and were configured for a reasonable amount of privacy. A targeted resident interview revealed there is no special housing based on how a resident identifies, which was also supported by staff interviews and observations.

Provision (d):

In deciding whether to assign a transgender or intersex resident to a facility for male or female residents, and in making other housing and programming assignments, the agency shall consider on a case-by-case basis whether a placement would ensure the resident's health and safety, and whether the placement would present management or security problems.

The Policy also provides that housing and program assignments for transgender or intersex residents would be made on a case-by-case basis and these residents would not be placed in particular or special housing which was evident from staff interviews. There were several residents who identified as transgender in the facility during the site visit and this audit period. The APC and Intake Staff's interviews confirmed the facility would consider on a case-by-case basis whether a placement would ensure the resident's health and safety, and whether the placement would present management or security problems.

Provision (e):

Placement and programming assignments for each transgender or intersex resident shall be reassessed at least twice each year to review any threats to safety experienced by the resident.

The Policy states placement and programming assignments for each transgender or intersex resident shall be reassessed at least twice each year. This function would be done to review any threats to safety experienced by the resident and the Intake Coordinator is aware of the requirement. The APC confirmed each transgender or intersex resident would be reassessed at least twice each year to review any threats to safety experienced by the resident. Based on the review of the Pre-audit Questionnaire and interview with the Intake Coordinator, the evidence shows the facility follows this provision of the standard.

Provision (f):

Transgender and intersex residents shall be given the opportunity to shower separately from other residents.

The Policy states transgender or intersex residents shall be given the opportunity to shower separately from other residents which is also supported by staff interviews.

If a resident is isolated pursuant to paragraph (b) of this section, the facility shall clearly document:

- (1) The basis for the facility's concern for the resident's safety; and
- (2) The reason why no alternative means of separation can be arranged.

The Policy states if a resident is isolated pursuant to part (B.2.) of this section, the facility shall document:

- The basis for the facility's concern for the resident's safety; and
- The reason why no alternative means of separation can be arranged.

No residents at risk of sexual victimization were placed in isolation in the 12 months preceding the audit. Interviews with the Director and APC confirmed the facility has not used isolation for this purpose. The policy is inclusive of this provision if there were to be an emergency situation. The Isolation/separation would be documented according to the provisions of the Policy and standard.

Every 30 days, the facility shall afford each resident described in paragraph (h) of this section a review to determine whether there is a continuing need for separation from the general population.

The Policy states every thirty (30) days, staff shall afford each resident described in provision (b) of this section a review to determine whether there is a continuing need for separation from the general population. No residents at risk of sexual victimization were placed in isolation in the 12 months preceding the audit. Interviews with the Director and APC confirmed the facility has not used isolation for this purpose. The policy is inclusive of this provision if there were to be an emergency situation.

Conclusion:

Based upon the review and analysis of the available evidence, the Auditor has determined the facility is fully compliant with this standard regarding use of screening information. The facility uses information from the risk screening required by §115.341 to inform housing, bed, work, education, and program assignments with the goal of keeping all residents safe and free from sexual abuse. The facility prohibits placing LGBTI residents' housing, bed, or other assignments solely on the basis of such identification or status and does not consider such identification or status as an indicator of likelihood of being sexually abusive. The facility is prepared to provide a safe and secure environment and follow all provisions of this standard

REPORTING

Standard 115.251: Resident reporting

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.251 (a)

- Does the agency provide multiple internal ways for residents to privately report: Sexual abuse and sexual harassment? Yes No
- Does the agency provide multiple internal ways for residents to privately report: Retaliation by other residents or staff for reporting sexual abuse and sexual harassment? Yes No
- Does the agency provide multiple internal ways for residents to privately report: Staff neglect or violation of responsibilities that may have contributed to such incidents? Yes No

115.251 (b)

- Does the agency also provide at least one way for residents to report sexual abuse or sexual harassment to a public or private entity or office that is not part of the agency? Yes No
- Is that private entity or office able to receive and immediately forward resident reports of sexual abuse and sexual harassment to agency officials? Yes No

- Does that private entity or office allow the resident to remain anonymous upon request?
 Yes No

115.251 (c)

- Do staff members accept reports of sexual abuse and sexual harassment made verbally, in writing, anonymously, and from third parties? Yes No
- Do staff members promptly document any verbal reports of sexual abuse and sexual harassment? Yes No

115.251 (d)

- Does the agency provide a method for staff to privately report sexual abuse and sexual harassment of residents? Yes No

Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documents Reviewed:

Facility Policy 13.1 Planning and Prevention Procedures
 Grievance Forms
 Medical Request Form
 Third Party Reporting Forms
 Safety Pamphlet
 Sample of Incident Report
 Resident Handbook
 Observed PREA Posters

Interviews:

Random Staff
 Residents
 APC

Provision (a):

The agency shall provide multiple internal ways for residents to privately report sexual abuse and 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.

HCBC policy covers this standard. For the reporting duties and confidentiality section A covers it. They have several ways to report incidents. They also have established hotlines for both staff and residents to use to report PREA incidents. The Auditor tried the phone number while on-site and it worked appropriately.

Facility Policy addresses this standard and provides for multiple internal ways a resident may report allegations of sexual abuse and sexual harassment, including how he can privately report sexual abuse and sexual harassment; retaliation for reporting; and staff neglect or violations of responsibilities that may have contributed to such. Residents may report allegations of sexual abuse or sexual harassment by telephone through the 24-hour hotline of an agency not a part of the facility as confirmed by resident interviews, posters, staff, MOU, and posted phone instructions. HCBC staff interviews revealed residents may use the telephone, located on each unit, to privately report sexual abuse and sexual harassment. The telephone was tested during the comprehensive site review and was found to be in working order.

The residents also identified internal ways a resident may report such as completing a grievance form; talking to a trusted staff member; completing a Medical Request Form; or tell an outside person or family member. There are designated locked boxes and forms on the living units for depositing the written grievance forms. If a resident uses a grievance form to report allegations of sexual abuse or sexual harassment, he just needs to place his name on the form, check the appropriate space and place it in the grievance box.

The resident receives a Safety Pamphlet and Resident Handbook which provides PREA-related information, including how to report allegations of sexual abuse. Posters are located in the living units and other areas visible to residents, staff, contractors and visitors. Residents revealed they have contact with someone who does not work at the facility such as a family member or other person they could report abuse to if needed. Staff members receive information on how to report allegations of sexual abuse or sexual harassment through policies and procedures, training, and staff meetings.

Provision (b):

The agency shall also provide 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 agency and that is able to receive and immediately forward resident reports of sexual abuse and sexual harassment to agency officials, allowing the resident to remain anonymous upon request. Residents detained solely for civil immigration purposes shall be provided information on how to contact relevant consular officials and relevant officials at the Department of Homeland Security.

Residents may use the emergency telephone located on each unit. The resident may select the appropriate line and dial a number to reach a victim advocate at The MOCSA to report an allegation of abuse and/or request advocacy services. Signs are posted explaining how to access MOCSA and contains telephone numbers for the agency. The resident is also instructed on the signage to dial 911 for emergencies. HCBC staff revealed staff could use the emergency phone to report allegations of abuse. Allegations of sexual abuse have not been reported during this audit period. The facility does not detain residents solely for civil immigration purposes.

Provision (c):

Staff shall accept reports made verbally, in writing, anonymously, and from third parties and shall promptly document any verbal reports.

HCBC requires all staff to report immediately, in accordance with HCBC Policy #13.5, any knowledge, suspicion, or information regarding an incident of offender sexual abuse or offender sexual harassment. All

staff are required to report retaliation against offenders or staff who reported such an incident, and any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation.

The staff interviews confirmed the methods available to residents for reporting allegations of sexual abuse and sexual harassment. Staff members are required to accept third-party reports and to document verbal reports. All residents interviewed revealed they are familiar with the provisions of the standard. The resident interviews demonstrated their familiarity with the various ways they may report either in person, in writing, by phone, completing a grievance or Medical Request Form, or through a third-party. The residents were aware third-party reports could be made and that reports can be made anonymously. Staff members interviewed were aware of their duty to receive and document third-party reports.

The facility shall provide residents with access to tools necessary to make a written report.

Writing materials are readily available for residents to complete the accessible forms. Prior to the site visit pictures were sent to the Auditor showing the reporting forms such as Grievance forms and Medical Request Forms and the accessibility of writing utensils. During the site visit and while on the site review, the Auditor observed the accessibility of writing utensils to the residents.

Provision (d):

The agency shall provide a method for staff to privately report sexual abuse and sexual harassment of residents.

The staff interviews revealed staff can privately report allegations of sexual abuse. The interviews collectively identified the following ways a report can be made privately: use of the telephone on the living units; use of telephone in an office; third-party reporting form online; report by email to administrative staff; and/or talk to supervisor in private.

All information concerning an event of offender sexual abuse or sexual harassment is to be treated as confidential. Apart from reporting to designated supervisors or officials, staff shall not reveal any information related to a sexual abuse/harassment report to anyone other to the extent necessary, as specified in HCBC Policy 13.5, to make treatment, investigation, and other security and management decisions.

Conclusion:

Based upon the review and analysis of the available evidence, the Auditor has determined the facility is compliant with this standard regarding resident reporting. The residents have multiple internal ways to privately report. Reports can be made verbally, in writing, anonymously, and from third parties. Verbal reports would be documented immediately. Residents have access to pens and pencils to write a grievance or complete a Medical Request Form. Staff can privately report sexual abuse and sexual harassment of residents.

Standard 115.252: Exhaustion of administrative remedies

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.252 (a)

- Is the agency exempt from this standard? NOTE: The agency is exempt ONLY if it does not have administrative procedures to address resident grievances regarding sexual abuse. This does not mean the agency is exempt simply because a resident does not have to or is not ordinarily expected to submit a grievance to report sexual abuse. This means that as a matter of explicit policy, the agency does not have an administrative remedies process to address sexual abuse. Yes No NA

115.252 (b)

- Does the agency permit residents to submit a grievance regarding an allegation of sexual abuse without any type of time limits? (The agency may apply otherwise-applicable time limits to any portion of a grievance that does not allege an incident of sexual abuse.) (N/A if agency is exempt from this standard.) Yes No NA
- Does the agency always refrain from requiring a resident to use any informal grievance process, or to otherwise attempt to resolve with staff, an alleged incident of sexual abuse? (N/A if agency is exempt from this standard.) Yes No NA

115.252 (c)

- Does the agency ensure that: A resident who alleges sexual abuse may submit a grievance without submitting it to a staff member who is the subject of the complaint? (N/A if agency is exempt from this standard.) Yes No NA
- Does the agency ensure that: Such grievance is not referred to a staff member who is the subject of the complaint? (N/A if agency is exempt from this standard.) Yes No NA

115.252 (d)

- Does the agency issue a final agency decision on the merits of any portion of a grievance alleging sexual abuse within 90 days of the initial filing of the grievance? (Computation of the 90-day time period does not include time consumed by residents in preparing any administrative appeal.) (N/A if agency is exempt from this standard.) Yes No NA
- If the agency determines that the 90-day timeframe is insufficient to make an appropriate decision and claims an extension of time [the maximum allowable extension of time to respond is 70 days per 115.252(d)(3)], does the agency notify the resident in writing of any such extension and provide a date by which a decision will be made? (N/A if agency is exempt from this standard.) Yes No NA
- At any level of the administrative process, including the final level, if the resident does not receive a response within the time allotted for reply, including any properly noticed extension, may a resident consider the absence of a response to be a denial at that level? (N/A if agency is exempt from this standard.) Yes No NA

115.252 (e)

- Are third parties, including fellow residents, staff members, family members, attorneys, and outside advocates, permitted to assist residents in filing requests for administrative remedies relating to allegations of sexual abuse? (N/A if agency is exempt from this standard.) Yes No NA
- Are those third parties also permitted to file such requests on behalf of residents? (If a third-party files such a request on behalf of a resident, the facility may require as a condition of processing the request that the alleged victim agree to have the request filed on his or her behalf, and may also require the alleged victim to personally pursue any subsequent steps in the administrative remedy process.) (N/A if agency is exempt from this standard.) Yes No NA

- If the resident declines to have the request processed on his or her behalf, does the agency document the resident's decision? (N/A if agency is exempt from this standard.)
 Yes No NA

115.252 (f)

- Has the agency established procedures for the filing of an emergency grievance alleging that a resident is subject to a substantial risk of imminent sexual abuse? (N/A if agency is exempt from this standard.) Yes No NA
- After receiving an emergency grievance alleging a resident is subject to a substantial risk of imminent sexual abuse, does the agency immediately forward the grievance (or any portion thereof that alleges the substantial risk of imminent sexual abuse) to a level of review at which immediate corrective action may be taken? (N/A if agency is exempt from this standard.)
 Yes No NA
- After receiving an emergency grievance described above, does the agency provide an initial response within 48 hours? (N/A if agency is exempt from this standard.) Yes No NA
- After receiving an emergency grievance described above, does the agency issue a final agency decision within 5 calendar days? (N/A if agency is exempt from this standard.)
 Yes No NA
- Does the initial response and final agency decision document the agency's determination whether the resident is in substantial risk of imminent sexual abuse? (N/A if agency is exempt from this standard.) Yes No NA
- Does the initial response document the agency's action(s) taken in response to the emergency grievance? (N/A if agency is exempt from this standard.) Yes No NA
- Does the agency's final decision document the agency's action(s) taken in response to the emergency grievance? (N/A if agency is exempt from this standard.) Yes No NA

115.252 (g)

- If the agency disciplines a resident for filing a grievance related to alleged sexual abuse, does it do so ONLY where the agency demonstrates that the resident filed the grievance in bad faith? (N/A if agency is exempt from this standard.) Yes No NA

Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documents Reviewed:

Facility Policy 13.1 Prevention Planning Procedures 6.01-1, Resident Grievances
Resident Handbook
Administrative Review of Grievance form
Third Party Reporting Form

Interviews:

Residents
Random Staff

Provision (a):

An agency shall be exempt from this standard if it does not have administrative procedures to address resident grievances regarding sexual abuse.

The Auditor confirmed HCBC has administrative procedures to address resident grievances regarding sexual abuse as determined by the review of Policy 13.1. Reportedly, no grievances have been filed related to sexual abuse and no evidence to the contrary.

Provision (b):

- (1) The agency shall not impose a time limit on when a resident may submit a grievance regarding an allegation of sexual abuse.
- (2) The agency may apply otherwise-applicable time limits on any portion of a grievance that does not allege an incident of sexual abuse.
- (3) The agency shall not require a resident to use any informal grievance process, or to otherwise attempt to resolve with staff, an alleged incident of sexual abuse.
- (4) Nothing in this section shall restrict the agency's ability to defend against a lawsuit filed by a resident claiming the applicable statute of limitations has expired.

The Facility Policy provide for the above provisions. Based on the review of the Resident Handbook, Administrative Review of Grievance form, resident interviews, and observations, the facility provides relevant information to the residents and has timelines in place to adhere to this provision of the standard.

Provision (c):

The agency shall ensure that—

- (1) A resident who alleges sexual abuse may submit a grievance without submitting it to a staff member who is the subject of the complaint, and
- (2) Such grievance is not referred to a staff member who is the subject of the complaint.

According to the Policy, formal and informal staff interviews, and observations, residents are not required to give a grievance to a staff member and staff members are not permitted to place a grievance in the box for the resident. A locked grievance box is located on each housing unit.

Provision (d):

- (1) The agency shall issue a final agency decision on the merits of any portion of a grievance alleging sexual abuse within 90 days of the initial filing of the grievance.
- (2) Computation of the 90-day time period shall not include time consumed by residents in preparing any administrative appeal.

(3) The agency may claim an extension of time to respond, of up to 70 days, if the normal time period for response is insufficient to make an appropriate decision. The agency shall notify the resident in writing of any such extension and provide a date by which a decision will be made.

(4) At any level of the administrative process, including the final level, if the resident does not receive a response within the time allotted for reply, including any properly noticed extension, the resident may consider the absence of a response to be a denial at that level.

There were no grievances filed that alleged sexual abuse in the 12 months preceding the audit. Based on the review of the Policy, resident interviews and Pre-audit questionnaire and associated memos of non-occurrence by the Director, evidence shows the facility follows this provision of the standard.

Provision (e):

(1) Third parties, including fellow residents, staff members, family members, attorneys, and outside advocates, shall be permitted to assist residents in filing requests for administrative remedies relating to allegations of sexual abuse, and shall also be permitted to file such requests on behalf of residents.

(2) If a third party, other than a parent or legal guardian, files such a request on behalf of a resident, the facility may require as a condition of processing the request that the alleged victim agree to have the request filed on his or her behalf and may also require the alleged victim to personally pursue any subsequent steps in the administrative remedy process.

(3) If the resident declines to have the request processed on his or her behalf, the agency shall document the residents' decision.

(4) A parent or legal guardian of a juvenile shall be allowed to file a grievance regarding allegations of sexual abuse, including appeals, on behalf of such juvenile. Such a grievance shall not be conditioned upon the juvenile agreeing to have the request filed on his or her behalf.

The Policy and the Third-Party Reporting Form provide that third parties may file a grievance on behalf of residents and such action is not conditioned upon the resident agreeing to the filing of the grievance. There were no grievances alleging sexual abuse filed in the 12 months preceding the audit in which the resident declined third-party assistance. Based on the review of the Pre-audit questionnaire, and associated memos of non-occurrence, evidence shows the facility follows this provision of the standard.

Provision (f):

(1) The agency shall establish procedures for the filing of an emergency grievance alleging that a resident is subject to a substantial risk of imminent sexual abuse.

(2) After receiving an emergency grievance alleging a resident is subject to a substantial risk of imminent sexual abuse, the agency shall immediately forward the grievance (or any portion thereof that alleges the substantial risk of imminent sexual abuse) to a level of review at which immediate corrective action may be taken, shall provide an initial response within 48 hours, and shall issue a final agency decision within five calendar days. The initial response and final agency decision shall document the agency's determination whether the resident is in substantial risk of imminent sexual abuse and the action taken in response to the emergency grievance.

The Policy provides for this provision of the standard. Once the grievance is received, it is dealt with through the appropriate administrative channels and Policy states that the resident will receive an initial response within 48 hours and a final agency decision within five calendar days.

Provision (g):

The agency may discipline a resident for filing a grievance related to alleged sexual abuse only where the agency demonstrates that the resident filed the grievance in bad faith.

The Policy requires the actions of this standard provision. During the past 12 months, there were no resident grievances alleging sexual abuse that resulted in disciplinary action by the agency against the resident for having filed the grievance in bad faith. Based on the review of the Policy, associated memos of non-occurrence, and posted information, evidence shows the facility follows this provision of the standard.

Conclusion:

Based upon the review and analysis of the available evidence, the Auditor has determined the facility is compliant with this standard regarding exhaustion of administrative remedies. HCBC has an administrative procedure for dealing with resident grievances regarding sexual abuse that is inclusive of all provisions required by the standard. The grievance procedure is contained in the Resident Handbook and explained to the residents.

Standard 115.253: Resident access to outside confidential support services

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.253 (a)

- Does the facility provide 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, of local, State, or national victim advocacy or rape crisis organizations? Yes No
- Does the facility enable reasonable communication between residents and these organizations and agencies, in as confidential a manner as possible? Yes No

115.253 (b)

- Does the facility inform residents, prior to giving them access, of the extent to which such communications will be monitored and the extent to which reports of abuse will be forwarded to authorities in accordance with mandatory reporting laws? Yes No

115.253 (c)

- Does the agency maintain or attempt to enter into memoranda of understanding or other agreements with community service providers that are able to provide residents with confidential emotional support services related to sexual abuse? Yes No
- Does the agency maintain copies of agreements or documentation showing attempts to enter into such agreements? Yes No

Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documents Reviewed:

Facility Policy 13.1 Prevention Planning Procedures
MOU, MOSCA
PREA Brochure (Safety Pamphlet)
PREA Notification/Acknowledgement Form
Resident Handbook
Posted Information

Interviews:

Residents
Director
PREA Coordinator
Program Director

Provision (a):

The facility shall provide residents with access to outside victim advocates for emotional support services related to sexual abuse, by providing, posting, or otherwise making accessible mailing addresses and telephone numbers, including toll-free hotline numbers where available, of local, State, or national victim advocacy or rape crisis organizations, and for persons detained solely for civil immigration purposes, immigrant services agencies. The facility shall enable reasonable communication between residents and these organizations and agencies in as confidential a manner as possible.

Contact information for advocacy services is a part of the PREA education sessions and is also provided to each resident in the PREA brochure and the Resident Handbook. Signs were posted throughout the facility and they have a MOU with MOSCA. Interviews with residents indicate that they were aware of the outside resources and how to contact them. The resident interviews revealed their knowledge of the advocacy services available to them and the limitations of confidentiality. The hotline telephone was observed in each living unit and the contact information for services from the agencies was posted. The telephone was tested and deemed in working order.

Provision (b):

The facility shall inform residents, prior to giving them access, of the extent to which such communications will be monitored and the extent to which reports of abuse will be forwarded to authorities in accordance with mandatory reporting laws.

The Policy addresses confidentiality of the advocacy support services. The resident receives information regarding the limitations of confidentiality during the intake process. An acknowledgement statement specific to the review of the reporting and advocacy services contains information regarding the advocacy services to be provided by MOSCA. Samples of acknowledgement statements were reviewed.

Provision (c):

The agency shall maintain or attempt to enter into memoranda of understanding or other agreements with community service providers that are able to provide residents with confidential emotional support services related to sexual abuse. The agency shall maintain copies of agreements or documentation showing attempts to enter into such agreements.

The Facility Policy states the facility has a MOU with the advocacy agency, available by telephone to the resident for access to outside confidential support services. The resident may use the phone, located on

each living unit, and push the appropriate number to gain access and speak with a victim advocate. The agency is identified on the signage along with directions for reporting allegations or requesting advocacy services. The Director and the APC confirmed the availability and accessibility of outside confidential support services to residents. The Program Manager of the advocacy agency stated that an advocate would go to the facility or the hospital upon request.

Conclusion:

Based upon the review and analysis of the available evidence, the Auditor has determined the facility is compliant with this standard regarding resident access to outside confidential support services and legal representation.

Standard 115.254: Third-party reporting

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.254 (a)

- Has the agency established a method to receive third-party reports of sexual abuse and sexual harassment? Yes No

- Has the agency distributed publicly information on how to report sexual abuse and sexual harassment on behalf of a resident? Yes No

Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

- Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documents Reviewed:

Facility Policy 13.5 Third Party Reporting of PREA Violations
Acknowledgement Statements
Third Party Reporting Form

Interviews:

Random Staff
Residents

Provision (a):

PREA Audit Report

The agency shall establish a method to receive third-party reports of sexual abuse and sexual harassment and shall distribute publicly information on how to report sexual abuse and sexual harassment on behalf of a resident.

The Policy addresses third-party reporting and interviews revealed random staff members are aware third-party reporting of sexual abuse and sexual harassment can be done and stated they will be accepted and reported. Staff members also stated they are to immediately document all verbal reports received. The interviews revealed they may report allegations privately through the use of the abuse reporting hotline or a third-party reporting form.

All residents interviewed stated they knew someone who did not work at the facility they could report to regarding allegations of sexual abuse and that person could make a report for them. The interviews with the residents revealed their knowledge of third-party reporting. The residents identified the methods within the facility in which they may make third-party reports such as file an emergency grievance, report to staff or a family member, or utilize the abuse reporting hotline telephone.

Information regarding reporting is provided through observed postings located in various areas of the facility accessible to visitors, residents, staff, contractors and volunteers. The facility's website contains information regarding third-party reporting of allegations of sexual abuse. The Third-Party Reporting Form is observed to be located on the website. Copies of the Third-Party Reporting form are maintained in the lobby and the reporting information is provided to parents/guardians. There were no third-party reports received during this audit period.

Conclusion:

Based upon the review and analysis of the available evidence, the Auditor determined the facility complies regarding third-party reporting. The facility provides various methods for third-party reports of sexual abuse or sexual harassment.

OFFICIAL RESPONSE FOLLOWING A RESIDENT REPORT
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Standard 115.261: Staff and agency reporting duties

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.261 (a)

- Does the agency require all staff to report immediately and according to agency policy any knowledge, suspicion, or information regarding an incident of sexual abuse or sexual harassment that occurred in a facility, whether or not it is part of the agency? Yes No
- Does the agency require all staff to report immediately and according to agency policy any knowledge, suspicion, or information regarding retaliation against residents or staff who reported an incident of sexual abuse or sexual harassment? Yes No
- Does the agency require all staff to report immediately and according to agency policy any knowledge, suspicion, or information regarding any staff neglect or violation of responsibilities that may have contributed to an incident of sexual abuse or sexual harassment or retaliation? Yes No

115.261 (b)

- Apart from reporting to designated supervisors or officials, do staff always refrain from revealing any information related to a sexual abuse report to anyone other than to the extent necessary, as specified in agency policy, to make treatment, investigation, and other security and management decisions? Yes No

115.261 (c)

- Unless otherwise precluded by Federal, State, or local law, are medical and mental health practitioners required to report sexual abuse pursuant to paragraph (a) of this section? Yes No
- Are medical and mental health practitioners required to inform residents of the practitioner's duty to report, and the limitations of confidentiality, at the initiation of services? Yes No

115.261 (d)

- If the alleged victim is under the age of 18 or considered a vulnerable adult under a State or local vulnerable persons statute, does the agency report the allegation to the designated State or local services agency under applicable mandatory reporting laws? Yes No

115.261 (e)

- Does the facility report all allegations of sexual abuse and sexual harassment, including third-party and anonymous reports, to the facility's designated investigators? Yes No

Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documents Reviewed:

Facility Policy 13.1 Prevention Planning Procedures
Case Managers' Case Notes
PREA Investigation Checklist

Interviews:

Random Staff
Director

PREA Coordinator

Provision (a) and (b):

The agency shall require all staff to report immediately and according to agency 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 agency; retaliation against residents or staff who reported such an incident; and any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation. Provision (b): The agency shall also require all staff to comply with any applicable mandatory child abuse reporting laws.

The Policies collectively address provisions of the standard including providing all staff immediately report any knowledge, suspicion, information, or receipt of information regarding an incident or allegation of sexual abuse, sexual harassment or incidents of retaliation and according to mandatory state reporting laws. The facility's trained investigators conduct administrative investigations and allegations that are criminal in nature are referred to the Kansas City Missouri Police Division. Allegations of sexual abuse are also reported to the child protective agency where the incident occurred. The documented case notes show the reporting by staff in accordance with facility Policies and the requirements of the standard. The staff interviews were aligned with the requirements of the Policies and standard. A review of documentation demonstrates information reported to staff is reported to the appropriate authorities. Staff members are instructed to immediately report all allegations of sexual abuse or sexual harassment to a Supervisor or the Director.

HCBC requires all staff to report immediately, in accordance with policy 13.5, any knowledge, suspicion, or information regarding an incident of offender sexual abuse or offender sexual harassment. All staff are required to report retaliation against offenders or staff who reported such an incident, and any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation.

Provision (c):

Apart from reporting to designated supervisors or officials and designated State or local services agencies, staff shall be prohibited from revealing any information related to a sexual abuse report to anyone other than to the extent necessary, as specified in agency policy, to make treatment, investigation, and other security and management decisions.

Facility Policy 13.1 supports that after allegations have been appropriately reported, staff will not be permitted to give out any other information relating to what was reported except when necessary to obtain treatment for the resident, aid in the investigation, or help retain the security of the facility. Staff is expected to continue to abide by the confidentiality requirements of the facility. Interviews with staff indicated their knowledge of the prohibition of 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. Based on the review of documentation and interviews with staff, it is evident the facility follows this provision of the standard.

Provision (d):

(1) Medical and mental health practitioners shall be required to report sexual abuse to designated supervisors and officials pursuant to paragraph (a) of this section, as well as to the designated State or local services agency where required by mandatory reporting laws.

(2) Such practitioners shall be required to inform residents at the initiation of services of their duty to report and the limitations of confidentiality.

The medical and mental health service individuals interviewed stated residents are informed at the initiation of services of the limitations of confidentiality and the duty of the members to report. The clinical staff interviewed at the local hospital revealed they are mandated reporters. They also indicated informed consent would be documented for a resident 18 years old and over regarding reporting allegations of sexual abuse that did not occur in an institutional setting.

Provision (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 Policies collectively provide for all allegations to be reported to the facility-based investigators, including third-party and anonymous reports as also verified by staff interviews.

Conclusion:

The interviews with random staff, mental health and medical staff and Director revealed their awareness of the requirements regarding the reporting duties. All staff interviewed acknowledged they are mandated reporters and a written report must immediately follow reported allegations or incidents. The random staff interviewed provided the reporting requirements and that staff is expected to document receipt of verbal reports immediately. The facility staff members are also required by the Policy to report allegations that were made anonymously or by a third-party. During this audit period, there were no allegations of sexual abuse.

Standard 115.262: Agency protection duties

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.262 (a)

- When the agency learns that a resident is subject to a substantial risk of imminent sexual abuse, does it take immediate action to protect the resident? Yes No

Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documents Reviewed:

Facility Policy 13.1 Prevention and Planning Procecd
Facility Policy 13.6, Employees Reporting Obligation

Interviews:

Director
Random Staff
PREA Coordinator

Provision (a) §115.362

When an agency learns that a resident is subject to a substantial risk of imminent sexual abuse, it shall take immediate action to protect the resident.

Facility Policy requires staff to protect the residents through implementing protective measures. Administration of the Vulnerability Assessment provides information that assists and guide staff in keeping residents safe through housing and program assignments. The interviews of the random staff and the Director revealed protective measures include but are not limited to alerting supervisors and management staff and separating the residents including moving to a different housing unit. The Director and the random staff indicated the expectation is that any action to protect a resident would be taken immediately.

The interviews with the residents revealed during the intake process, how they feel about their safety is part of the inquiries by staff in completing paperwork. A review of a sample of Vulnerability Assessments supports the information provided by residents. The Director and APC report during the past 12 months, no residents were identified as being subject to substantial risk of imminent sexual abuse. The Checklists regarding the investigations of allegations serves to assist the investigator in ensuring the required protocols are followed.

Conclusion:

Based upon the review and analysis of the available evidence, the Auditor has determined the facility is compliant with this standard and the provisions regarding agency protection duties.

Standard 115.263: Reporting to other confinement facilities

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.263 (a)

- Upon receiving an allegation that a resident was sexually abused while confined at another facility, does the head of the facility that received the allegation notify the head of the facility or appropriate office of the agency where the alleged abuse occurred? Yes No

115.263 (b)

- Is such notification provided as soon as possible, but no later than 72 hours after receiving the allegation? Yes No

115.263 (c)

- Does the agency document that it has provided such notification? Yes No

115.263 (d)

- Does the facility head or agency office that receives such notification ensure that the allegation is investigated in accordance with these standards? Yes No

Auditor Overall Compliance Determination

Exceeds Standard (*Substantially exceeds requirement of standards*)

- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documents Reviewed:

Facility Policy 13.6 - Employees Reporting Obligation
Facility Policy 13.1 Prevention Planning Procedures

Interviews:

Director
APC

Provisions (a), (b), (c), and (d):

Upon receiving an allegation that a resident was sexually abused while confined at another facility, the head of the facility that received the allegation shall notify the head of the facility or appropriate office of the agency where the alleged abuse occurred and shall also notify the appropriate investigative agency. (b) Such notification shall be provided as soon as possible, but no later than 72 hours after receiving the allegation. (c) The agency shall document that it has provided such notification. (d) The facility head or agency office that receives such notification shall ensure that the allegation is investigated in accordance with these standards.

HCBC has not had any incidents reported to them or that they have had to report during the auditing period. They do have a policy that cover their responsibilities if it were to occur. HCBC 13.6, E. Reporting to Other Confinement Facilities.

HCBC Policy provides that upon receiving an allegation that a resident was sexually abused while confined at another facility, the Director/designee shall notify the head of the facility or appropriate office of the agency where the alleged abuse occurred and the appropriate investigative agency. Notification should be made as soon as possible but no longer than 72 hours after receiving the information. The Director/designee must document the notification as required by Policy. It is the responsibility of the receiving agency to ensure an investigation is completed. According to the Director, there has been no allegation of sexual abuse made by a resident regarding confinement at another facility. The Director is familiar with the Policy and her responsibilities regarding such situation.

Conclusion:

Based upon the information received and interviews, the Auditor has determined the facility is compliant with this standard regarding reporting to other confinement facilities.

Standard 115.264: Staff first responder duties

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.264 (a)

- Upon learning of an allegation that a resident was sexually abused, is the first security staff member to respond to the report required to: Separate the alleged victim and abuser?
 Yes No
- Upon learning of an allegation that a resident was sexually abused, is the first security staff member to respond to the report required to: Preserve and protect any crime scene until appropriate steps can be taken to collect any evidence? Yes No
- Upon learning of an allegation that a resident was sexually abused, is the first security staff member to respond to the report required to: 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, if the abuse occurred within a time period that still allows for the collection of physical evidence? Yes No
- Upon learning of an allegation that a resident was sexually abused, is the first security staff member to respond to the report required to: 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, if the abuse occurred within a time period that still allows for the collection of physical evidence? Yes No

115.264 (b)

- If the first staff responder is not a security staff member, is the responder required to request that the alleged victim not take any actions that could destroy physical evidence, and then notify security staff? Yes No

Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documents Reviewed:

Facility Policy 13.1 Prevention Planning Procedures
Criminal Investigation Checklist

Interviews:

Random Staff
Non-Security Staff First Responder

Provision (a):

Upon learning of an allegation that a resident was sexually abused, the first 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.

Facility Policy provides that upon learning of an allegation that a resident was sexually abused, the first security-level staff member to respond to the report shall be required to:

- a. Separate the alleged victim and abuser;
- b. Preserve and protect any crime scene until appropriate steps can be taken to collect any evidence;
- c. 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.

The interviews with staff confirmed awareness of first responder duties and the training they had been provided. There were no allegations that a resident was sexually abused in the last 12 months.

Provision (b):

If the first staff responder is not a security staff member, the responder shall be required to request that the alleged victim not take any actions that could destroy physical evidence, and then notify security staff.

The Counselor interviewed as non-security staff who may act as a first responder was familiar with his duties in that role. He indicated he would alert the supervisor, separate the victim and perpetrator, and request the victim and perpetrator do not take any actions that could destroy physical evidence. He further stated he would go with the victim to the hospital.

Conclusion:

Based upon the review and analysis of the available evidence, the Auditor has determined the facility is compliant with this standard regarding staff first responder duties.

Standard 115.265: Coordinated response

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.265 (a)

- Has the facility developed a written institutional plan to coordinate actions among staff first responders, medical and mental health practitioners, investigators, and facility leadership taken in response to an incident of sexual abuse? Yes No

Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documents Reviewed:

Facility Policy 13.1 Prevention Planning Procedures
Facility Policy 13.7
Coordinated Response Documentation
Criminal Investigation Checklist
Administrative Investigation Checklist

Interviews:

Director
APC
Random Staff
Sexual Abuse Response Team (SART) Members

Provision (a): §115.365

The facility shall develop 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.

HCBC Sexual Abuse and Harassment Prevention and Intervention Program addresses the requirements of this standard. A review of the facility policies and procedures indicates that there would be a coordinated response plan to resolve sexual abuse and/or sexual harassment incidents that includes first responders, referral to medical and mental health practitioners, investigators and facility leadership. There were no incidents requiring a coordinated response within the past 12 months at this facility.

The random staff interviewed was familiar with the roles regarding the response to an allegation of sexual abuse. The Director discussed the coordinated actions in response to an incident of sexual abuse which was parallel to Policy and the flow chart. Staff members are directed to follow the steps outlined and to utilize the Checklist in addressing the situation.

Forensic medical examinations will be provided free of charge to the victim at Truman Hospital by a Sexual Assault Nurse Examiner (SANE). The Hospital has 24/7 access to a SANE provider. A qualified medical professional shall perform a forensic medical examination if there is no SANE available as stated in the Hospital's Sexual Assault Policy. The victim will be provided unimpeded access to crisis intervention and medical services.

Conclusion:

Based upon the review and analysis of the available evidence, the Auditor has determined the facility complies with the provisions of the standard regarding a coordinated response to an incident of sexual abuse. No allegations of sexual abuse have been reported during this audit period.

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

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.266 (a)

- Are both the agency and any other governmental entities responsible for collective bargaining on the agency's behalf prohibited from entering into or renewing any collective bargaining agreement or other agreement that limits the agency's ability to remove alleged staff sexual abusers from contact with any residents pending the outcome of an investigation or of a determination of whether and to what extent discipline is warranted? Yes No

115.266 (b)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Provision (a):

HCBC has not been involved with any new negotiations with bargaining units. There is no policy that would prohibit the HCBC from removing alleged staff sexual abusers from contact with any resident pending the outcome of an investigation or of a determination of whether and to what extent discipline is warranted.

Standard 115.267: Agency protection against retaliation

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.267 (a)

- Has the agency established 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? Yes No
- Has the agency designated which staff members or departments are charged with monitoring retaliation? Yes No

115.267 (b)

- Does the agency 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? Yes No

115.267 (c)

- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor the conduct and treatment of residents or staff who reported the sexual abuse to see if there are changes that may suggest possible retaliation by residents or staff? Yes No
- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor the conduct and treatment of residents who were reported to have suffered sexual abuse to see if there are changes that may suggest possible retaliation by residents or staff? Yes No
- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Act promptly to remedy any such retaliation? Yes No
- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor any resident disciplinary reports? Yes No
- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor resident housing changes? Yes No
- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor resident program changes? Yes No
- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor negative performance reviews of staff? Yes No

- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor reassignments of staff? Yes No
- Does the agency continue such monitoring beyond 90 days if the initial monitoring indicates a continuing need? Yes No

115.267 (d)

- In the case of residents, does such monitoring also include periodic status checks?
 Yes No

115.267 (e)

- If any other individual who cooperates with an investigation expresses a fear of retaliation, does the agency take appropriate measures to protect that individual against retaliation?
 Yes No

115.267 (f)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documentation Reviewed:

Facility Policy 13.1, Protection against Retaliation for Reporting Checklist
Retaliation Status Check Checklist
Retaliation Monitoring Checklist

Interviews:

Retaliation Monitor/PREA Coordinator
Director

Provision (a):

The agency shall establish 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 and shall designate which staff members or departments are charged with monitoring retaliation.

The HCBC Policy states the facility shall protect all residents and staff from retaliation who report sexual abuse, sexual harassment or cooperate with sexual abuse or sexual harassment investigations. The APC is charged with monitoring retaliation. The interview with the APC confirmed he serves as the retaliation monitor. Although there have been no allegations of sexual abuse or sexual harassment and the need for retaliation monitoring, the APC revealed his understanding of the role of the retaliation monitor.

Provision (b):

The agency 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.

The Policy identifies measures to protect staff and residents including the following:

- a. Initiating housing changes or transfers for resident victims or abusers;
- b. Removing alleged staff or resident abusers from contact with victims; and
- c. Providing emotional support services.

The interview confirmed the facility would protect residents and staff from retaliation for sexual abuse and sexual harassment allegations. Protective measures would include housing changes, transfers, removing alleged abusers, and emotional support services. The APC identified protective measures that are aligned with the Policy and standard, including separating the alleged abuser from the alleged victim.

Provision (c):

For at least 90 days following a report of sexual abuse, the agency shall monitor the conduct or treatment of residents or staff who reported the sexual abuse and of residents who were reported to have suffered sexual abuse to see if there are changes that may suggest possible retaliation by residents or staff and shall act promptly to remedy any such retaliation. Items the agency should monitor include any resident disciplinary reports, housing, or program changes, or negative performance reviews or reassignments of staff. The agency shall continue such monitoring beyond 90 days if the initial monitoring indicates a continuing need.

The Policy requires the monitoring of items identified in this provision of the standard. The PREA Coordinator explained during the interview how he would discharge those duties, including monitoring the items identified in the standard and whether a resident filed a grievance alleging sexual abuse or sexual harassment. Retaliation monitoring would occur for 90 days to see if there are any changes that may suggest possible retaliation by residents or staff, and shall act promptly to remedy any such retaliation, according to Policy. The monitoring will continue beyond 90 days, if the initial monitoring indicates a continuing need. There have been no incidents of retaliation during the 12 months preceding the audit.

Provision (d):

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

The APC indicated status checks would be initiated with staff and residents. The Policy states periodic status will occur. The Retaliation Status Checklist would be used to document the status checks as well as the Retaliation Monitoring Checklist to document the ongoing monitoring and use of the Retaliation Status Checklist.

Provision (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.

The Policy states if any other individual who cooperates with an investigation expresses the occurrence retaliation from another resident or staff member, HCBC shall take appropriate measures to protect that individual against retaliation.

Provision (f):

An agency's obligation to monitor shall terminate if the agency determines that the allegation is unfounded.

The HCBC Policy states the facility's obligation to monitor shall terminate if it is determined that the allegation is unfounded.

Conclusion:

Based upon the review and analysis of the available evidence, the Auditor has determined the facility is compliant with this standard regarding agency protection against retaliation

INVESTIGATIONS

Standard 115.271: Criminal and administrative agency investigations

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.271 (a)

- When the agency conducts its own investigations into allegations of sexual abuse and sexual harassment, does it do so promptly, thoroughly, and objectively? [N/A if the agency/facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations. See 115.221(a).] Yes No NA

- Does the agency conduct such investigations for all allegations, including third party and anonymous reports? [N/A if the agency/facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations. See 115.221(a).] Yes No NA

115.271 (b)

- Where sexual abuse is alleged, does the agency use investigators who have received specialized training in sexual abuse investigations as required by 115.234? Yes No

115.271 (c)

- Do investigators gather and preserve direct and circumstantial evidence, including any available physical and DNA evidence and any available electronic monitoring data? Yes No

- Do investigators interview alleged victims, suspected perpetrators, and witnesses? Yes No

- Do investigators review prior reports and complaints of sexual abuse involving the suspected perpetrator? Yes No

115.271 (d)

- When the quality of evidence appears to support criminal prosecution, does the agency conduct compelled interviews only after consulting with prosecutors as to whether compelled interviews may be an obstacle for subsequent criminal prosecution? Yes No

115.271 (e)

- Do agency investigators assess the credibility of an alleged victim, suspect, or witness on an individual basis and not on the basis of that individual's status as resident or staff?
 Yes No
- Does the agency investigate allegations of sexual abuse without requiring a resident who alleges sexual abuse to submit to a polygraph examination or other truth-telling device as a condition for proceeding? Yes No

115.271 (f)

- Do administrative investigations include an effort to determine whether staff actions or failures to act contributed to the abuse? Yes No
- Are administrative investigations documented in written reports that include a description of the physical evidence and testimonial evidence, the reasoning behind credibility assessments, and investigative facts and findings? Yes No

115.271 (g)

- Are criminal investigations documented in a written report that contains a thorough description of the physical, testimonial, and documentary evidence and attaches copies of all documentary evidence where feasible? Yes No

115.271 (h)

- Are all substantiated allegations of conduct that appears to be criminal referred for prosecution?
 Yes No

115.271 (i)

- Does the agency retain all written reports referenced in 115.271(f) and (g) for as long as the alleged abuser is incarcerated or employed by the agency, plus five years? Yes No

115.271 (j)

- Does the agency ensure that the departure of an alleged abuser or victim from the employment or control of the agency does not provide a basis for terminating an investigation?
 Yes No

115.271 (k)

- Auditor is not required to audit this provision.

115.271 (I)

- When an outside entity investigates sexual abuse, does the facility cooperate with outside investigators and endeavor to remain informed about the progress of the investigation? [N/A if an outside agency does not conduct administrative or criminal sexual abuse investigations. See 115.221(a).] Yes No NA

Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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Documents Reviewed:

Facility Policy 13.1 Prevention Planning Procedures
MOU, Kansas City Missouri Police Division
MOSCO Sexual Assault Protocol for Adolescent and Adult Victims

Interviews:

Investigative Staff (2)
Director
Random Staff
PREA Coordinator

Provision (a):

When the agency conducts its own investigations into allegations of sexual abuse and sexual harassment, it shall do so promptly, thoroughly, and objectively for all allegations, including third-party and anonymous reports.

Policy 13.1 states any time an allegation of sexual abuse is received, including third-party reports or anonymous reports, the Kansas City Police Division will be notified to conduct the criminal investigation and collect evidence. Resident allegations of sexual harassment by staff will also be referred to the Police Division. The facility-based investigators will conduct investigations for allegations of sexual harassment by residents. The Policy addresses the provisions of the standard and the interviews of the two investigators were aligned with the Policy and standard. There have been no allegations of sexual abuse or sexual harassment during this audit period. The investigations will be conducted promptly as evidenced through a review of the Policies and staff interviews.

Provision (b):

Where sexual abuse is alleged, the agency shall use investigators who have received special training in sexual abuse investigations involving juvenile victims pursuant to § 115.334.

The facility has a MOU with the Kansas City Police Division to conduct criminal investigations. A letter from the Chief of Police provides information regarding the experience and training of investigators who may conduct investigations at the facility. The APC provided documentation that support the training and qualifications for the Police Division investigators to conduct investigations regarding allegations of sexual abuse deemed to be criminal in nature.

Provision (c):

Investigators 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.

The APC has received additional training in conducting investigations as confirmed by a review of training certificates, training log, and training curriculum. The online training course provided by the National Institute of Corrections, specifically addresses conducting administrative investigations in confinement settings as confirmed by the staff interviews and the documents reviewed.

Provision (d):

The agency shall not terminate an investigation solely because the source of the allegation recants the allegation.

HCBC Policy provides that an investigation will not be terminated solely because the source recants the allegation. The interviews confirmed what the practice will be in accordance with the Policy and standard.

Provision (e):

When the quality of evidence appears to support criminal prosecution, the agency shall conduct compelled interviews only after consulting with prosecutors as to whether compelled interviews may be an obstacle for subsequent criminal prosecution.

Investigations that are criminal in nature are investigated by the Kansas City Missouri Police Division as determined by staff interviews and Policy 3.11, supports this provision.

Provision (f):

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. No agency shall 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.

HCBC Policy states the credibility of an alleged victim, suspect, or witness shall be assessed on an individual basis and not be determined by the person's status as a resident or staff. Additionally, no resident who alleges sexual abuse will be subjected to a polygraph examination or other truth telling device as a condition for proceeding with the investigation of the allegation. The interviews with the facility-based investigators support the Policy.

Provision (g):

Administrative investigations:

- (1) Shall include an effort to determine whether staff actions or failures to act contributed to the abuse; and
- (2) Shall be documented in written reports that include a description of the physical and testimonial evidence, the reasoning behind credibility assessments, and investigative facts and findings.

The Policies, interviews and training documentation are inclusive of this provision of the standard. Administrative staff members have been identified as PREA Coordinator, Director, Assistant Director, and Security Supervisors. The Policy provides for the investigators to be trained. The APC and the assistant PREA Coordinator have received the regular PREA training as evident through documentation. The online training course provided by the National Institute of Corrections, specifically addresses conducting administrative investigations in confinement settings, including the provisions of the standard, as confirmed by the staff interviews.

Provision (h):

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.

The MOU with the Kansas City Missouri Police Division confirms the appropriate training received by the Division's investigators and their experience to conduct a professional investigation. No criminal investigations have been conducted at the facility during this audit period. HCBC shall conduct an internal administrative investigation if the law enforcement agency determines the allegation of sexual abuse or sexual harassment is not criminal and chooses not to investigate the matter. In such a case, the Vice President, DCS shall request authorization that any contractors (Missouri Department of Corrections, as applicable), promptly initiate an investigation into the report of non-criminal sexual abuse and/or allow HCBC to conduct an internal administrative investigation.

Provision (i):

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

The Policy provides that all criminal investigations are referred to and conducted by the Kansas City Missouri Police Division. The Police Division is responsible for referring for prosecution based on the outcome of the investigation. Policy 3.11 is inclusive of this provision of the standard.

Provision (j):

The agency shall retain all written reports referenced in paragraphs (g) and (h) of this section for as long as the alleged abuser is incarcerated or employed by the agency, plus five years, unless the abuse was committed by a juvenile resident and applicable law requires a shorter period of retention.

HCBC Policy states all reports shall be retained while the abuser is incarcerated or employed by the agency, plus five years, unless applicable law requires a shorter period of retention.

Provision (k):

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

Policy 3.11 provides and interviews support that the departure of the alleged abuser or victim from employment or control of HCBC shall not provide a basis for terminating an investigation, which was also supported by interviews.

Provision (l):

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

HCBC Policy states staff shall cooperate with any outside investigators and shall remain informed about the progress of the investigation. According to the Director, the case number is provided when an outside investigation is conducted so that follow-up can occur as needed. There have not been any allegations of sexual abuse during this audit period.

Conclusion:

Based upon the review and analysis of the available evidence, the Auditor has determined the facility is compliant with this standard regarding criminal and administrative agency investigations.

Standard 115.272: Evidentiary standard for administrative investigations

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.272 (a)

- Is it true that the agency does not impose a standard higher than a preponderance of the evidence in determining whether allegations of sexual abuse or sexual harassment are substantiated? Yes No

Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documents Reviewed:

Facility Policy 13.1 Prevention Planning Procedures

Interviews:

APC
Investigative Staff (2)

Provision (i): §115.272

The agency shall impose no standard higher than a preponderance of the evidence in determining whether allegations of sexual abuse or sexual harassment are substantiated.

HCBC Policy 13.7 states the facility shall impose no standard higher than a preponderance of the evidence in determining whether allegations of sexual abuse or sexual harassment are substantiated. The interviews with the two facility-based investigators, Counselor and Intake Coordinator, were aligned with the Policy.

Conclusion:

Based upon the review and analysis of the available evidence and the interviews, the Auditor has determined the facility is compliant with this standard regarding evidentiary standard for administrative investigations.

Standard 115.273: Reporting to residents

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.273 (a)

- Following an investigation into a resident's allegation that he or she suffered sexual abuse in an agency facility, does the agency inform the resident as to whether the allegation has been determined to be substantiated, unsubstantiated, or unfounded? Yes No

115.273 (b)

- If the agency did not conduct the investigation into a resident's allegation of sexual abuse in an agency facility, does the agency request the relevant information from the investigative agency in order to inform the resident? (N/A if the agency/facility is responsible for conducting administrative and criminal investigations.) Yes No NA

115.273 (c)

- Following a resident's allegation that a staff member has committed sexual abuse against the resident, unless the agency has determined that the allegation is unfounded, or unless the resident has been released from custody, does the agency subsequently inform the resident whenever: The staff member is no longer posted within the resident's unit? Yes No
- Following a resident's allegation that a staff member has committed sexual abuse against the resident, unless the agency has determined that the allegation is unfounded, or unless the resident has been released from custody, does the agency subsequently inform the resident whenever: The staff member is no longer employed at the facility? Yes No
- Following a resident's allegation that a staff member has committed sexual abuse against the resident, unless the agency has determined that the allegation is unfounded, or unless the resident has been released from custody, does the agency subsequently inform the resident whenever: The agency learns that the staff member has been indicted on a charge related to sexual abuse in the facility? Yes No
- Following a resident's allegation that a staff member has committed sexual abuse against the resident, unless the agency has determined that the allegation is unfounded, or unless the resident has been released from custody, does the agency subsequently inform the resident whenever: The agency learns that the staff member has been convicted on a charge related to sexual abuse within the facility? Yes No

115.273 (d)

- Following a resident's allegation that he or she has been sexually abused by another resident, does the agency subsequently inform the alleged victim whenever: The agency learns that the alleged abuser has been indicted on a charge related to sexual abuse within the facility?
 Yes No

- Following a resident's allegation that he or she has been sexually abused by another resident, does the agency subsequently inform the alleged victim whenever: The agency learns that the alleged abuser has been convicted on a charge related to sexual abuse within the facility?
 Yes No

115.273 (e)

- Does the agency document all such notifications or attempted notifications? Yes No

115.273 (f)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documents Reviewed:

Facility Policy 13.1 Prevention Planning Procedures
 Residents Notification of Findings form

Interviews:

Investigative Staff
 Director
 PREA Coordinator

Provision (a):

Following an investigation into a resident's allegation of sexual abuse suffered in an agency facility, the agency shall inform the resident as to whether the allegation has been determined to be substantiated, unsubstantiated, or unfounded.

Facility Policy addresses the resident being informed by staff when the investigation is completed, informed of the outcome of the investigation, and the documentation of the notification. The Director and the APC will remain abreast of an investigation conducted by any of the investigative entities by serving as the primary contact person(s), as determined by the interviews. The HCBC Policy provides that any resident who makes an allegation of sexual abuse shall be informed verbally by the Director or Counselor and in writing following an investigation, as to whether or not the allegation was substantiated, unsubstantiated, or unfounded.

Provision (b):

If the agency did not conduct the investigation, it shall request the relevant information from the investigative agency in order to inform the resident.

The HCBC Policy states the facility shall request all relevant information from the investigating agency in order to inform the resident of the outcome of the investigation.

Provision (c):

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

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

The Policy requires that following a resident's allegation that a staff member committed sexual abuse against the resident, the resident will be informed of the following, unless it has been determined that the allegation is unfounded, whenever:

- a. The staff member is no longer assigned within the resident's housing unit;
- b. The staff member is no longer employed at the facility;
- c. The staff member has been indicted on a charge related to sexual abuse within HCBC; or
- d. The staff member has been convicted on a charge related to sexual abuse within the facility.

Provision (d):

Following a resident's allegation that he or she has been sexually abused by another resident, the agency shall subsequently inform the alleged victim whenever:

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

The Policy provides that following a resident's allegation that he has been sexually abused by another resident, the alleged victim shall be subsequently informed whenever:

- a. The alleged abuser is criminally charged related to the sexual abuse; or
- b. The alleged abuser is adjudicated on a charge related to sexual abuse.

Provision (e):

All such notifications or attempted notifications shall be documented.

The Policy provides that all such notifications or attempted notifications be documented. The HCBC Resident Notification of Findings form has been created and would serve to notify the resident, in writing, regarding the provisions of this standard. HCBC policy 13.7 discusses this procedure for this standard, they provided examples of the follow up after an incident. Following an investigation into an offender's allegation of sexual abuse at HCBC, the APC shall inform the offender as to whether the allegation has been determined to be substantiated, unsubstantiated, or unfounded.

Provision (f):

An agency's obligation to report under this standard shall terminate if the resident is released from the agency's custody.

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

Conclusion:

The interviews with the identified staff confirm the Policy requirements and their knowledge of the process of reporting to a resident regarding the outcomes of an allegation of sexual abuse. Based on the review and analysis of the available documentation and interviews, the Auditor has determined the facility is compliant with this standard regarding reporting to residents.

DISCIPLINE

Standard 115.276: Disciplinary sanctions for staff

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.276 (a)

- Are staff subject to disciplinary sanctions up to and including termination for violating agency sexual abuse or sexual harassment policies? Yes No

115.276 (b)

- Is termination the presumptive disciplinary sanction for staff who have engaged in sexual abuse? Yes No

115.276 (c)

- Are disciplinary sanctions for violations of agency policies relating to sexual abuse or sexual harassment (other than actually engaging in sexual abuse) 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? Yes No

115.276 (d)

- Are all terminations for violations of agency sexual abuse or sexual harassment policies, or resignations by staff who would have been terminated if not for their resignation, reported to: Law enforcement agencies unless the activity was clearly not criminal? Yes No
- Are all terminations for violations of agency sexual abuse or sexual harassment policies, or resignations by staff who would have been terminated if not for their resignation, reported to: Relevant licensing bodies? Yes No

Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)

Does Not Meet Standard (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documents Reviewed:

Facility Policy 13.1 Prevention Planning Procedures

Interview:

Director
APC

Provision (a):

Staff shall be subject to disciplinary sanctions up to and including termination for violating agency sexual abuse or sexual harassment policies.

HCBC Policy provides that staff be subject to disciplinary sanctions up to and including termination for violating facility sexual abuse or sexual harassment policies. The interview with the Director, who performs personnel duties, confirmed the Policy.

Provision (b):

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

The Policy states that termination shall be the presumptive disciplinary sanction for staff who has engaged in sexual abuse with a resident as confirmed by the Director.

Provision (c):

Disciplinary sanctions for violations of agency policies relating to sexual abuse or sexual harassment (other than engaging in sexual abuse) shall be 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.

HCBC Policy provides that disciplinary sanctions for violations of HCBC policies relating to sexual abuse or sexual harassment (other than engaging in sexual abuse) shall be 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. Additionally, the Policy states all employee discipline and termination are governed solely by At Will employee law.

Provision (d):

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

HCBC Policy states all terminations for violations of the facility's sexual abuse or sexual harassment policies, or staff resignations related to violations of this policy, shall be reported to law enforcement, unless the activity is clearly not criminal. In addition, it shall be reported to relevant licensing bodies. HCBC staff shall be subject to disciplinary sanctions up to and including termination for violating HCBC sexual abuse or sexual harassment policies.

Termination shall be the presumptive disciplinary sanction for staff who has engaged in sexual abuse. Disciplinary sanctions for violations of HCBC policies relating to sexual abuse or sexual harassment (other than actually engaging in sexual abuse) shall be 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.

All staff terminations for violations of HCBC sexual abuse or sexual harassment policies, or resignations by staff who would have been terminated if not for their resignation, shall be reported to law enforcement agencies, unless the activity was clearly not criminal. In all cases, the termination of staff pursuant to HCBC's zero tolerance policy shall also be reported to the representative of the contractor and to relevant licensing bodies.

Conclusion:

Based upon the review of Policy and interview, the Auditor has determined the facility is compliant with this standard regarding disciplinary sanctions for staff. HCBC policy 13.8 cover this standard. They had no incidents to report.

Standard 115.277: Corrective action for contractors and volunteers

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.277 (a)

- Is any contractor or volunteer who engages in sexual abuse prohibited from contact with residents? Yes No
- Is any contractor or volunteer who engages in sexual abuse reported to: Law enforcement agencies unless the activity was clearly not criminal? Yes No
- Is any contractor or volunteer who engages in sexual abuse reported to: Relevant licensing bodies? Yes No

115.277 (b)

- In the case of any other violation of agency sexual abuse or sexual harassment policies by a contractor or volunteer, does the facility take appropriate remedial measures, and consider whether to prohibit further contact with residents? Yes No

Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documents Reviewed:

Facility Policy 13.8, PREA: Corrective Action for Contractors and Volunteers

Interviews:

Contractor

APC

Director

Provision (a):

Any contractor or volunteer who engages in sexual abuse shall be prohibited from contact with residents and shall be reported to law enforcement agencies, unless the activity was clearly not criminal, and to relevant licensing bodies.

The Policy provides for contractors and volunteers who engage in sexual abuse to be reported to law enforcement and to relevant licensing bodies. Training records revealed the facility provides volunteers and contractors a clear understanding that sexual misconduct with a resident is strictly prohibited. During this audit period, there have been no allegations of sexual abuse or sexual harassment regarding a contractor or volunteer

Provision (b):

The facility shall take appropriate remedial measures and shall consider whether to prohibit further contact with residents, in the case of any other violation of agency sexual abuse or sexual harassment policies by a contractor or volunteer.

The Policy states the Director will take appropriate remedial measures and consider whether to prohibit further contact with residents in the case of any other violation of the sexual abuse and sexual harassment policies by a contractor or volunteer.

Conclusion:

Based upon the review and analysis of the available documentation, the Auditor has determined the facility is in compliant with this standard regarding corrective action for contractors and volunteers.

Standard 115.278: Interventions and disciplinary sanctions for residents

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.278 (a)

- Following an administrative finding that a resident engaged in resident-on-resident sexual abuse, or following a criminal finding of guilt for resident-on-resident sexual abuse, are residents subject to disciplinary sanctions pursuant to a formal disciplinary process? Yes No

115.278 (b)

- Are sanctions 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? Yes No

115.278 (c)

- When determining what types of sanction, if any, should be imposed, does the disciplinary process consider whether a resident's mental disabilities or mental illness contributed to his or her behavior? Yes No

115.278 (d)

- If the facility offers therapy, counseling, or other interventions designed to address and correct underlying reasons or motivations for the abuse, does the facility consider whether to require the offending resident to participate in such interventions as a condition of access to programming and other benefits? Yes No

115.278 (e)

- Does the agency discipline a resident for sexual contact with staff only upon a finding that the staff member did not consent to such contact? Yes No

115.278 (f)

- For the purpose of disciplinary action does a report of sexual abuse made in good faith based upon a reasonable belief that the alleged conduct occurred NOT constitute falsely reporting an incident or lying, even if an investigation does not establish evidence sufficient to substantiate the allegation? Yes No

115.278 (g)

- Does the agency always refrain from considering non-coercive sexual activity between residents to be sexual abuse? (N/A if the agency does not prohibit all sexual activity between residents.)
 Yes No NA

Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Document Reviewed:

Facility Policy 13.1 Prevention Planning Procedures

Interviews:

Director

APC

Provision (a):

A resident may be 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 or following a criminal finding of guilt for resident-on-resident sexual abuse.

The Policy addresses an administrative process for dealing with rule violations and references the policy that deals with discipline. Sanctions are directly related to the seriousness of the negative behavior. The interview with the Director revealed the process regarding allegations of resident-on-resident abuse which can include the resident being removed from the facility and placed in the detention center during the investigation by law enforcement.

Provision (b):

Any disciplinary 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. In the event a disciplinary sanction results in the isolation of a resident, agencies shall not deny the resident daily large-muscle exercise or access to any legally required educational programming or special education services. Residents in isolation shall receive daily visits from a medical or mental health care clinician. Residents shall also have access to other programs and work opportunities to the extent possible.

HCBC Policy provides that disciplinary sanctions are 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. In the extreme event a disciplinary sanction results in the isolation of a resident, HCBC shall not deny the resident daily large-muscle exercise or access to any legally required educational programming or special education services. Policy further provides for daily visits by mental health and medical personnel.

Provision (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.

The HCBC Policy provides that the disciplinary process considers 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. This was confirmed by the interview with the Director.

Provision (d):

If the facility offers therapy, counseling, or other interventions designed to address and correct underlying reasons or motivations for the abuse, the facility shall consider whether to offer the offending resident participation in such interventions. The agency may require participation in such interventions as a condition of access to any rewards-based behavior management system or other behavior-based incentives, but not as a condition to access to general programming or education.

HCBC Policy provides the facility considers whether to offer the offending resident therapy, counseling, or other interventions designed to address and correct underlying reasons or motivations for the abuse participation. The facility may require participation in such interventions as a condition of access to privileges, but not as a condition to access to general programming or education.

Provision (e):

The agency may discipline a resident for sexual contact with staff only upon a finding that the staff member did not consent to such contact.

HCBC Policy provides the facility may discipline a resident for sexual contact with staff only upon finding that the staff member did not consent to such contact.

Provision (f):

For the purpose of disciplinary action, a report of sexual abuse made in good faith based upon a reasonable belief that the alleged conduct occurred shall not constitute falsely reporting an incident or lying, even if an investigation does not establish evidence sufficient to substantiate the allegation.

The HCBC Policy states a report of sexual abuse made in good faith based upon a reasonable belief that the alleged conduct occurred shall not constitute falsely reporting an incident or lying, even if an investigation does not establish evidence sufficient to substantiate the allegation.

Provision (g):

An agency may, in its discretion, prohibit all sexual activity between residents and may discipline residents for such activity. An agency may not, however, deem such activity to constitute sexual abuse if it determines that the activity is not coerced.

The Policy prohibits any sexual conduct between residents. All such conduct is subject to disciplinary action. Court processes occur after determination the sexual activity was coerced.

Conclusion:

There have been no residents placed in isolation as a disciplinary sanction for sexual abuse in the past 12 months. Additionally, there have been no administrative or criminal findings of resident-on-resident sexual abuse in the past 12 months. Based upon the review and analysis of the available documentation, the Auditor determined the facility is compliant with this standard regarding interventions and disciplinary sanctions for residents.

MEDICAL AND MENTAL CARE

Standard 115.282: Access to emergency medical and mental health services

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.282 (a)

- Do resident victims of sexual abuse receive timely, unimpeded access to emergency medical treatment and crisis intervention services, the nature and scope of which are determined by medical and mental health practitioners according to their professional judgment?
 Yes No

115.282 (b)

- If no qualified medical or mental health practitioners are on duty at the time a report of recent sexual abuse is made, do security staff first responders take preliminary steps to protect the victim pursuant to § 115.262? Yes No

- Do security staff first responders immediately notify the appropriate medical and mental health practitioners? Yes No

115.282 (c)

- Are resident victims of sexual abuse 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? Yes No

115.282 (d)

- Are treatment services 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? Yes No

Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documentation Reviewed:

Facility Policy 13.1 Prevention Planning Procedures
Intake Screening Receiving notes
Case Managers Case Note
Informed Consent Form

Interviews:

Staff Responsible for Risk Screening
Medical Practitioners
Mental Health Practitioners

Provision (a) and (b):

If the screening pursuant to § 115.341 indicates that a resident has experienced prior sexual victimization, whether it occurred in an institutional setting or in the community, staff shall ensure that the resident is offered a follow-up meeting with a medical or mental health practitioner within 14 days of the intake screening. Provision (b): If the screening pursuant to § 115.341 indicates that a resident has previously perpetrated sexual abuse, whether it occurred in an institutional setting or in the community, staff shall ensure that the resident is offered a follow-up meeting with a mental health practitioner within 14 days of the intake screening. This standard is covered under HCBC policy 13.9. They did not have any examples as these services have not been needed. Treatment services shall be 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.

The Policy provides that a resident who indicates during initial screening that they were a victim or perpetrator of sexual abuse shall be offered a follow-up visit with medical or mental health staff within 14 days of the intake screening. A review of documentation, including Counselor Case Notes, demonstrates residents are offered follow-up meetings in a timely manner, prior to the 14 days. This information was also confirmed through the interview with the Intake Coordinator.

Provision (c):

Any information related to sexual victimization or abusiveness that occurred in an institutional setting shall be strictly limited to medical and mental health practitioners and other staff, as necessary, to inform treatment plans and security and management decisions, including housing, bed, work, education, and program assignments, or as otherwise required by Federal, State, or local law.

The Policy supports that any information related to sexual victimization or abusiveness that occurred in an institutional setting shall be strictly limited to medical and mental health practitioners and other staff, as necessary, to inform treatment plans and security and management decisions, including housing, bed, work, education, and program assignments, or as otherwise required by Federal, State, or local law. The Auditor observed the resident files maintained in a secure manner. The files are secured in a locked cabinet behind a locked door, when the office is unoccupied. The files have a list of individuals that have access to them.

Provision (d):

Medical and mental health practitioners shall obtain informed consent from residents before reporting information about prior sexual victimization that did not occur in an institutional setting, unless the resident is under the age of 18.

The Policy provides that medical and mental health practitioners shall obtain informed consent from residents before reporting information about prior sexual victimization that did not occur in an institutional setting, unless the resident is under the age of 18. The facility has created the Informed Consent form to document this type of situation.

Conclusion:

Based upon the review and analysis of the available evidence, the Auditor has determined the facility is compliant with this standard regarding medical and mental health screenings; and history of sexual abuse.

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

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.283 (a)

- Does the facility offer 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? Yes No

115.283 (b)

- Does the evaluation and treatment of such victims 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? Yes No

115.283 (c)

- Does the facility provide such victims with medical and mental health services consistent with the community level of care? Yes No

115.283 (d)

- Are resident victims of sexually abusive vaginal penetration while incarcerated offered pregnancy tests? (N/A if all-male facility.) Yes No NA

115.283 (e)

- If pregnancy results from the conduct described in paragraph § 115.283(d), do such victims receive timely and comprehensive information about and timely access to all lawful pregnancy-related medical services? (N/A if all-male facility.) Yes No NA

115.283 (f)

- Are resident victims of sexual abuse while incarcerated offered tests for sexually transmitted infections as medically appropriate? Yes No

115.283 (g)

- Are treatment services 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? Yes No

115.283 (h)

- Does the facility attempt to conduct a mental health evaluation of all known resident-on-resident abusers within 60 days of learning of such abuse history and offer treatment when deemed appropriate by mental health practitioners? Yes No

Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documents Reviewed:

Facility Policy 13.1 Prevention Planning Procedures

Vulnerability Assessment: Risk of Victimization and/or Sexual Aggressiveness

Interviews:

Medical Practitioners

Mental Health Providers

APC

Provision (a):

The facility shall offer 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.

The Policy requires that a medical and mental health evaluation and treatment be offered to resident victims of sexual abuse. According to the interviews, medical and mental health providers at local hospitals are aware of the Policy mandates. The Policy and interviews support medical and mental health evaluations and treatment will be offered to all residents who have been victimized by sexual abuse. Interviews with the clinical staff and observations confirmed on-going medical and mental health care will be provided as appropriate, including assessments and therapy.

Provision (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.

Interviews with the clinical staff and observations confirmed on-going medical and mental health care will be provided as appropriate and will include but not limited to additional testing and medical services; medication management, if prescribed; individual counseling; trauma group; and referrals as needed. The Policy states that follow-up services will be provided.

Provision (c):

The facility shall provide such victims with medical and mental health services consistent with the community level of care.

Facility Policy, staff interviews and observations revealed medical and mental health services are consistent with the community level of care.

Provision (d):

Resident victims of sexually abusive vaginal penetration while incarcerated shall be offered pregnancy tests.

Provision (e):

If pregnancy results from conduct specified in paragraph (d) of this section, such victims shall receive timely and comprehensive information about and timely access to all lawful pregnancy-related medical services.

Provision (f):

Resident victims of sexual abuse while incarcerated shall be offered tests for sexually transmitted infections as medically appropriate.

The Policy and interviews ensure that victims of sexual abuse will be provided tests for sexually transmitted infections as medically appropriate. Testing would be done at Wood County Hospital and follow-up services may be done at the facility, as needed.

Provision (g):

Treatment services shall be 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.

All treatment services will be provided at no cost to the victim, according to Policy and staff interviews.

Provision (h):

The facility shall attempt to conduct a mental health evaluation of all known resident-on-resident abusers within 60 days of learning of such abuse history and offer treatment when deemed appropriate by mental health practitioners.

Facility Policy provides for attempts to be made for a mental health practitioner to conduct a mental health evaluation within 60 days on all known resident-on-resident abusers and offer appropriate treatment by mental health staff. Services will include but not be limited to individual, group and family counseling. Additionally, an evaluation or reassessment will be administered utilizing the Vulnerability Assessment. The Counselor's interview supported the Policy.

Conclusion:

Based upon the review and analysis of the documentation, the Auditor has determined the facility is compliant with this standard regarding ongoing medical and mental health care for sexual abuse victims and abusers.

DATA COLLECTION AND REVIEW

Standard 115.286: Sexual abuse incident reviews

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.286 (a)

- Does the facility conduct a sexual abuse incident review at the conclusion of every sexual abuse investigation, including where the allegation has not been substantiated, unless the allegation has been determined to be unfounded? Yes No

115.286 (b)

- Does such review ordinarily occur within 30 days of the conclusion of the investigation? Yes No

115.286 (c)

- Does the review team include upper-level management officials, with input from line supervisors, investigators, and medical or mental health practitioners? Yes No

115.286 (d)

- Does the review team: Consider whether the allegation or investigation indicates a need to change policy or practice to better prevent, detect, or respond to sexual abuse? Yes No
- Does the review team: Consider whether the incident or allegation was motivated by race; ethnicity; gender identity; lesbian, gay, bisexual, transgender, or intersex identification, status, or perceived status; gang affiliation; or other group dynamics at the facility? Yes No
- Does the review team: Examine the area in the facility where the incident allegedly occurred to assess whether physical barriers in the area may enable abuse? Yes No
- Does the review team: Assess the adequacy of staffing levels in that area during different shifts? Yes No
- Does the review team: Assess whether monitoring technology should be deployed or augmented to supplement supervision by staff? Yes No
- Does the review team: Prepare a report of its findings, including but not necessarily limited to determinations made pursuant to §§ 115.286(d)(1) - (d)(5), and any recommendations for improvement and submit such report to the facility head and PREA compliance manager? Yes No

115.286 (e)

- Does the facility implement the recommendations for improvement, or document its reasons for not doing so? Yes No

Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documents Reviewed:

Facility Policy 13.1 Prevention Planning Procedures
Facility Policy 13.10, Sexual Abuse Incident Reviews
Post Incident Review form

Interviews:

Director

APC

Incident Review Team Member

Provision (a):

The facility shall conduct a sexual abuse incident review at the conclusion of every sexual abuse investigation, including where the allegation has not been substantiated, unless the allegation has been determined to be unfounded.

The Policy requires the facility to conduct a sexual abuse incident review at the conclusion of every sexual abuse investigation, including where the allegation has not been substantiated, unless the allegation has been deemed to be unfounded. The Director is familiar with the Policy requirements.

Provision (b):

Such review shall ordinarily occur within 30 days of the conclusion of the investigation.

The Policy requires that the reviews occur within 30 days of the conclusion of the investigation. Although there has not been an allegation of sexual abuse, the APC and Director confirmed incident reviews would occur within 30 days of the conclusion of an investigation in accordance with facility Policy and the standard.

Provision (c):

The review team shall include upper-level management officials, with input from line supervisors, investigators, and medical or mental health practitioners.

The Policy identifies the incident review team members as administrators with input from line supervisors, investigators, medical staff, and Counselors. The investigators from the Kansas City Missouri Police Division would be invited to the meeting, according to the Policy. The interview with the Director confirmed the Policy requirements.

Provision (d):

The review team shall: (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; and (6) Prepare a report of its findings, including but not necessarily limited to determinations made pursuant to paragraphs (d)(1)-(d)(5) of this section, and any recommendations for improvement and submit such report to the facility head and PREA compliance manager.

The Policy outlines the requirements of the standard for the areas to be assessed by the incident review team. The interview with the Director, review of Policy and documentation method confirmed the incident review team is charged with considering the factors identified in this standard provision regarding the results of the investigation, including: considering the make-up and vulnerability of the population such as gang affiliation; whether the resident identifies as gay, bisexual, transgender, or intersex; other group dynamics; assessment of the area relative to the allegations; and adequacy of staffing.

The Policy requires the meeting to be documented, including recommendations and the document provided to the Director. The interview with the PREA Coordinator/Incident Review Team Member confirmed the facility would prepare a report of its findings and any recommendations for improvement when conducting a sexual abuse incident review. She confirmed the team would consider all factors required by the standard. A sexual abuse incident review has not been conducted during this audit period.

Provision (e):

The facility shall implement the recommendations for improvement or shall document its reasons for not doing so.

The Policy states the administration shall implement the recommendations for improvement or shall document its reasons for not doing so. The Director is familiar with this Policy requirement. The form, Alleged Sexual Abuse & Sexual Assault Post-Incident Review, has been developed for documenting the incident review team meeting and it allows for documentation of the considerations of the standard. Additionally, the form provides for recommendations for improvement by the team members. There were no allegations of sexual abuse in the past 12 months.

Conclusion:

Based upon the review and analysis of the available documentation, the Auditor has determined the facility is compliant with this standard regarding sexual abuse incident reviews.

Standard 115.287: Data collection

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.287 (a)

- Does the agency collect accurate, uniform data for every allegation of sexual abuse at facilities under its direct control using a standardized instrument and set of definitions? Yes No

115.287 (b)

- Does the agency aggregate the incident-based sexual abuse data at least annually? Yes No

115.287 (c)

- Does the incident-based data include, 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? Yes No

115.287 (d)

- Does the agency maintain, review, and collect data as needed from all available incident-based documents, including reports, investigation files, and sexual abuse incident reviews? Yes No

115.287 (e)

- Does the agency also obtain incident-based and aggregated data from every private facility with which it contracts for the confinement of its residents? (N/A if agency does not contract for the confinement of its residents.) Yes No NA

115.287 (f)

- Does the agency, upon request, provide all such data from the previous calendar year to the Department of Justice no later than June 30? (N/A if DOJ has not requested agency data.)
 Yes No NA

Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documents Reviewed:

Facility Policy 13.1 Prevention Planning Procedures
HCBC PREA Data (Annual Report)
Instrument with Definitions

Interviews:

PREA Coordinator
Director

Provisions (a) & (c):

The agency shall collect accurate, uniform data for every allegation of sexual abuse at facilities under its direct control using a standardized instrument and set of definitions. The incident-based data collected shall include, 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.

The Policy requires the use of a standardized instrument with definitions to collect accurate, uniform data for every allegation of sexual abuse. A review of the PREA Data document demonstrates that it includes data necessary to answer all questions from the most recent version of the Survey of Sexual Violence conducted by the U. S. Department of Justice.

Provision (b):

The agency shall aggregate the incident-based sexual abuse data at least annually.

The Policy and review of the annual report and data gathering instrument and other documents confirm the facility collects incident-based, uniform data regarding allegations of sexual abuse and sexual harassment. A standardized instrument and specific guidelines and definitions are used to assist in identifying the data.

Provision (d):

The agency shall maintain, review, and collect data as needed from all available incident-based documents, including reports, investigation files, and sexual abuse incident reviews. The facility provided the auditors

examples of reports, the actions taken why investigating the report and the results of the investigations. They have the procedures in HCBC policy 13.10.

The facility maintains and collects various types of identified data and related documents regarding PREA. The facility collects and maintains data in accordance with Policy directives and Ohio Department of Juvenile Justice and aggregates the data which culminates into an annual report.

Provision (e):

The agency also shall obtain incident-based and aggregated data from every private facility with which it contracts for the confinement of its residents.

HCBC does contract with outside facilities for confinement of its residents.

Provision (f):

Upon request, the agency shall provide all such data from the previous calendar year to the Department of Justice no later than June 30.

The Policy states that upon request, HCBC shall provide all such data from the previous calendar year to the Department of Justice no later than June 30. A request was not made for the previous calendar year.

Conclusion:

Based upon the review and analysis of the documentation, the Auditor has determined the facility is compliant with this standard regarding data collection.

Standard 115.288: Data review for corrective action

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.288 (a)

- Does the agency review 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, practices, and training, including by: Identifying problem areas? Yes No
- Does the agency review 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, practices, and training, including by: Taking corrective action on an ongoing basis? Yes No
- Does the agency review 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, practices, and training, including by: Preparing an annual report of its findings and corrective actions for each facility, as well as the agency as a whole? Yes No

115.288 (b)

- Does the agency's annual report include a comparison of the current year's data and corrective actions with those from prior years and provide an assessment of the agency's progress in addressing sexual abuse? Yes No

115.288 (c)

- Is the agency's annual report approved by the agency head and made readily available to the public through its website or, if it does not have one, through other means? Yes No

115.288 (d)

- Does the agency indicate the nature of the material redacted where it redacts specific material from the reports when publication would present a clear and specific threat to the safety and security of a facility? Yes No

Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documents Reviewed:

Facility Policy 13.1 Prevention Planning Procedures
HCBC PREA Data (Annual Report)

Interviews:

Director
PREA Coordinator

The Policy requires the review of data collected and aggregated in order to improve the PREA efforts. The interviews revealed the collected and aggregated data is reviewed to assess and improve the effectiveness of the PREA related initiatives by identifying problem areas; developing and implementing corrective actions where needed; and preparing an annual report based on the collected data. The interviews supported the provisions of the Policy and the standard. The Policy also indicates an annual report will be prepared that will provide information regarding the facility's corrective actions in addressing sexual abuse.

The annual report is approved as required by Policy, per the interviews and a review of the report was conducted by the Auditor. The annual report reflects a comparison of the results of annual data, by calendar year. The annual report has been reviewed and the report is accessible to the public through the facility's website. There are no personal identifiers on the annual report.

HCBC policy dictates information is reviewed and actions are taken based on the review. He showed the auditors where they had reviewed incidents that had occurred at their facility and the actions they took based on the review.

Conclusion:

Based upon the review and analysis of the documentation, the Auditor has determined the facility is compliant with this standard regarding data review for corrective action.

Standard 115.289: Data storage, publication, and destruction

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.289 (a)

- Does the agency ensure that data collected pursuant to § 115.287 are securely retained?
 Yes No

115.289 (b)

- Does the agency make all aggregated sexual abuse data, from facilities under its direct control and private facilities with which it contracts, readily available to the public at least annually through its website or, if it does not have one, through other means? Yes No

115.289 (c)

- Does the agency remove all personal identifiers before making aggregated sexual abuse data publicly available? Yes No

115.289 (d)

- Does the agency maintain sexual abuse data collected pursuant to § 115.287 for at least 10 years after the date of the initial collection, unless Federal, State, or local law requires otherwise? Yes No

Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Documents Reviewed:

Facility Policy 13.1 Prevention Planning Procedures
HCBC PREA Data (Annual Report)

Interviews:

Director
PREA Coordinator

The Policy provides that all data collected will be securely stored and maintained for at least 10 years after the initial collection date, unless State or local statutes require otherwise. According to the facility Policy, the aggregated sexual abuse data will be readily available to the public through the agency's website; the practice is that the report is posted on the agency's website. A review of the annual report verified there are no personal identifiers and it was observed posted on the website, as required. Related documentation in the facility was observed to be securely stored.

Conclusion:

Based upon the review and analysis of the documentation, interviews and observations, the Auditor has determined the facility is compliant with this standard regarding data storage, publication, and destruction.

AUDITING AND CORRECTIVE ACTION

Standard 115.401: Frequency and scope of audits

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.401 (a)

- During the prior three-year audit period, did the agency ensure that each facility operated by the agency, or by a private organization on behalf of the agency, was audited at least once? (*Note: The response here is purely informational. A "no" response does not impact overall compliance with this standard.*) Yes No

115.401 (b)

- Is this the first year of the current audit cycle? (*Note: a "no" response does not impact overall compliance with this standard.*) Yes No
- If this is the second year of the current audit cycle, did the agency ensure that at least one-third of each facility type operated by the agency, or by a private organization on behalf of the agency, was audited during the first year of the current audit cycle? (N/A if this is **not** the *second* year of the current audit cycle.) Yes No NA
- If this is the third year of the current audit cycle, did the agency ensure that at least two-thirds of each facility type operated by the agency, or by a private organization on behalf of the agency, were audited during the first two years of the current audit cycle? (N/A if this is **not** the *third* year of the current audit cycle.) Yes No NA

115.401 (h)

- Did the auditor have access to, and the ability to observe, all areas of the audited facility?
 Yes No

115.401 (i)

- Was the auditor permitted to request and receive copies of any relevant documents (including electronically stored information)? Yes No

115.401 (m)

- Was the auditor permitted to conduct private interviews with inmates, residents, and detainees? Yes No

115.401 (n)

- Were residents permitted to send confidential information or correspondence to the auditor in the same manner as if they were communicating with legal counsel? Yes No

Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

PREA audits for the facility have been conducted as required for the initial three-year period. The facility, in conjunction with the Ohio Department of Youth Services, has embarked on fulfilling the auditing requirements for this second three-year period. The facility has provided the Auditor with the required documentation which have maintained as required by the standards and the auditing process.

A comprehensive site review was provided to the auditors during the site visit and additional documentation was reviewed during the site visit. The staff members were cooperative in providing additional documentation as requested. The Director provided appropriate work spaces which included conditions for conducting interviews in private with the residents and staff.

The posted notices regarding the audit were observed throughout the facility, accessible to residents; staff; visitors; contractors; and volunteers. The notices provided directions and contact information informing those who wanted to contact the Auditor of how to do so. No correspondence was received by the Auditor.

Standard 115.40a: Frequency and scope of audits states that during the three-year period starting on August 20, 2013, and during each three-year period thereafter, the agency ensures that each facility operated by the agency, or by a private organization on behalf of the agency, was audited at least once. All final reports are posted on the agency website. During this audit, the Auditor had access to previous audits, and had the ability to observe all areas of the audited facility. The Auditor received copies of any relevant documents (including electronically-stored information) requested and was able to conduct private interviews with staff and residents. The Auditor received confidential information and correspondence from residents in

the same manner as if they were communicating with legal counsel. A review of documentation and interviews with the Administrative and the PREA Manager support the finding that this facility is in compliance with this standard.

Standard 115.403: Audit contents and findings

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.403 (f)

- The agency has published on its agency website, if it has one, or has otherwise made publicly available, all Final Audit Reports within 90 days of issuance by auditor. The review period is for prior audits completed during the past three years PRECEDING THIS AGENCY AUDIT. In the case of single facility agencies, the auditor shall ensure that the facility's last audit report was published. The pendency of any agency appeal pursuant to 28 C.F.R. § 115.405 does not excuse noncompliance with this provision. (N/A if there have been no Final Audit Reports issued in the past three years, or in the case of single facility agencies that there has never been a Final Audit Report issued.) Yes No NA

Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

This facility was previously audited in 2015 and the Auditor confirmed the audit report was posted on the agency's website as is the practice with the facility. This report does not contain any personal identifying information and there were no conflicts of interest regarding the completion of the audit. The facility policies and other documentation were reviewed regarding compliance with the standards and have been identified in the report. The audit findings were based on a review of policies and procedures and supporting documentation; interviews with staff, residents, contractors and a volunteer; and observations.

The agency has published on its agency website and has otherwise made publicly available, all Final Audit Reports within 90 days of issuance by auditor. The review period is for prior audits completed during the past three years starting January 2014 through December 2017. The pendency of any agency appeal pursuant to 28 C.F.R. § 115.405 does not excuse noncompliance with this provision.

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

Auditor Instructions:

Type your full name in the text box below for Auditor Signature. This will function as your official electronic signature. Auditors must deliver their final report to the PREA Resource Center as a searchable PDF format to ensure accessibility to people with disabilities. Save this report document into a PDF format prior to submission.¹ Auditors are not permitted to submit audit reports that have been scanned.² See the PREA Auditor Handbook for a full discussion of audit report formatting requirements.

Dwight L. Fondren

September 6, 2018

Auditor Signature

Date

¹ See additional instructions here: <https://support.office.com/en-us/article/Save-or-convert-to-PDF-d85416c5-7d77-4fd6-a216-6f4bf7c7c110>.

² See *PREA Auditor Handbook*, Version 1.0, August 2017; Pages 68-69.