

**PREA AUDIT REPORT Interim Final
COMMUNITY CONFINEMENT FACILITIES**

Date of report: July 29, 2016

Auditor Information			
Auditor name: Wendy J. Roal Warner			
Address: 2693 Shadywood Road, Excelsior, MN 55331			
Email: wjrw62@msn.com			
Telephone number: (309) 241-0796			
Date of facility visit: July 7-8, 2016			
Facility Information			
Facility name: St. Louis Community Release Center			
Facility physical address: 1621 N. 1 st Street, St. Lois, MO 63102			
Facility mailing address: <i>(if different from above)</i> Click here to enter text.			
Facility telephone number: (314) 877-0300			
The facility is:	<input type="checkbox"/> Federal	<input checked="" type="checkbox"/> State	<input type="checkbox"/> County
	<input type="checkbox"/> Military	<input type="checkbox"/> Municipal	<input type="checkbox"/> Private for profit
	<input type="checkbox"/> Private not for profit		
Facility type:	<input type="checkbox"/> Community treatment center	<input checked="" type="checkbox"/> Community-based confinement facility	
	<input type="checkbox"/> Halfway house	<input type="checkbox"/> Mental health facility	
	<input type="checkbox"/> Alcohol or drug rehabilitation center	<input type="checkbox"/> Other	
Name of facility's Chief Executive Officer: John D. Young, Superintendent			
Number of staff assigned to the facility in the last 12 months: 123			
Designed facility capacity: 538			
Current population of facility: 372			
Facility security levels/inmate custody levels: All Levels; Probation and Parole Facility			
Age range of the population: 21 - 65			
Name of PREA Compliance Manager: Joseph Sampson		Title: Associate Superintendent	
Email address: Joe.Sampson@doc.mo.gov		Telephone number: (314) 877-0300	
Agency Information			
Name of agency: Missouri Department of Corrections; Division of Probation and Parole			
Governing authority or parent agency: <i>(if applicable)</i> Missouri Department of Corrections			
Physical address: 2729 Plaza Drive, Jefferson City, MO 65109			
Mailing address: <i>(if different from above)</i>			
Telephone number: (573) 526-6607			
Agency Chief Executive Officer			
Name: George Lombardi		Title: Director	
Email address: George.lombardi@doc.mo.gov		Telephone number: (573) 526-6607	
Agency-Wide PREA Coordinator			
Name: Vevia Sturm		Title: PREA Coordinator	
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AUDIT FINDINGS

NARRATIVE

The St. Louis Community Release Center (SLCRC), St. Louis, Missouri (MO), is under the authority of the Missouri Department of Corrections (MODOC), Probation and Parole Division. The PREA Audit of the SLCRC started with a review of the Pre-Audit Questionnaire, which was provided on a USB flash drive, along with numerous policies, forms, Emergency Plans, and data. The USB flash drive was received by myself as Auditor on June 2, 2016. After review of the Pre-Audit Questionnaire, a list of questions and areas needing clarification was submitted to the Agency PREA Coordinator and the SLCRC PREA Site Coordinator (Compliance Manager). A teleconference was held on June 16, 2016, and clarification was provided. The notifications of the on-site audit were posted May 11, 2016, eight weeks prior to the first day of the on-site audit. The notices were posted in various locations throughout the facility.

The on-site audit was conducted July 7-8, 2016. After meeting with the Probation and Parole Regional Administrator, Superintendent, PREA Coordinator, and PREA Site Coordinator, a tour of the institution was conducted. During the tour, I was able to observe the physical plant and grounds of the facility. The tour included: intake/screening area; housing units; food service; maintenance area; laundry; indoor recreation/library, and outdoor recreation areas. The institution has 125 cameras throughout the facility and no blind spots were noted. The on-site visit included a review of secondary documentation and interviews. A total of 21 staff, to include those working all shifts, were conducted which included line staff randomly selected by myself and staff with job responsibilities for areas of inquiry regarding the PREA Standards. In addition interviews were conducted with: the MODOC Chief State Supervisor for the Division of Probation and Parole, (Agency Head Designee); the MODOC Purchasing Manager; one contract medical staff from Corizon Health; one Volunteer; the Director for the Crime Victims Advocacy Center (CVAC), St. Louis, MO, and the Forensic Nursing Coordinator for St. Louis University Hospital, St. Louis, MO.

A total of eight residents were interviewed to include at least one resident from each housing unit. No resident correspondence was received prior to the on-site audit. During the on-site audit, one resident requested to speak to me and he was included in the resident interviews.

DESCRIPTION OF FACILITY CHARACTERISTICS

The SLCRC is located in downtown St. Louis, MO. The SLCRC provides the Missouri Parole Board and Courts with a structured residential program to supervise offenders transitioning from prison to the community or offenders who are at risk of revocation from community supervision.

SLCRC is a 550-bed male facility which houses all levels of adult males; the facility occasionally houses females as holdovers in the Administrative Segregation Unit. The Center had a count of 372 males at the beginning of the on-site audit; no female residents were at SLCRC. The average length of stay for residents is six months. The facility has 123 full time staff. Staff are designated as custody or non-custody (Probation and Parole, food service, maintenance or recreation). There is one on-site contract Reentry Mental Health Specialist who coordinates access for continuing mental health care and medication during the transition from institution to the community.

The facility consists of one building containing eight housing units; four units have cells without doors which each contain two - six bunks, and four units are open dormitory. One unit was off-line during the audit due to not needing the bed space, and one unit is for short term use for residents transitioning out of segregation or in need of closer supervision. Custody staff are not assigned to individual units and required to monitor activities in multiple units; the exception is the transition unit which is continuously staffed. The SLCRC also has a segregation unit. The facility offers indoor and outdoor recreation to all housing units. Food is prepared in the food service department and residents are called by unit to consume their meals in the dining room. Food is delivered to the segregation unit.

SLCRC is not accredited by any other organizations.

SUMMARY OF AUDIT FINDINGS

The audit of the SLCRC was to determine compliance with the national PREA standards. During the Audit, it was clear the leadership of MODOC have made PREA compliance a high priority and have gone to great efforts to implement PREA throughout its facilities to help ensure the safety of all inmates/residents in their custody. The SLCRC's policies and procedures are derived from MODOC's policies and directives.

Results of the SLCRC PREA audit indicate residents understand their right to be free from sexual abuse/harassment and how to report incidents.

Interviews with staff, however, revealed they lacked a working knowledge of PREA hindering their ability to implement the PREA Standards and Agency policy on Offender Sexual Abuse and Harassment (OSAH) and corrective action would be needed to achieve full compliance; the deficient areas are addressed under their respective standards. At the conclusion of the on-site audit, a determination was made between the Agency PREA Coordinator, Superintendent, and myself as Auditor that training would be conducted to correct the deficient areas. On July 19-20, 2016, training was conducted by the Agency PREA Coordinator and her staff to all SLCRC staff. On July 22, 2016, documentation was submitted verifying the training material was detailed and thoroughly covered the areas noted as deficient and that all SLCRC staff had been trained. As a result of this training, SLCRC IS IN FULL COMPLIANCE WITH THE PREA STANDARDS AND THIS SERVES AS A FINAL REPORT.

Number of standards exceeded: 0

Number of standards met: 38

Number of standards not met: 0

Number of standards not applicable: 1

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

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

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

The MODOC’s OSAH policy and Sexual Misconduct and Harassment Annual Guide for Staff, Contractors and Volunteers, state the facility has zero tolerance for all forms of offender sexual abuse, harassment and retaliation. The policy delineates how the facility will work towards preventing, detecting and responding to any such conduct. The policy contains definitions, goals, prohibited conduct, and how to respond to sexual abuse/harassment. Interviews with custody staff, non-custody staff, Corrections Supervisors, and the PREA Site Coordinator confirm staff are aware of their roles and responsibilities.

MODOC’s agency wide PREA Coordinator, an upper-level employee as indicated on the Agency’s organizational chart, is responsible for developing, implementing, and overseeing the Agency’s efforts to comply with the PREA Standards. The SLCRC has a PREA Site Coordinator, an Associate Superintendent, who is responsible for implementing and overseeing PREA at the facility. Both the PREA Coordinator and PREA Site Coordinator indicate they have sufficient time and authority to oversee and implement PREA and are able to make necessary changes to policy and procedures when necessary.

Standard 115.212 Contracting with other entities for the confinement of residents

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

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

The MODOC contracts with four Community Release Centers (CRC). A review of the OSAH policy, contract language for CRCs, and interviews with the MODOC’s Purchasing Manager, PREA Coordinator, and PREA Site Coordinator all confirm the contracts require compliance with the PREA Standards and for the CRCs to achieve PREA compliance through PREA Audits. The interviews and document review indicate all CRCs have successfully achieved PREA compliance.

Standard 115.213 Supervision and monitoring

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

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

SLCRC is staffed with 123 staff who are led by a Superintendent, two Associate Superintendents, and various supervisors for custody and Probation and Parole staff. A review of the Pre-Audit Questionnaire revealed a staffing plan was not submitted; a staffing plan was provided on the first day of the on-site visit. Review of the staffing plan confirms it meets the requirements of the standard by indicating the number of staff needed per department to meet the needs of the facility and to help protect residents from sexual abuse/harassment. The plan takes into consideration the number and placement of cameras, the capacity for housing residents, the layout and design of the facility, and the prevalence of substantiated and unsubstantiated sexual abuse/harassment allegations. SLCRC provided a yearly analysis of the staffing plan including justification why the facility is not staffed at optimal levels (budget constraints). The yearly analysis is required to be submitted to the MODOC for review once signed by the Superintendent. Interviews with the Superintendent, PREA Site Coordinator, and Associate Superintendents confirm when staff shortages occur due to staff being sick or on emergency medical escort, staff are held-over from previous shift, called in, or pulled from other areas to ensure adequate staffing is maintained. The interviews and document review confirm shortages are documented when they occur.

Standard 115.215 Limits to cross-gender viewing and searches

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

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

The Pre-Audit Questionnaire review regarding limits to cross gender viewing and searches found MODOC’s policies and training material are clear regarding searches of offenders to include prohibiting cross gender searches of females for other than exigent circumstances, how to search transgender/intersex residents, and requiring staff of the opposite gender to announce their presence when entering resident housing units. During the tour camera locations were observed and

viewed from the control center monitors. Observation confirms cameras do not capture areas where residents would be dressing or using the toilets or showers. Interviews with the PREA Site Coordinator and Training Supervisor, as well as a review of four staff training files, confirm staff are trained on limits to cross gender viewing and searches.

However, interviews with custody staff, Custodial Supervisors and residents reveal varied responses to questions regarding searches and female staff announcing their presence. Specifically, approximately 65% of staff and residents interviewed stated female staff do not announce their presence when entering housing units, and most female staff interviewed indicated they only announce their presence when looking in the shower/toilet area. Staff gave varied responses or were unsure when responding to questions regarding male staff being allowed to search female residents in other than exigent circumstances and if transgender/intersex residents could be searched for the sole purpose of determining their sex. Additionally, when asked to describe how they would conduct a pat search of a transgender/intersex resident, the majority of staff stumbled on the description.

The problems with staffs' knowledge of proper searches and females announcing their presence on housing units are viewed as training issues as policy and training material are clear, specific and in accordance with the standard. These training issues are addressed under Standard 115.231.

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

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

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

The Pre-Audit Questionnaire review found SLCRC has several contracts with companies providing interpretative services in seven different languages, large print, and braille. The OSAH policy states staff will provide PREA related education in formats accessible to all offenders, including those who are limited English proficient, deaf, visually impaired, or otherwise disabled. While policy does not specifically prohibit the use of resident interpreters, the available contracts would eliminate the need for such use and interviews indicate resident interpreters are not utilized. Document review confirms the facility also maintains a list of staff who speak different languages. Observation during the tour confirms resident handbooks are available in both English and Spanish. It is noted; however, the population at SLCRC has few non-English speaking residents.

Interviews with intake staff and custody staff reveal line staff are not aware of the contracts for interpretative service nor how to access the services. Interviews confirm only supervisors are allowed to initiate services with the interpretative companies. During the PREA training session that occurred after the on-site audit, line staff were informed of the various ways supervisors have access

to interpretative services. Interviews with residents confirm all residents have been provided education on PREA in a format they could understand.

Standard 115.217 Hiring and promotion decisions

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

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

A review of MODOC’s Application for Employment specifically asks applicants the PREA related questions required by the standard. A review of emails from the MODOC Human Resource Department to the SLCRC regarding checks being conducted for PREA related issues prior to promotion confirms the checks are being completed. MODOC’s Policy on Background Investigations and interviews with the Superintendent, PREA Site Coordinator, and Associate Superintendents confirm background checks are conducted on all employees, volunteers, and contractors who have resident contact prior to admission to the facility. Yearly background re-checks are completed for all staff and volunteers; re-checks for contract workers are conducted yearly or each time they enter the facility depending on the frequency of the visits. Interviews also confirm if applicable, MODOC contacts other correctional institutions to inquire as to if the applicant had any PREA incidents during their tenure at that facility.

Standard 115.218 Upgrades to facilities and technologies

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

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

The review of the PREA-Audit Questionnaire and interviews with the Regional Administrator for Probation and Parole, PREA Coordinator, Superintendent, and PREA Site Coordinator all indicate the MODOC was proactive when PREA was enacted and conducted a PREA review of all facilities. The review looked at the facility layout, toilet and shower areas, and the number, types, and location of cameras. As a result SLCRC received 125 new cameras to increase camera coverage and eliminate blind spots; installed new encoders to increase camera clarity and storage capacity; installed half

doors on all resident toilet stalls, and installed shower curtains on the eight handicap showers and in resident bathrooms. No blind spots were noted during the tour of the facility, and the doors and shower curtains were in place. SLCRC has not made any other upgrades or modifications to the facility.

Standard 115.221 Evidence protocol and forensic medical examinations

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

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

Document review confirms all MODOC investigations are conducted by Investigators who work for the Department’s Office of Inspector General (IG). MODOC’s Evidence Collection, Accountability and Disposal policy describes the evidence protocol utilized at SLCRC and documentation was submitted by the IG’s Office verifying the protocol is based off of the DOJ’s Office on Violence Against Women publication. In the event the St. Louis County Sheriff’s office would be involved in an investigation, a letter has been sent to them asking they comply with the requirements of this standard. Interviews with the PREA Site Coordinator, Investigators, custody staff, Correctional Supervisors and the Forensic Nursing Coordinator for the local hospital confirm three hospitals in St. Louis provide SANE nurses. Additionally, the OSAH policy specifies resident victims of sexual abuse are to be provided access to forensic medical examinations by SANE Nurses. The review found MODOC has partnered with the Missouri Coalition Against Domestic and Sexual Violence to assist in providing advocacy services for MODOC. The CVAC is the agency designated by the Coalition to provide advocacy services at SLCRC.

Standard 115.222 Policies to ensure referrals of allegations for investigations

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

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

A review of the OSAH policy reveals it requires administrative and/or criminal investigations be completed for all allegations of sexual abuse/harassment. Interviews with the Investigators, Agency Head Designee and Superintendent all confirm all allegations are promptly investigated. Document

review of completed investigations verifies investigations are timely and thorough.

Standard 115.231 Employee training

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

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

A review of training material utilized to train staff along with the Employee Handbook was conducted during the Pre-Audit Questionnaire review. A sample of four training files were reviewed during the on-site visit. The review found MODOC has a very thorough and detailed policy and training materials that cover all 10 areas required by the standards. The material is tailored to both male and female offenders. Staff receive PREA training during orientation at basic training and refresher training every two years. Training is presented through on-line training courses. The OSAH policy indicates staff who transfer from other facilities receive training if needed due to the sex of the offenders at the new institution, or if needed to keep the employee current in the time frames for training. During the years staff do not receive refresher training, PREA material is presented throughout the year by SLCRC staff. Staff training file review confirms staff sign they have been trained and understand the training material.

During the on-site visit interviews were conducted with custody staff, Custodial Supervisors, staff who conduct intake and perform risk screening, Investigators, the PREA Site Coordinator, Superintendent and Associate Superintendents. The interviews for other than upper management revealed staff did not understand PREA, search procedures nor the Coordinated Response Plan. This lack of understanding was found to hinder the ability of SLCRC staff from being able to efficiently and effectively work together to help prevent, detect, report and respond to sexual abuse/harassment of residents.

Specific areas staff interviewed were unclear on the following: how line staff are to help prevent, detect, report and respond to PREA issues; how/when male staff can search female residents; how to conduct searches of transgender/intersex residents to include if searches can be conducted to determine their sex; if female staff are to announce their presence when entering the housing unit or only when looking in the shower area; how residents can report PREA incidents other than to staff; how staff can report PREA incidents other than to supervisors; how the Coordinated Response Plan works other than first responder duties and how staffs’ various roles link together; if advocacy and medical services are available for residents who have been sexually assaulted; who investigates PREA incidents; who ensures the advocate is contacted to be present during questioning at the institution if requested by the resident, and how to communicate with non-English speaking.

On July 19-20, 2016, the Agency PREA Coordinator and her staff provided detailed and thorough PREA training to all SLCRC staff. Documentation was submitted verifying the training material covered the areas found deficient and outlined the material in a manner that should make it clear to staff how the overall PREA plan works at SLCRC. The submitted material included the PowerPoint presentations as well as staff attendance records. As a result of this training, SLCRC is now in compliance with this standard.

Standard 115.232 Volunteer and contractor training

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

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

The MODOC’s OSAH policy requires all contract staff and volunteers be trained in PREA prior to having resident contact. The training is based on the level of services provided and type of resident contact encountered. Document review of training material submitted with the Pre-Audit Questionnaire confirms the training is detailed and meets the requirements of the standard. Policy requires refresher training is to be provided yearly and contractors and volunteers are required to sign an acknowledgement form indicating they have been trained and understand the PREA material. Interviews with the Volunteer Coordinator, Training Coordinator, a volunteer and the contract medical staff, along with document review, confirm contractors and volunteers have received PREA training and sign acknowledgement forms.

Standard 115.233 Resident education

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

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

A review of the OSAH policy reveals all residents are to receive PREA education upon their admission to SLCRC. Policy requires staff assigned to the Orientation Unit meet with each new resident to explain PREA policy and provide a PREA handout. On a weekly basis, orientation is conducted where a PREA video is shown. Observation of an orientation session was made during the tour. A review of

the orientation information provided to residents confirms it explains the facility's zero tolerance policy, how to report incidents, and residents right to be free from sexual abuse/harassment and retaliation. Residents are required to sign they have received PREA training and a review of documentation confirms this is being done. Observation during the on-site audit confirms PREA material is continuously and readily available to residents in the form of posters. Additionally, SLCRC has contract interpretative services and PREA brochures are available in seven different languages as well as large print. Policy requires and staff interviews confirm staff read the material to inmates with visual or mental impairments rendering them unable to read.

Standard 115.234 Specialized training: Investigations

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

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

A review of the OSHA policy confirms all Investigators assigned to investigate offender sexual abuse allegations are required to receive specialized PREA Investigative training. While MODOC has 43 investigators, two are primarily assigned to SLCRC. Interviews with the Investigators and a review of their training certificates confirms they have received specialized training that included how to conduct interviews with sexual abuse victims, proper use of Miranda and Garrity, evidence collection in confinement settings, and the criteria and evidence required to substantiate a case for administrative or criminal charges.

Standard 115.235 Specialized training: Medical and mental health care

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

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

Due to the mission of the SLCRC, all medical and mental health care is provided by community providers. While SLCRC does have a contract with Corizon and one mental health provider is on-site, his role is to coordinate access for continuing mental health care and medication during the transition

from institution to the community.

Standard 115.241 Screening for risk of victimization and abusiveness

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

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

Document review of the OSAH policy, CRC Policy and Procedure Manual, and the SLCRC Standing Operating Procedures on Risk of Victimization and Abusiveness Screening Instrument all confirm residents are screened for risk of sexual victimization and abusiveness. The screening instrument utilized is detailed and includes all nine areas required by the standard. Policy requires the initial screening be conducted within 72 hours of admission, and requires a reassessment within 30 days. A reassessment is also conducted when warranted based on receipt of additional relevant information or following an incident of abuse or victimization. Interviews with residents and staff who conduct the screenings, along with document review of completed screening forms, confirm screenings are being conducted as required. Interviews with screening staff did reveal a need for clarification on the requirement to ask residents if they identify as LBGTI, as well as for the screener to note their perception of the resident being LBGTI, and this area was addressed in the training session conducted after the on-site audit.

Standard 115.242 Use of screening information

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

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

A review of the CRC Policy and Procedure Manual and OSAH policy confirms the screening tool for risk of victimization or abusiveness is used to guide housing, work detail, education and program assignments. The manual requires staff to make individualized determinations to ensure the safety of each resident. Staff interviews confirm staff who make housing, work, education and programming assignments are utilizing the forms to make these assignments. Policy requires housing assignments for transgender/intersex residents be made on a case-by-case basis, with consideration

given in regard to the resident's own view of their safety. The SLCRC has a Transgender/Intersex Committee that makes decisions on the housing, programming, and searches of transgender/intersex residents and staff interviews confirm they take into consideration the resident's own views when making housing assignments. The tour of the SLCRC during the on-site audit confirms all residents are allowed to shower separately. No transgender/intersex residents were at the facility during the on-site audit.

Standard 115.251 Resident reporting

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

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

MODOC's policy on Crime Tips and PREA Hotline outlines the procedures for residents and staff to report sexual abuse or harassment. Policy and the Coordinated Response to Offender Sexual Abuse Response Protocol for Community Release Centers and Community Supervision Centers indicate all information regarding sexual abuse/harassment, including those received verbally, in writing, anonymously or by third party, will be investigated. Interviews with Investigators verifies all allegations are investigated. Observation during the on-site audit confirms various posters are visible throughout the facility advising residents how they can report such incidents. The posters provide contact information for the PREA Hotline which goes to the MODOC; Just Detention International (toll-free), and the Rape, Abuse and Incest National Network (RAINN) (toll-free). Residents can also write to the Department of Public Safety (DPS), Crime Victims Services Unit, through an agreement they have with MODOC. Upon receipt of a sexual abuse/harassment allegations, DPS notifies the MODOC IG Office of the allegation. During the on-site visit, a call to the PREA Hotline number revealed the number posted was incorrect and the toll-free number to the CVAC was not posted. Both of these were corrected prior to the close of the on-site audit.

Standard 115.252 Exhaustion of administrative remedies

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

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

A review of MODOC’s policy on Complaints, Inquiries and Investigations confirms residents are allowed to file grievances regarding sexual abuse. The policy addresses all areas required by the standard including time frames, emergency grievances, and allowing assistance to residents in filing grievances. Interviews with the PREA Site Coordinator, who oversees the grievance program, confirms staff are following the requirements of the standard.

Standard 115.253 Resident access to outside confidential support services

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

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

As indicated previously, MODOC has a MOU with the Missouri Coalition Against Domestic and Sexual Violence to provide advocacy services, and the CVAC in St. Louis provides services to residents at SLCRC. Residents are notified of their ability to contact the CVAC through PREA information provided to them at intake and through posters displayed throughout the facility. Posters also advise residents of their ability to contact Just Detention International, RAINN, DPS, and the MODOC’s Prea Hotline. Review of the OSAH policy finds it delineates procedures for residents to have access to advocates. A review of the PREA information available to residents confirms they inform residents of the extent of confidentiality for contacting the various advocacy centers. Interviews with custody and probation and parole staff and residents confirms residents are aware of their ability to contact advocacy centers.

Standard 115.254 Third-party reporting

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

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

The MODOC’s website review confirms detailed PREA information is available and informs the public of their ability to submit sexual abuse/harassment allegations on behalf of residents. The OSAH policy also indicates the public may submit allegations on behalf of residents and all such allegations will be investigated. Interviews with the Investigators confirm all third party information regarding

sexual assault/harassment are reviewed and investigated if warranted.

Standard 115.261 Staff and agency reporting duties

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

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

MODOC’s OSAH policy requires all staff, contractors and volunteers to immediately report any knowledge, suspicion, or information regarding incidents of sexual abuse/harassment, as well as retaliation against offenders or staff who report incidents. Staff are required to report staff neglect or violations of responsibilities that may have contributed to an incident or retaliation, and policy informs staff failure to report is a misdemeanor. Policy indicates medical and mental health staff are to inform residents of their duty to report at the initiation of services. Interviews with custody and probation and parole staff, Correctional Supervisors, and the Superintendent all confirm staff are aware of their duty to report.

Standard 115.262 Agency protection duties

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

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

A review of the OSAH policy reveals it requires staff to take immediate action if it is learned a resident may be at risk for imminent sexual abuse. Interviews with line staff, the PREA Site Coordinator, and the Superintendent confirm would staff take immediate action if they learn a resident is at risk for imminent sexual abuse; no such incidents have occurred at SLCRC.

Standard 115.263 Reporting to other confinement facilities

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

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

The MODOC’s OSAH policy specifies procedures if a facility learns an inmate/resident may have been sexually abused/harassed while confined at another facility. Police requires all notifications be made within 72 hours and documented. An interview with the PREA Coordinator confirms if the information is regarding another MODOC facility, the information is forwarded to the IG’s office who initiates an investigation. If the information is regarding a facility outside the MODOC, she as the Agency PREA Coordinator, is notified and she informs the Head of that facility. Policy review and the PREA Coordinator interview confirm if an allegation of sexual abuse/harassment is made at another facility regarding an incident at SLCRC, the incident is investigated. Document review of investigations submitted with the Prea-Audit Questionnaire confirms notifications are being made and investigations conducted.

Standard 115.264 Staff first responder duties

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

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

A review of MODOC’s Basic Training Lesson Plan on PREA confirms it is detailed and delineates the steps first responders are to take if staff become aware of a sexual assault. Similar information is also stated in the OSAH policy and the CRC Policy and Procedure Manual. Policy provides a detailed form for first responders to fill out if an inmate/resident reports sexual abuse to them. During the on-site audit, observation reveals staff had recently been issued laminated cards listing first responder duties. Interviews with custody and non-custody line staff, Correctional Supervisors and the PREA Site Coordinator reveal staff are knowledgeable on first responder duties.

Standard 115.265 Coordinated response

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

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

During the Pre-Audit Questionnaire review, the OSAH policy and Coordinated Response to Offender Sexual Abuse Response Protocol for Community Release Centers and Community Supervision Centers were reviewed. The plan and policy are detailed, thorough, and delineate the coordinated response staff in different roles are to take in the event of a sexual assault. The plan requires first responders separate the residents, protect the victim, protect the scene, and inform the victim not to take any actions that could destroy evidence. The plan spells out actions medical, mental health, and investigative staff are to take when a sexual assault occurs, as well as steps to take if penetration occurred with specifications depending on the timeframe since penetration.

Interviews were conducted with custody staff, Custodial Supervisors, staff who conduct intake and perform screening, Investigators, the PREA Site Coordinator, Superintendent and Associate Superintendents. The interviews revealed all staff under the Associate Superintendent level had a basic, at best, understanding of the Coordinated Response Plan and how the different roles of staff bridge together. This lack of understanding was found to hinder the ability of SLCRC being able to efficiently and effectively work together to help prevent, detect, report and respond to sexual abuse/harassment of residents.

Specific areas related to the Coordinated Response staff interviewed were unclear included: how the Coordinated Response Plan works other than first responder duties; if advocacy and medical services are available for residents; who investigates PREA incidents, and who notifies the advocate to be present during questioning that occurs at the institution if requested by the resident.

On July 19-20, 2016, the Agency PREA Coordinator and her staff provided detailed and thorough PREA training to all SLCRC staff to include the Coordinated Response Plan. Documentation was submitted verifying the training material covered the areas found deficient and outlined the material in a manner that should make it clear to staff how the overall PREA plan works at SLCRC. The submitted material included the PowerPoint presentations as well as staff attendance records. As a result of this training, SLCRC is now in compliance with this standard.

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

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

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

A review of the MODOC’s policy on Labor Organizations confirms it clearly states that in accordance with PREA, the department will not enter into or renew any collective bargaining agreements or other agreements that limit the department’s ability to remove alleged staff sexual abuses from contact with offenders or residents pending the outcome of an investigation or determination of whether and to what extent discipline is warranted. During the on-site audit, interviews with the Agency Head Designee and Superintendent indicate there are no restrictions on the Agency’s ability to remove staff from contact with residents if needed.

Standard 115.267 Agency protection against retaliation

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

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

A review of the OSAH policy reveals it is very detailed as to retaliation against staff or residents who report sexual abuse being prohibited. The policy contains all the elements required by the standard, and has a detailed form for staff to utilize when monitoring staff and residents for retaliation with specific areas listed for the monitor to review. A review of the CRC Policy and Procedure Manual finds it also prohibits retaliation against staff or residents who report PREA incidents. Interviews with Agency Head Designee, Superintendent, and PREA Site Coordinator, indicate the PREA Site Coordinator monitors staff and residents for retaliation, with Captains and Shift Supervisors making contact with staff and residents under his direction, and the procedures comply with the standard.

Standard 115.271 Criminal and administrative agency investigations

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

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

MODOC’s Investigation Unit Policy review indicates it contains detailed information on conducting investigations, including the specifics for what evidence is required for both administrative and criminal cases; polygraph tests are not utilized in MODOC. A review of training certificates verifies Investigators have received specialized training on conducting PREA investigations. Interviews with Investigators confirm they conduct both administrative and criminal investigations, are knowledgeable on conducting PREA investigations, and refer cases for prosecution if criminal charges are indicated. The Investigators indicate if a suspected staff perpetrator resigns, or the victim or resident perpetrator releases, during the course of the investigation it does not stop the investigation. As residents at SLCRC have access to outside law enforcement personnel, the Investigators indicate on occasion, residents will report allegations to the local Police Department. In those circumstances, Investigators report they take a supporting role and work with the Police Department; however, ordinarily, the Police Department refers cases back to the IG to investigate. The interviews, along with a review of completed investigations confirms the reports are detailed, meet the requirements of the standard and make note if staffs’ actions or inactions have contributed to incidents.

Standard 115.272 Evidentiary standard for administrative investigations

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

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

The MODOC’s OSAH and Investigation Unit policies both indicate the preponderance of evidence is the evidentiary standard utilized for administrative cases. This was confirmed during interviews with the Investigators and a review of completed investigation confirms investigators appropriately apply this evidentiary standard.

Standard 115.273 Reporting to residents

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

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

A review of the OSAH policy finds it clearly states inmates/residents are to be notified of the outcome of investigations. Policy requires notification to the resident if the perpetrator is indicted, convicted, or in the case of a staff perpetrator, when the staff member is no longer assigned to the inmate’s/resident’s unit or no longer employed at the facility. The policy contains a form to be utilized for this purpose. Interviews with Investigators and the Superintendent confirm the SLCRC residents are notified of the above requirements. A review of tracking logs verified the notifications are being sent to residents.

Standard 115.276 Disciplinary sanctions for staff

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

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

The OSAH policy clearly indicates staff will be subject to disciplinary sanctions, up to and including termination, for violating the sexual abuse/harassment policy and termination is the presumptive disciplinary action. Policy requires all terminations for violations, or the resignation of staff who would have been terminated if not for resignation, will be reported to relevant licensing or accreditation bodies and law enforcement. Interviews with the Superintendent and Investigators confirm they are knowledgeable with and follow the requirements of the standard.

Standard 115.277 Corrective action for contractors and volunteers

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

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

MODOC’s OSAH policy indicates contractors or volunteers who engage in sexual abuse will be prohibited from contact with offenders and will be reported to relevant licensing bodies and law enforcement. The policy requires the Chief Accounting Officer or designee of the facility is to take appropriate measures and consider whether to prohibit further contact with offenders in the case of any other violations. A review of the policy on volunteers finds it reiterates the same requirements. An interview with the Superintendent confirms he would take appropriate measures in accordance with the standard if warranted. No incidents with contractors or volunteers have occurred that required corrective action.

Standard 115.278 Disciplinary sanctions for residents

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

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

A review of the OSAH and Documenting and Responding to Violations of Facility Rules policies both indicate offenders are subject to disciplinary sanctions pursuant to a formal disciplinary process after a finding of guilt on administrative or criminal charges. Policy requires an offender’s mental disabilities be taken into consideration when considering disciplinary sanctions, and residents who make reports “in good faith” are not to receive disciplinary action. Document review confirms sexual activity between residents is prohibited at SLCRC and offenders found guilty of sexual abuse are referred for appropriate treatment. Interviews with staff confirm resident disciplinary policies are being followed.

Standard 115.282 Access to emergency medical and mental health services

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

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor’s analysis and reasoning, and the auditor’s conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final

Report, accompanied by information on specific corrective actions taken by the facility.

The MODOC's OSAH policy and Investigative Unit Policy both require medical treatment for offenders who are sexually abused and specifies the medical treatment is to occur prior to any investigative questioning. Interviews with the Superintendent, PREA Site Coordinator, custody staff, Correctional Supervisors, the Forensic Nursing Coordinator for St. Louis and the Director of the CVAC all confirm residents who have been sexually abused at SLCRC would be escorted to the local hospital for medical examination by a SANE Nurse. As SLCRC does not have medical staff on-site, there is not a preliminary assessment made at the facility and the decision to transport the resident to the hospital is made by the Correctional Supervisor. Once at the hospital, protocol calls for the YWCA Sexual Assault Response Team (SART) to be present for the examination and investigative questioning if requested by the victim. The MODOC's policy and the Forensic Nursing Coordinator both indicate the resident would receive screening for sexually transmitted diseases and follow-up care as indicated. Female victims are offered information on emergency contraception, and residents are not charged for medical care. The SLCRC has not had any cases requiring SANE examination.

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

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

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

As indicated, SLCRC does not have on-site medical or mental health staff and all services are provided by community treatment providers. Interviews with the Director of Forensic Nursing and the Director of the CVAC both indicate ongoing medical and mental health services are offered to all sexual abuse victims. The local hospital provides any on-going medical treatment and testing that is warranted, and through the YWCA, the SART provides on-going counseling as needed. The CVAC also provides counseling and services to residents who have been sexually assaulted. Documentation from the SLCRC indicates known resident perpetrators would be referred for a mental health evaluation after an incident of sexual abuse.

Standard 115.286 Sexual abuse incident reviews

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

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

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

The MODOC's OSAH policy and CRC Policy and Procedure Manual both require incident reviews be conducted after receipt of completed investigations unless the case was unfounded. A PREA Sexual Abuse Debriefing Form is included in policy and covers all areas required for review by the standard. Interviews with the Superintendent and PREA Compliance Manager, along with review of completed forms, confirm incident reviews are being conducted and the forms completed. Participants in the reviews include the Superintendent, PREA Compliance Manager, Associate Superintendents, and other supervisory and/or line staff as deemed appropriate. A copy of the completed Debriefing Forms are forwarded to the MODOC's PREA Coordinator.

Standard 115.287 Data collection

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

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

The OSAH policy requires each facility to collect and aggregate sexual abuse/harassment data and submit a yearly report to the MODOC's PREA Coordinator. An interview with the PREA Coordinator confirms the agency maintains the data from each of its facilities.

Standard 115.288 Data review for corrective action

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

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

The MODOC's OSAH policy requires each facility submit an annual report regarding sexual abuse/harassment data. The facilities are to make a comparison of the current year's data and corrective actions with those from previous years and make an assessment of their progress in addressing sexual abuse, to include if changes are needed to staffing, camera and monitoring systems, or other resources. A review of the annual report submitted by the SLCRC, as well as a

review of the MODOC's website confirms the annual reports are being completed as required.

Standard 115.289 Data storage, publication, and destruction

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

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

A review of the MODOC's website confirms the agency makes available to the public sexual abuse data from all of its facilities and identifying information is appropriately redacted. Data is available from 2010 – 2014. An interview with the PREA Coordinator indicates the 2015 data is temporarily not available as the Agency has made a change in the way it concludes investigations. This change requires a review of completed investigations to ensure they meet the new requirement. Once finalized, the 2015 data will be made available on the website. A review of the OSAH policy confirms it requires all sexual abuse data be retained for the time frame required in the standard.

AUDITOR CERTIFICATION

I certify that:

- The contents of this report are accurate to the best of my knowledge.
- No conflict of interest exists with respect to my ability to conduct an audit of the agency under review, and
- I have not included in the final report any personally identifiable information (PII) about any inmate or staff member, except where the names of administrative personnel are specifically requested in the report template.

Wendy J. Roal Warner
Auditor Signature

July 28, 2016
Date