

**PREA AUDIT REPORT**     INTERIM     FINAL  
**ADULT PRISONS & JAILS**

**Report Date:** April 4, 2016

<b>Auditor Information</b>			
<b>Auditor name:</b> Nancy Hardy			
<b>Address:</b> PO Box 942883, Sacramento, CA 9483-0001			
<b>Email:</b> Nancy.Hardy@cdcr.ca.gov			
<b>Telephone number:</b> 916 324-0791			
<b>Date of facility visit:</b> February 10 – 12, 2016			
<b>Facility Information</b>			
<b>Facility name:</b> Pendleton Correctional Facility			
<b>Facility physical address:</b> 4490 W. Reformatory Road, Pendleton, IN 46064			
<b>Facility mailing address:</b> <i>(if different from above)</i>			
<b>Facility telephone number:</b> 765 778-2107			
<b>The facility is:</b>	<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		
<b>Facility type:</b>	<input checked="" type="checkbox"/> Prison	<input type="checkbox"/> Jail	
<b>Name of facility's Chief Executive Officer:</b> Superintendent Dushan Zatecky			
<b>Number of staff assigned to the facility in the last 12 months:</b> 457 + 87 contract staff			
<b>Designed facility capacity:</b> 1940			
<b>Current population of facility:</b> 1731			
<b>Facility security levels/inmate custody levels:</b> Level IV			
<b>Age range of the population:</b> 18 - 76			
<b>Name of PREA Compliance Manager:</b> Andrew Cole		<b>Title:</b> Assistant Superintendent, Re-Entry	
<b>Email address:</b> ACole@idoc.in.gov		<b>Telephone number:</b> 765 778-2107 ext. 1317	
<b>Agency Information</b>			
<b>Name of agency:</b> Indiana Department of Corrections			
<b>Governing authority or parent agency:</b> <i>(if applicable)</i>			
<b>Physical address:</b> 302 W. Washington Street, Indianapolis, IN 46204			
<b>Mailing address:</b> <i>(if different from above)</i>			
<b>Telephone number:</b> 317 232-5705			
<b>Agency Chief Executive Officer</b>			
<b>Name:</b> Bruce Lemmon		<b>Title:</b> Commissioner	
<b>Email address:</b> BLemmon@idoc.IN.gov		<b>Telephone number:</b> 317 232-5705	
<b>Agency-Wide PREA Coordinator</b>			
<b>Name:</b> Bryan Pearson		<b>Title:</b> Executive Director of PREA	
<b>Email address:</b> BPearson@idoc.IN.gov		<b>Telephone number:</b> 317 232-5288	

## AUDIT FINDINGS

### NARRATIVE

The Pendleton Correctional Facility (PCF) agreed to participate in a Prison Rape Elimination Act (PREA) audit to be conducted by certified auditors from the California Department of Corrections and Rehabilitation (CDCR). The audit was conducted at 4490 W. Reformatory Road, Pendleton, Indiana 46064. The on-site phase of the audit took place during the period of February 10 – 12, 2016. Following extensive coordination, preparatory work and collaboration with PREA management staff at PCF, the audit team completed some of the pre-audit work before traveling to the facility for the on-site portion of the audit.

### PRE-AUDIT PHASE

On December 17, 2015, CDCR provided the audit notice to the agency's PREA Coordinator with instructions to post copies in the housing units and other places deemed appropriate by facility staff. CDCR received the pre-audit questionnaire, audit process map, checklist of policies/procedures and other documents from Indiana Department of Corrections (IDOC), PCF in January 2016. Notices were to be posted in areas accessible to both offenders and staff.

Pre-audit section of the compliance tool: In January 2016, the PREA Coordinator provided the completed pre-audit questionnaire, including supporting documentation, to the audit team. The certified auditors started completing the compliance tool by transferring information from the pre-audit questionnaire and from supporting documentation to the pre-audit section of the compliance tool.

The auditor received three letters from offenders at the facility prior to arrival at the institution and three upon return to the office after completion of the on-site review. The audit team interviewed two of the offenders who had submitted letters and resolved their concerns. The other correspondence did not raise PREA issues; all offenders will be advised to seek resolution through the agency's administrative processes.

### ON-SITE PHASE

On February 10, 2016, the audit team arrived at PCF. The audit team consisted of 3 certified auditors and 4 additional CDCR staff who have been assigned to the PREA team and have applied to attend formal auditor training. The team included myself, retired Chief Deputy Administrator and previous PREA Coordinator for the CDCR; Shannon Stark, PREA Coordinator for CDCR; Matthew Rustad, Correctional Lieutenant and certified PREA auditor; James Moore, Correctional Lieutenant; John Day, retired Chief of the Office of Internal Affairs, Ray Harrington, retired Correctional Administrator; and Roger Benton, retired Captain.

On February 10, 2016, the audit team met with the Superintendent, PREA Coordinator, and PREA management staff for greetings, introductions and information sharing. The team was escorted to a conference room which served as a home base for audit preparation and organization.

Upon arrival at PCF, the audit team requested and received the names of the employees assigned in the management and specialized staff positions, who might be interviewed during the on-site portion of the audit. The audit team selected the names of staff who would be interviewed. Also on this date, the audit team received a roster of all offenders at the facility with identification numbers and assigned bed numbers, sorted by housing unit. The auditor also requested a list of offenders classified into any of the following categories:

- Disabled Inmates
- Limited English Proficient Inmates
- Transgender & Intersex Inmates
- Gay & Bisexual Inmates
- Inmates in Segregated Housing for Risk of Sexual Victimization

- Inmates who Reported Sexual Abuse
- Inmates who Disclosed Sexual Victimization during Risk Screening

The audit team requested and received a list of all security staff assigned during the days of the on-site review, sorted by shift. The auditor explained that these rosters were required for the audit team to select random security staff and offenders for interviews. The auditor informed the PREA Coordinator that audit team members would compile lists of security staff and offenders selected randomly for interviews. The list did not specifically identify offenders according to all of the seven categories. However, the PREA Compliance Manager worked with the auditor to identify the offenders in the categories, a complete list was later supplied.

On-site Review: The audit team conducted a thorough site review of the facility. The Superintendent, PREA Coordinator, PREA Compliance Manager and security staff escorted the audit team. The team toured all of the housing units, out-patient medical, mental health, the main kitchen, offender transportation, the warehouse, intake processing area, the laundry, main control, the pharmacy, the minimum support facility, the basement, maintenance shops, industries areas, the steam plant, academic education, recreation yards, chapels, etc.

During the tour, audit team members asked impromptu questions of staff and offenders, noted the placement and coverage of surveillance cameras, inspected surveillance monitors, identified potential blind spots, inspected bathrooms and showers to identify potential cross gender viewing concerns, etc. In offender dayrooms, audit team members tested offender phones to determine the functionality of the facility's hotline for reporting sexual abuse or harassment. In offender work areas, audit team members assessed the level of staff supervision and asked questions to determine whether offenders are in lead positions over other offenders. Audit team members also noted the placement of PREA information posters, noted the placement of the PREA audit notice provided to the facility. In some areas, audit team members took photos to document the on-site review.

PREA Management Interviews: Two audit team members were assigned the responsibility for interviewing members of the management team, including the Commissioner (Agency Head or designee), the Superintendent (Warden or designee), the PREA Coordinator, and the PREA Compliance Manager. The auditors worked with facility staff to schedule a time for each of these interviews; audit team members were escorted to the office of the respective manager where the auditor conducted the interviews using the applicable interview protocols and recorded the responses by hand.

Specialized Staff Interviews: Using the list of specialized staff received from the PREA Compliance Manager, two audit team members were escorted to the work locations of individual specialized staff to perform the required interviews. In some cases, it was necessary to conduct the interview via telephone because the person to be interviewed was at a distant location; examples of these were the agency contract manager and the sexual assault nurse examiner.

The audit team identified specialized staff to be interviewed. Interviews included the following:

- Medical and Mental Health
- Incident Review Team Member
- Staff who Conduct Intake Screening
- Classification Staff
- Social Worker
- Internal Affairs (facility level investigations)
- Sexual Assault Nurse Examiner
- Human Resources
- Person Responsible for Contractor, Volunteer and Vendor Clearances
- Segregated Housing Sergeant
- Person Responsible for Monitoring Retaliation (Not Assigned to a Specific Employee)
- Higher Level Supervisor
- Aramark Contractor

- Grace College Volunteer
- First Responders
- Training Director

During interviews with investigative staff, the team learned that offender grievances against staff are forwarded to the grievance coordinator; Investigations and Intelligence (I&I) may investigate where appropriate or may just track the progress of staff's response to the offender. The members of the audit team interviewed two investigators and questioned designated staff about the process for logging and tracking cases assigned and offender grievances received by the facility. Where the circumstances dictate, the interviewer would ask to review documentation, logs, computerized tracking, or other material necessary to make a determination of compliance with the standard. During these interviews, the audit team members based the line of questioning on the interview protocols and recorded responses by hand.

Random Staff Interviews: The audit team identified random staff to be interviewed. These random staff were selected from the shift rosters, considering a variety of work locations and various shifts. Two audit team members were escorted to the various work locations where the identified staff member was available for the interview. The interviews were conducted in a private interview room. The auditor introduced the members of the team, communicated the advisory statements to the staff, proceeded to ask the line of questions from the interview protocols for random staff and recorded the answers by hand. Audit team members asked for clarifications where needed to ensure the responses were clear enough to make a determination of compliance with applicable standards. A total of 19 random staff interviews were conducted.

Random Offender Interviews: The auditor determined that at least one offender from each housing unit would be interviewed. Two audit team members were assigned responsibility for the various offender interviews. Audit team members used the alphabetical roster of offenders to randomly select one or two offenders from their assigned housing units. Audit team members were escorted to the housing units where the identified offenders were available to participate in the interview in a private interview room/office. The audit team members introduced themselves, communicated the standard advisory statements to the offender before proceeding with the standard line of questions from the random offender interview protocols and recorded the offender answers by hand using the designated form. Clarification was requested, as needed to ensure the offender's responses were clear. A total of 22 offenders were interviewed as part of the random offender interviews.

PREA-Interest Offender Interviews: Two audit team members were assigned responsibility for interviewing specific categories of offenders identified for interviews based upon their relevance to specific PREA standards. These categories are:

- Disabled Inmates
- Limited English Proficient Inmates
- Transgender and Intersex Offenders (None Currently at Facility)
- Gay & Bisexual Inmates
- Inmates in Segregated Housing for Risk of Sexual Victimization (None Currently at Facility)
- Inmates who Reported Sexual Abuse
- Inmates who Disclosed Sexual Victimization during Risk Screening

Audit team members selected offenders from the list received from the PREA Compliance Manager. Each offender's housing location was determined from the alphabetical roster and audit team members were escorted to the offender's housing unit. The offender was escorted to a private room/office where the auditor introduced the members of the audit team, communicated the standard advisory statement and asked the line of questions in the respective interview protocols. Audit team members also conducted these interviews if a random offender interviewee disclosed information suggesting that one of the above categories of PREA interest applied to him. Audit team members interviewed one offender identified as limited visibility, three limited English proficient (Spanish) offenders, four offenders who were identified as being gay, several offenders who have mental health concerns, one offender who reported sexual abuse, and one offender who disclosed sexual victimization during risk

screening; a total of 10 offenders were interviewed based upon PREA-interest categories. Facility staff did not identify offenders in any of the other categories.

Document Reviews: The document review process was divided up between 3 auditors. One auditor reviewed all documents related to allegations of sexual abuse. Two auditors reviewed a random sample of training records, personnel records, contractor and volunteer records, and the records maintained through the offender intake process. These auditors collected copies of documents, as necessary.

The PREA Compliance Manager provided Sexual Incident Report (SIR) for all 11 allegations received during the previous twelve month period. The list included the report number, date of report, name of the victim, name of the suspect, and the disposition or status of the case. The auditor obtained the SIR and investigative reports from facility investigative staff. These reports were reviewed using a PREA audit investigative records review tool to record the following information relative to each investigative report:

- Case#/ID
- Date of Allegation
- Date of Investigation
- Staff or Inmate on Inmate
- Sexual Abuse or Sexual Harassment?
- Disposition
- Is Disposition Justified?
- Investigating Officer
- Notification Given to Inmate?

Throughout the on-site review, the team had discussion about what was being observed and reviewed and discrepancies that were being identified. Various team members would seek clarification, when discrepancies were identified to ensure that we were not missing pertinent information. The audit team scheduled a close-out discussion with the Superintendent and his staff. During this close-out discussion, the facility staff and the PREA Coordinator were provided with an overview of what had been identified as areas of concern.

#### **POST-AUDIT PHASE**

Following the on-site portion of the audit, the team met and discussed the post audit phase and the next steps. The auditor gathered written information and feedback from the team members and took responsibility for completing the interim report. The auditor, as a probationary certification, has 21 days to turn the interim report in to the department of justice, which has 10 days to review it. The probationary auditor then has 10 days to consider the Department of Justice's suggestions and provide the interim report to the facility by March 24, 2016 (total of 41 days). This information was also provided to the agencies PREA Coordinator via the probationary certification template letter. This process was lengthened slightly due to some confusion in document preparation.

The auditor and PREA Compliance Manager agreed that any documents not received during the pre-audit phase or on-site review would be requested via email and provided by the PREA Compliance Manager. Also, community-based victim advocates were interviewed via telephone during the post-audit phase. This interview was conducted on March 3, 2016. An audit team member conducted a telephone interview with Alternatives, Inc. Alternatives, Inc. was identified as the community-based victim advocacy agency and was also identified as the primary outside agency designated to receive reports of sexual abuse and sexual harassment of offenders in the custody of PCF.

Audit team members documented all clarification questions, missing information, requests for additional documentation, etc. to follow-up with the PREA Compliance Manager and sent the request on February 23, 2016. Requested information was returned to the auditors on Friday, February 26, 2016.

Audit Section of the Compliance Tool: The auditor reviewed on-site document review notes, staff and offender interview notes and on-site tour notes and began the process of completing the audit section of the compliance

tool. Auditors used the audit section of the compliance tool as a guide to determine which question(s) in which interview guide(s), which on-site document review notes and/or which facility tour site review notes should be reviewed in order to make a determination of compliance for each standard. After checking appropriate "yes" or "no" boxes on the compliance tool for each applicable subsection of each standard, the auditors completed the "overall determination" section at the end of the standard indicating whether or not the facility's policies and procedures exceeds, meets or does not meet standard. Where the auditor found the facilities policies and procedures did not meet the standard, the auditor entered appropriate comments explaining why the standard is not met and what specific corrective action(s) is/are needed for facility's policies and procedures to comply with the standard. The auditor entered this information in the designated field at the end of the standard in review.

Interim Audit Report: Following completion of the compliance tool, the auditor started completing the interim report. The interim report identifies which policies and other documentation were reviewed, which staff and/or offender interviews were conducted and what observations were made during the on-site review of the facility in order to make a determination of compliance for each standard provision. The auditor then provided an explanation of how evidence listed was used to draw a final conclusion of whether the facility's policies and procedures exceed, meet, or do not meet the standard. The interim report was submitted to the PREA Resource Center for review/approval on 03/04/2016. The interim report was forwarded to PCF on April 4, 2016.

Corrective Action Plan: Along with the interim report, a Corrective Action Plan (CAP) was also provided to the facility on April 4, 2016. Via a conference call between the auditor and PCF staff, the CAP was discussed including actions needed and tentative completion dates. All items identified on the CAP were corrected and a final review of the CAP was completed by the auditor on September 1, 2016.

Final Audit Report: Following final review of the CAP, the auditor completed the final audit report for PCF and provided to the facility on Wednesday, September 7, 2016.

## **DESCRIPTION OF FACILITY CHARACTERISTICS**

In March of 1922, construction for a new prison began on a plot of land located in Fall Creek Township in Madison County about 25 miles northeast of Indianapolis. The new reformatory was established in 1923 to replace the Indiana State Reformatory that had been severely damaged during a fire.

PCF is located at 4490 W. Reformatory Road, Pendleton, Indiana. PCF includes 12 housing units. Housing units include single and double cell and dormitory style housing. The facility has self-contained medical, laundry, and food preparation facilities. In addition, there is a small intake unit, which accommodates the process used to receive offenders from either the Reception and Diagnostics Center or other state correctional facilities. Finally there are a number of maintenance shops and prison industries areas, a warehouse, a basement, and a steam power plant.

Housing is comprised of multi-tier housing units, each containing single-bunked cells and toilet/sink fixtures. Each housing unit also contains individual shower facilities on each tier. Four of the housing units do not contain a day room. In these units, telephones are cordless and checked out to the offenders to use in their assigned cell. There are five housing units where mental health offenders are housed; these are double tier buildings with single cells. These housing units have a day room and telephones are available for use by the offenders on the walls. The cells have sink/toilet fixtures in them and the showers are at the end of each tier. Each of the celled housing units have at least 2 individual holding cells (dry).

The main entrance to the facility allows for the screening of all visitors, both offender and professional, who enter the facility. All staff, visitors and their property are screened by metal detector and x-ray for weapons and contraband. In addition, all staff and visitors are pat-searched upon entering the facility. There is a central control booth which all must pass through to enter the visiting room and facility. Finally, there is a sally-port which leads to the inside of the institution.

The central control unit is staffed by a correctional officer, who views some of the facilities video monitoring output.

In the basement of the facility is a number of storage rooms, including storage for many of the maintenance shops and equipment.

The facility has a commercial kitchen, which facilitates the daily feeding of the offender population. The kitchen operates nearly around the clock and is staffed by correctional officers and three correctional cooks on each shift. The kitchen is a fragmented area with many rooms all lumped together to function as an institutional kitchen. One of the rooms is an offender/worker breakroom for offender breaks and meals. Some of the rooms within the kitchen area include dry storage rooms, cold storage lockers and freezers. There is a staff office in the kitchen area, which contains a desk and logs. There is also a scullery area, a spice room, a fruit and vegetable wash/prep station, and storages area for rolling carts which carry food to the steam-line.

There is a secure corridor which leads to the back dock and trash storage/removal area. Both the supervising correctional cook and the assigned custody staff have key access to this area. Offenders must be accompanied by either one or the other.

The facility has a large commercial laundry which is staffed by offenders and supervised by one correctional officer and one laundry supervisor. The laundry contains many large commercial washers and dryers, which present many blind spots. The audit team discussed concerns about the blind spots behind and in between the machinery. Facility staff is developing plans to address these concerns.

PCF has program activities available for all offenders not classified as either "restricted custody", "administrative segregation" or "protective custody"; and therefore restricted from contact with other offenders.

These activities include education, recreational library, law library, religious services, substance abuse counseling groups, dayroom activities with television viewing, and an outdoor recreation yard. The facility has classrooms, a barbershop, and a chapel, which facilitates personal grooming activities and religious services. Family/friend visits occur in the visiting room.

## SUMMARY OF AUDIT FINDINGS

The on-site portion of the audit went very well. Facility staff was very helpful and responsive to the needs of the auditors and any concerns that were expressed. The audit team thanks the Superintendent, PREA Coordinator, and the entire staff for this because it simplified the process that needed to be completed.

Overall, it is evident that staff at PCF has been working toward compliance with the PREA standards. Because of this hard work, the facility is in compliance with a significant number of the standards.

Some of the positives observed by the audit team included:

- Many of the housing units had already addressed concerns about cross-gender viewing.
- Announcement of opposite gender staff entering the housing units seemed to be routine and part of everyday business.
- Supervisory and management staff have a clear understanding of the policy.
- The offender population understands their rights under PREA and could explain to the auditors how they would report an allegation.
- Training records reflected that mandatory staff training had been completed and that a process was in place to ensure mandatory training will be completed for new hires.
- Staff has already begun to address issues that the audit team identified.
- Classification staff has taken ownership of the PREA intake process and are very thorough in their reviews of newly arriving offenders.
- Human Resources staff was well prepared and able to quickly provide the needed information.

Some of the areas of general concern include:

115.15 Limits to cross-gender viewing and searches

115.16 Inmates with disabilities and inmates who are limited English proficient

115.17 Hiring and promotion decisions

115.52 Exhaustion of administrative remedies

115.67 Agency protection against retaliation

115.71 Criminal and administrative agency investigations

115.73 Reporting to Inmates

115.86 Sexual abuse incident reviews

Based on the additional information provided during the corrective action period, the facility now meets all of the applicable PREA standards.

There are a total of 43 standards for adult correctional facilities and jails.

Number of standards exceeded: 0

Number of standards met: 41 (95.3%)

Number of standards not met: 0 (0%)

Number of standards not applicable: 2 (4.7%)

**Standard 115.11 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.**

Policy and Administrative Procedure (PAP) #02-01-115, Sexual Abuse Prevention Policy outlines the agencies zero tolerance and includes sanctions for those who violate the zero tolerance policy. The policy further outlines implementation of the agency’s approach to prevent, detect, and respond to sexual abuse and sexual harassment. The 31-page policy provides definitions of prohibited behaviors and a description of agency strategy and response to reduce and prevent sexual abuse and harassment of offenders.

The Commissioner’s designee and Superintendent confirmed the agency’s commitment to achieving PREA certification and the agency’s zero tolerance policy.

The policy mandates that a PREA Coordinator will be assigned, this is confirmed by review of the agency organizational chart provided with the pre-audit questionnaire. He has regular contact with the assigned PREA Compliance Managers through site visits and direct conversations. In addition, Bryan Pearson, Executive Director of PREA, was at the facility for the entire audit and answered questions, as needed. Mr. Pearson is leading the agency’s commitment to attain PREA compliance.

The policy mandates the assignment of the facility PREA Compliance Manager. Andrew Cole is assigned to the role of PREA Compliance Manager. He is assisted by Camay Francham. Mr. Cole reports to the Executive Director of PREA, for PREA related issues and Ms. Francham reports directly to Mr. Cole for PREA related issues. The facility organizational chart indicated Mr. Cole is the PREA Compliance Manager. During formal and informal discussions with the auditors, it was evident Mr. Cole was knowledgeable about the standards and was able to answer most questions and could explain the process the facility followed in preparation for this audit.

The staff looks to Mr. Pearson and Mr. Cole to provide direction regarding PREA compliance. It was also clear that Mr. Pearson provides guidance, as needed, to the PREA Compliance Managers.

**Standard 115.12 Contracting with other entities for the confinement of inmates**

- 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 GEO Group contract was provided and demonstrates compliance with this standard. The contract directs that the contractor (GEO Group) will comply with PREA and will ensure all applicable PREA standards, state policies related to PREA and standards related to preventing, detecting, monitoring, investigating, and eradicating any form of sexual abuse within state facilities/programs/offices owned, operated or contracted by the GEO Group.

The Contract Administrator indicated that for each contract that is renewed, the updated PREA language is added. Monitoring is done by either the PREA Coordinator or a contract analyst. He further indicated that the agency has entered into or renewed only one contract during this review period.

### **Standard 115.13 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.**

The Superintendent and PREA Compliance Manager stated that during development of the staffing plan, the eleven (11) criteria outlined in standard provision 115.13(a) were considered.

The staffing plan establishes a minimum staffing level of 101 posts. A first line supervisor is assigned to control, rear gate, yard, health care, outside dorm, G cell house, H cell house, J cell house, and the incident review team. The staff assigned in the housing units provide offender supervision and supervisors were available as outlined in the staffing plan.

The staffing plan is evaluated annually or more frequently if needed, and provides for adequate levels of staff to protect offenders against abuse. Average daily number of offenders is 1762, the same number of offenders that the staffing plan was predicated upon.

Deviations from the staffing plan are documented on the shift rosters, as required by policy. In the pre-audit questionnaire and during the on-site review, PCF provided copies of several shift rosters that displayed the deviations that had occurred and the reasons for the deviation. The reasons for deviations included sick leave, long term medical, military duty, etc.

Policy mandates that intermediate level or higher level supervisors conduct and document unannounced rounds on all shifts. These rounds are documented on the shift report including the date, time, and person's name who made the rounds. Audit team members reviewed the documents and noted consistent entries by supervisors.

Staff are prohibited from alerting other staff when these rounds are occurring, barring legitimate operational functions of the facility. There were 4 interviews conducted with intermediate or higher level staff. These interviews affirmed that staff are making unannounced rounds and documenting these rounds. In addition, during random discussions, line staff were asked about the policy on the unannounced rounds. The auditor was told that supervisors conduct unannounced tours of their housing units and document them in the log book.

### Standard 115.14 Youthful inmates

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

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

This standard is N/A for PCF as they do not house offenders under the age of 18.

### Standard 115.15 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.**

PAP #02-03-101, Searches and Shakedown clearly prohibits cross gender strip searches and body cavity searches except in exigent circumstances. If exigent circumstances arise, these searches are documented on the incident report. PAP #02-01-115 states that offenders must be able to shower, perform bodily functions and change clothing without non-medical staff of opposite gender viewing their breasts, buttocks and genital areas except in exigent circumstances or when viewing is incidental to routine cell checks. Policy also requires staff of the opposite gender to announce their presence when entering an offender housing unit. PAP #02-01-115 also prohibits staff from searching or physically examining a transgender or intersex offender for the sole purpose of determining the offender's genital status.

There was 19 random staff questioned about cross gender search practices. The majority of these staff reported that cross gender strip searches or cross gender body cavity searches do not occur at this facility. The pre-audit questionnaire reported no incidents of cross gender strip or body cavity searches in the last 12 months.

Most of the offender cells are single occupancy and the toilet is inside each cell. During the random offender and random staff interviews, most offenders reported that any viewing by staff is incidental to routine cell checks. Most of the shower doors have been modified to address opposite gender viewing; however, there remains doors in G cell house and the Infirmary which have not been modified. Almost all offenders report that opposite gender staff announces their presence when entering the housing area. Many staff also reported that opposite gender staff makes announcements when entering the housing areas.

Opposite gender staff was observed entering the housing units and announcing their presence. Opposite gender auditors were announced when entering the offender housing units.

The training presentation guide for "Pat, Frisk, and Modified Frisk Searches" which was provided to the auditors outlines the process used to conduct opposite gender pat searches and searches of transgender or intersex offenders. The pre-audit questionnaire indicates 100% of the staff received training in proper search procedures. Auditors reviewed the search curriculum.

During the random staff interviews, many staff recall receiving training on opposite gender pat searches, but did not recall the training on searches of transgender/intersex offenders. However, staff were able to articulate the "j" and "plus" method to be used when conducting transgender pat searches. Most staff indicated they had had PREA training within the last year. In reviewing the training records, it was clear that training for all staff had been conducted during the last year. A small number of staff who were off work had not received the training.

The following corrective measure(s) are recommended to bring the Agency/Facility into compliance with this Standard.

1. The facility should provide adequate privacy for offenders while they are showering in R cell house and in the Infirmary. This is required in order to prevent opposite gender staff from viewing the offenders and comply with PREA standard 115.15.

During the corrective action period, the facility made the necessary modifications. Pictures of R cell house showers and the Infirmary restroom showing installation of half doors were provided. Infirmary post was changed to a male only post and a copy of the written materials were provided.

Based on the additional information provided, this standard has been met.

#### **Standard 115.16 Offenders with disabilities and inmates 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.**

PAP #02-01-115, PAP #00-02-202, Offenders with Physical Disabilities and the contract with Language Training Center, Inc. were reviewed.

Written documents are provided in English and Spanish to the offender population. During the tour, it was noted that posters were prominently displayed in areas in both English and Spanish. Nothing was observed related to offenders with disabilities. During discussion with the PREA Coordinator, he shared that brochures are available in braille, for offenders who are able to read braille.

PAP #02-01-115 and #00-02-202 mandate steps to be taken to ensure offenders with disabilities (including offenders who are deaf or hard of hearing, blind or 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 include, when necessary to ensure effective communication with offenders 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. Policy prohibits reliance on offender interpreters, offender readers, or other types of offender assistants except in limited circumstances where an extended delay in obtaining an effective interpreter could compromise the offender's safety, the performance of first-response duties, or the investigations of the offender's allegations.

The Language Training Center Inc. contract provides over the phone and in person interpretation services. Language line staff confirmed the contract with the facility and stated telephonic interpretive services are provided for most languages.

The Commissioner's Designee stated the inmate handbook is provided in English and Spanish and the language line is available to provide interpreter services for disabled and non-English proficient offenders.

The PREA Compliance Manager indicated they have braille materials available for blind offenders; they have staff that reads the materials to offenders who are unable to read; and they have staff translators including American Sign Language for offenders with speech impairments.

During interviews and various discussions, staff in the facility was not aware of services available through the contract. Most indicated they would try and find another staff member to provide translation. Offender interviews were difficult because the translator (staff) provided could not provide adequate translation. Staff was not able to find the telephone number for the interpretation services.

Some of the limited English proficient offenders, that were interviewed, complained that they were not provided PREA information in a way they could understand the agency's PREA program. Interviews were conducted with one disabled offender who indicated he did not have a need for special services.

Facility policy does not provide a mandate that requires documenting limited circumstances in which offender interpreters, readers or other types of offender assistances are used. Staff indicates there have been no instances of use of offender interpreters over the past 12 months.

The following corrective measure(s) are recommended to bring the agency/facility into compliance with this standard.

1. Ensure that all staff are aware of the services available through the Language Training Center contract.
2. Ensure effective communication is provided when disabled or limited English proficient offenders need to understand PREA materials.
3. It is recommended that the facility revise current policy to mandate that staff document any cases in which offender interpreters, readers or other types of offender assistance is provided.

As part of the corrective action, item 1 was enhanced by supervisory staff making notification of this service during Roll Call for all brackets. In addition, an informational sheet about how to use the service was posted on the Server and e-mail guidance was provided to all staff.

Items 2 and 3 were addressed by issuance of Executive Directive (ED) 16-21 that will be incorporated in AP 02-01-115, "Sexual Abuse Prevention" at its next annual review. A copy of ED 16-21 was provided to the auditor.

Based on the additional information provided, this standard has been met.

#### **Standard 115.17 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 was conducted of PAP #04-03-103, Information and Standards of Conduct for Departmental Staff. During the site visit, a random sample of applications for contractors and employees and a random sample of criminal records and background checks were reviewed by the audit team.

PAP #04-03-103 prohibits the hiring or promotion of anyone who may have contact with offenders, who have engaged in the 3 criteria outlined in standard provision 115.17(a) such as sex abuse in a confinement facility, convicted of engaging or attempting to engage in sexual activity in the community by force, threats, coercion or non-consent of victim, or has been civilly or administratively adjudicated to have engaged in the activity previously described. It also mandates the agency to consider any incidents of sexual harassment in determining whether to hire or promote anyone that may have contact with offenders. This policy mandates a criminal background records check be completed before hiring staff that may have contact with offenders and make 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. PAP #04-03-103 also mandates a criminal background records check be performed before enlisting the services of any contractor who may have contact with offenders. It also requires that all applicants & employees who may have contact with offenders be asked directly about previous sexual misconduct in written applications or interviews for hiring or promotions and in interviews or written self-evaluations conducted as part of reviews of current employees. PAP #04-03-103 also imposes upon employees a continuing affirmative duty to disclose any such previous misconduct and mandates that material omissions regarding sexual misconduct, or the provision of materially false information, shall be grounds for termination which requires the agency to 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 number of persons hired over the past 12 months who may have contact with offenders who have had criminal records checks was reported as 128 state employees, 22 Aramark contract employees and 22 Corizon Health Services contract employees.

During the document review, it was found that the three questions are being asked on state applications and on pre-interview questionnaire for staff. Personnel file reviews are required prior to making hiring decisions. It was noted background checks are being run, however, all of them were not being maintained by the Human Resources Department. The Superintendent has put in place a policy that will require background checks for all staff to be completed and maintained every 4 years. The process is currently underway for non-custody staff and is expected to be completed by May 2016.

Formal and informal interviews with human resource supervisors and staff were conducted during the site visit. They stated the facility performs criminal record background checks and considers pertinent civil or administrative adjudications for all newly hired employees who may have contact with offenders and all employees being considered for promotions. This is accomplished through completion of background forms and IDACS. The facility responds to requests from other institutions to allow access to the entire personnel file and status of ongoing and

incomplete investigations.

The following corrective measure(s) are recommended to bring the agency/facility into compliance with this standard.

1. The Superintendent has already implemented a plan to correct this issue and it is expected to be completed in May 2016. Provide proof of practice to the auditor when the process is completed.

During the corrective action period, IDACs were completed on all staff and will be updated every four years. The auditor received a memo from Superintendent confirming all checks have been completed with the exception of those who are off work. The auditor was provided with copies of completed documents.

Based on the additional information provided, this standard has been met.

### **Standard 115.18 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.**

PAP #02-01-115 was reviewed by the audit team. Staff indicated they made modifications to the chapel in 2014 and that PREA standards were considered in the planning of this renovation. Photos were provided of the modifications. During the site visit, we toured the recently renovated chapel which was converted to a dormitory living unit. This dorm was renovated in a very effective manner which allowed for clear line-of-sight for staff who provides custody supervision. It had been equipped with video surveillance equipment to provide an extra layer of supervision of the housing area. The toilet and shower facilities addressed opposite gender viewing.

During interviews with the Commissioner's Designee, he stated that in projects where installation or updating of video equipment is anticipated, a case by case review is included in the determination of locations. Areas where PREA incidents have occurred or where blind spots have been identified are considered in the case by case review. He indicated they have installed or updated video monitoring systems, electronic surveillance systems, or other monitoring technology since August 20, 2012. This is agency's 1<sup>st</sup> PREA audit.

The Superintendent told the auditor that PCF reviews previous PREA reports and considers identified blind spots in determining the placement of cameras. The institution has added more than 100 cameras since August 2012. The auditor was told that placement of the cameras were decided after discussion with a variety of staff including the PREA Compliance Manager.

### **Standard 115.21 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)

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.**

PAP #00-01-103, The Operation of the Office of Investigations and Intelligence and a copy of the Sexual Assault Manual, Health Services Division were provided to the audit team for review.

The agency is responsible to conduct both administrative and criminal sexual abuse investigations for incidents of offender on offender and staff sexual misconduct. PAP #02-01-115 and #00-01-103 provide uniform evidence protocol for sexual abuse. The facility ensures that offenders who allege the incident occurred within the last 96 hours are offered a forensic medical examination and if accepted, transported promptly to ensure evidence is not lost. The facility through the existing MOU is following the growing trend across the United States in the use of sexual assault nurse examiners (SANEs) to conduct the exam. SANEs are registered nurses who receive specialized education and fulfill clinical requirements to perform these exams. The facility strives to ensure that victims of a recent sexual assault have access to specially educated and clinically prepared examiners to perform the medical forensic exam. I&I staff are trained in the collection and preservation of evidence, according to jurisdictional policy, which might include:

- Offenders' clothing and underwear and foreign material dislodged from clothing;
- Bedding or other items identified by the offender; and
- Foreign materials on offenders' bodies which might be lost during transport, including blood or body fluids, fibers, loose hairs, vegetation, or soil/debris.

There is specific language for staff to separate victim and perpetrator and to ensure both do not destroy evidence, secure the scene and either secure or obtain usable physical evidence.

The PAQ indicates that when SAFEs or SANEs are not available, a qualified medical practitioner performs the forensic medical examination.

Based on discussions with staff and a review of the policy, the agency offers all offenders who experience sexual abuse access to a forensic medical examination at no financial cost to the victim, where evidentiary or medically appropriate. Exams are performed by SAFEs or SANEs where possible and the facility documents efforts to provide SANEs or SAFEs. Over the past 12 months, no forensic medical exams have been conducted.

The PREA Compliance Manager was interviewed and verified that the role of the Victim Advocate is provided through the MOU with Alternatives, Inc. Auditors interviewed one offender who reported an incident of sexual abuse. The offender indicated that he was touched inappropriately by staff during an unclothed body search. The offender indicated that staff did not take any action based on his allegation. In reviewing other information provided, it is noted this issue was evaluated and determined not to be a PREA incident. The offender was not notified of the decision. No disciplinary action was taken and no referral to Alternatives, Inc. was made.

In the 11 cases reviewed, evidence or lack of evidence was not clearly documented.

Interviews with 19 random staff indicate that a majority of staff would contact their supervisor and close off the

cell to limit who had access. They would separate the victim and suspect. Photographs would be taken. They would make sure all evidence was collected and the offender was given a SANE exam. They indicated that investigative staff usually handles this process.

The PREA Compliance Manager indicated the current forensic evidence collection protocol was based on the most recent edition of the U.S. Department of Justice's Office of Violence Women publication, "A National Protocol for Sexual Assault Medical Forensic Examinations, Adults/Adolescents".

Through an interview with a SAFE/SANE staff, the auditor was informed that services are provided 24 hours a day 7 days a week. When services are requested the SAFE/SANE response time is one hour from the time of notification. St Vincent Anderson Regional Hospital currently has six SAFE/SANE staff available with two additional staff in training. SAFE/SANE services are always provided by the SAFE/SANE staff. In the event of life threatening injuries, the emergency room physician may perform the services.

Review of the Alternatives, Inc. MOU determines the MOU is written to provide services to offender victims. In compliance with the existing MOU and as requested by victim, a victim advocate or qualified community-based organization staff member accompanies and supports the victim in all steps of the forensic medical examination and investigation. Of the 11 cases reviewed, there was no documented request by victims for access to a victim advocate.

The victim advocate provides assistance and support during the forensic medical examinations and through the local court process. Victims are provided with the victim advocate contact information and are given, education, mental health referrals, and offered follow-up services.

The auditor has determined this standard is met because the facility has a contract in place to ensure forensic medical examinations can be conducted and the evidence protocols being used are in compliance with the PREA standards. Staff interviews revealed that they understand the need to ensure a forensic examination is conducted, when appropriate. Documentation of evidence collection will be addressed in 115.71.

**Standard 115.22 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.**

PAP #02-01-115 mandates that an administrative or criminal investigation is completed for all allegations of sexual abuse and sexual harassment and to notify the State Police liaison of the assault to request assistance, if needed. This investigation shall be conducted by either the facility's Internal Affairs staff or staff from the Internal Affairs Section in Central Office. It further requires that all allegations of sexual abuse shall be investigated even when the alleged perpetrator or alleged victim have left the Department's employment, or are no longer under the Departments authority. The facility documents all allegations on a Sexual Incident Report. The policy is published on the department's public website.

PAP 00-01-103-01-103 The Operation of the Office of Investigations and Intelligence outlines investigative staff's responsibilities in response to allegations of sexual abuse and harassment.

The Commissioner's Designee stated that the agency, through the PREA Coordinator, ensures that an administrative or criminal investigation is completed for all allegations of sexual abuse or sexual harassment. Investigative staff stated that the agency has authority to conduct criminal investigations. Criminal cases are referred to the Indiana State Police and presented to the District Attorney.

Investigative staff stated that all allegations are documented on an SIR and are referred to them for investigation.

Over the past 12 months, this facility received 11 allegations of sexual abuse and sexual harassment, resulting in 11 administrative investigations & 0 criminal investigations.

### **Standard 115.31 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.**

The audit team reviewed PAP #02-01-115, PAP #01-05-101, Staff Development and Training, the PREA Presentation Guide, Training Records and Training Acknowledgement Sheets.

PAP #01-05-101 mandates the agency to train all employees who may have contact with offenders on all 10 specified criteria as outlined in standard provision 115.31(a). The training curriculum includes 9 of the 10 criteria outlined in standard provision 115.31. The requirement for civil immigration was not addressed in the lesson plan because Indiana Department of Corrections does not house offenders detained for civil immigration purposes. Employee training is to be tailored to the gender of the offenders at the employee's facility and provides employees additional training if he/she is reassigned from a facility that houses only male offenders to a facility that houses only female offenders or visa versa.

The lesson plan is a general lesson plan designed to help train all levels of staff on the implications of PREA. Refresher training is scheduled on an annual basis. Two phases of PREA training is provided. Initial training is provided during orientation and additional facility specific training is provided later through on-the-job training.

Through random staff interviews, the auditors learned that staff had received training on PREA within the last 12 months. The training included prevention, detection, reporting and response. The policy is zero tolerance and retaliation is not allowed. Staff also indicated they had been provided with written information.

During the on-site visit, record reviews were conducted and it was determined that almost all staff had received the mandatory PREA training. The few staff who had not received the training was currently off work and the facility had a plan to ensure training was completed upon the staff's return to work. 457 staff who may have contact with offenders were trained or retrained in PREA requirements.

PREA training requirements mandate attendance at the required training be documented, through employee signature that they understand the training they have received. Employees are required to complete the Acknowledgement of Receipt of Training and Brochures "Sexual Assault Prevention" upon completion of training. As part of this acknowledgement process, the employee is certifying that they understood the training materials.

#### **Standard 115.32 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.**

PAP #02-01-115 was reviewed by the audit team. The policy mandates all volunteers and contractors who have contact with offenders to be trained in their responsibilities under PREA. The facility has 388 volunteers and contractors currently authorized to enter the facility. All have been trained in the agency's policies and procedures per policy. The policy further mandates the level and type of training provided to volunteers and contractors is based on the services they provide and level of contact they have with offenders. Both volunteers and contractors have been notified of the agency's zero tolerance policy regarding sexual abuse and sexual harassment and informed how to report such incidents.

During the site visit, volunteers and contractors were interviewed and training records were checked. It appears the facility has a good process in place to ensure contractors and volunteers receive PREA training.

During the interviews, auditors were told that volunteers and contractors are provided PREA training annually. All of the individuals who were interviewed were able to explain to the auditor the components of the training and the requirement to report immediately, should they be made aware of an incident. Verification of this training being done is via completion of the PREA Acknowledgement of Receipt of Training and Brochure.

#### **Standard 115.33 Inmate 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.**

PAP #02-01-115, the Offender Handbook, PREA Offender Education Sign-Off Sheets, and PREA posters were

reviewed by the audit team. The audit team reviewed written materials in English and Spanish. We were also informed the brochure is available in braille.

Policy mandates that offenders receive information at intake regarding the zero-tolerance policy and how to report incidents of sexual abuse/harassment. Information is provided in the Inmate Handbook on page 23. It further mandates that within 30 days of intake, offenders receive comprehensive education either in person or through video regarding their rights to be free from sexual abuse/harassment and retaliation for reporting such incidents, and regarding agency policies and procedures for responding to such incidents. The policy states that offenders received PREA education within 7 days of intake or transfer. All current offenders received PREA information by 12/31/2013. This was certified by the Superintendent of the facility.

During the intake process, 454 offenders were admitted to the facility over last 12 months whose length of stay in the facility was for 30 days or more, per facility characteristics, all of them were provided with their reporting information, and how to respond to such incidents. The percentage provided the information vs total offenders admitted was 100%.

Per the Facility Characteristics provided, over the last 12 months during the intake process, 978 offenders were admitted to PCF and 978 were provided the zero-tolerance policy which equates to 100% compliance.

During interviews with Intake staff, they shared that offenders are provided with orientation upon arrival at a new institution. They are also provided with a 2-sided brochure, each time they transfer. Offenders sign an acknowledgement form which is maintained in the offender's packet. Staff completes an orientation for new arrivals form with the offender and the offender signs the form. The acknowledgment is a receipt for a PREA pamphlet. In addition, there are flyers posted around the institution and information on the kiosk about the PREA policy. The orientation is generally provided on the same day as the offender arrives.

During random offender interviews, about half of the offenders remembered receiving written materials when they arrived at the institution. Several that were interviewed had been at the facility for more than 12 months. A few more indicated that they didn't remember receiving anything in writing, but remember a staff member explaining about the PREA policy. Of the offenders who recalled receiving information (either verbally or in writing), they all indicated it was within a few days of their arrival.

PAP #02-01-115 mandates the agency to provide offender education in formats accessible to all offenders, including those who are limited English proficient, deaf, visually impaired, or otherwise disabled, as well as to offenders who have limited reading skills. The agency does have access to a braille brochure for the visually impaired, but states they would read the inmate handbook to the offender to provide effective communication, if necessary. The policy ensures that key information is continuously and readily available or visible to offenders through posters, inmate handbooks, or other written formats.

The facility maintains documentation of offender participation in PREA education sessions. Documentation is made via their signature on the Offender Education Program form which is maintained in the offender packet.

During the site visit, the team observed posters available for viewing around the institution in housing units and other areas. Also, the information is available on the kiosk and through brochures that are provided to offenders. There are slides about PREA being run on the offender television system. Language lines were available through a contract provider.

#### **Standard 115.34 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.**

PAP #02-01-115 and #00-01-103, Conducting Sexual Assault Investigations Presentation Guide, IDOC–SART Training Curriculum, and training records and certificates were reviewed by the audit team.

Policy mandates that in addition to the general training provided to all employees, the facility shall ensure that, to the extent the agency itself conducts sexual abuse investigations; its investigators have received training in conducting such investigations in a confinement setting. The agency conducts both administrative and criminal investigations on sex abuse cases. It requires that the facility maintain documentation that investigators have completed the required specialized training in conducting sexual abuse investigations.

PAP #00-01-103 requires specialized training to include techniques for interviewing sexual abuse victims, proper use of Miranda and Garrity warnings, sexual abuse evidence collection in confinement settings, and the criteria and evidence required to substantiate a case for administrative action or prosecutor referral.

Investigative staff receive training specific to conducting sexual abuse investigations in confinement settings. Trainings include quarantining area, interviews, start scene log, medical response, reporting and making determinations. One of the staff interviewed indicated he received a police academy certificate and a SART certificate.

Through documentation reviews, investigator training certificates were provided which demonstrate completion of “PREA – Investigating Sexual Abuse in a Confinement Setting” presented by the National Institute of Corrections, State of Indiana-SART Training and Sexual Assault Prevention Program training.

Investigative staff interviews confirmed receipt of specialized training in all areas required per this provision during SART training and investigator academy/training. Garrity training is provided during NIC training.

**Standard 115.35 Specialized training: Medical and mental health care**

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

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

PAP #02-01-115 and Corizon Health Services specialized training materials were reviewed by the audit team.

Medical and mental health services are provided by Corizon via an approved contract with the Indiana Department of Corrections.

The agency policy provided does not mandate that all full and part-time medical and mental health care practitioners who work regularly in its facilities be trained in all 4 of the criteria as outlined in standard provision 115.35(a). The facility employs 61 medical and mental health care practitioners who work regularly at the facility. 100% have received the general training. Corizon provides specialized training for medical and mental health staff. Auditors reviewed training materials which addressed the requirements of 115.35(a).

Medical and mental health care practitioners receive general PREA training mandated for employees, volunteers & contractors as identified in policy and outlined in PREA standards, depending upon the practitioner's status in the agency. During the on-site visit, audit team members reviewed and verified attendance at PREA training through the training records. Documentation is maintained that medical and mental health practitioners have received the general PREA training and the specialized training referenced in standard 115.35 either from the agency or elsewhere. Acknowledgement of Receipt of Training and Brochures forms are completed, but it is only for general training. Corizon in-service check off list is used to document participation in specialized PREA training.

Medical and mental health staff interviewed indicated they have received both the general and the specialized training, as required in the standards. Through discussions with supervisory personnel, it was clear that all medical staff are prohibited by procedure from performing forensic examinations on sexual abuse victims.

#### **Standard 115.41 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.**

PAP #02-01-115, PAP #04-01-101, Adult Offender Classification, a random sample of intake records, and a random sample of Sexual Violence Assessment Tool (SVAT) were reviewed by the audit team.

Policy requires all offenders to be assessed during an intake screening and upon transfer to another facility for their risk of being sexually abused or sexually abusive toward other offenders via the use of the standardized SVAT. It further mandates intake screening ordinarily be conducted within 24 hours of the offenders arrival at the facility. Refusal to answer questions asked during screening does not result in disciplinary action. Policy also requires that within a set time period, not to exceed 30 days from the offender's arrival at the facility, the facility will reassess the offender's risk of victimization or abusiveness based upon any additional relevant information received by the facility since the intake screening. PCF indicated that all offenders are reassessed within 30 days of arrival at their facility based on criteria outlined in standard provision 115.41(f). The assessments are done annually, thereafter.

About half of the offenders interviewed indicated they had been asked questions about sexual abuse when they arrived at this institution. The remainder of the offenders indicated that either they didn't remember if it happened or that it did not happen. Of the offenders which remembered participating in an intake screening, all

indicated that it occurred either on the day they arrived or the next day. Several of the offenders interviewed had been housed at PCF for more than 12 months.

Auditors interviewed intake and classification staff regarding this process. They were very knowledgeable about the classification process and verified that the screening/assessment was completed in a prompt manner.

Auditors also interviewed screening staff regarding this process. They verified that the screening/assessment was generally completed within 24 hours of the offender's arrival and that the risk screening is completed utilizing a standardized SVAT. Offenders are provided with orientation and given a 2-sided brochure which outlines the IDOC PREA policy. Policy mandates the SVAT consider prior acts of sexual abuse, prior convictions for violent offenses, and any history of prior institutional violence or sexual abuse, as known to the agency, in assessing offenders for risk of being sexually abusive. The offender is assigned housing, then the case worker or case manager screens the offender and provides PREA education. Classification staff is responsible for assessing the housing assignment. During their interview with the offender, the staff goes over the intake packet and the offender's Conduct Report looking at their prior criminal history. They discuss programs available and tell the offender how to report sexual abuse.

The facility assesses offenders promptly upon arrival as part of the intake process. This process evaluates risk of sexual victimization and abusiveness. The auditors were provided with a copy of the SVAT, on which these risks are documented. The SVAT meets all protocols under PREA except for 115.41(d)(10). This criterion is related to offenders retained solely for civil immigration issues and is not met because IDOC does not house offenders detained solely for civil immigration purposes.

During the site visit, auditors observed the actual intake process. The screening/assessment process is completed as part of an overall intake assessment and the standardized SVAT was being used. Intake and screening records were also reviewed by the audit team to demonstrate institutionalization of this screening practice. It was noted that SVAT forms were present in the offender packets that were reviewed.

Even though some of the offenders did not remember participating in the screening process, this auditor believes this standard is met because the intake process was observed where all offenders were being screened in compliance with policy and through the record review, completed SVAT forms were present in the offender packets.

#### **Standard 115.42 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.**

PAP #02-01-115 and #04-01-101 were reviewed by the audit team. Agency policy mandates the facility to use information from the risk screening to inform housing, programming, and education assignments, to keep offenders at high risk of sexual victimization apart from high risk abusive offenders. The SVAT which is used for the risk assessment is incorporated into the electronic offender record and is available for use in making housing decisions. Use of the standardized SVAT and the instructions included assist staff in determining appropriate

housing for each offender.

Staff responsible for risk screening shared that information obtained through the interview with the offender is used to assess the appropriateness of housing for the offender. Staff evaluate the answers on the questionnaire and determine if the offender is likely a victim or an aggressor. Once the information is gathered, it is submitted to classification for review. They will house the offender in general population, administrative segregation, or protective custody.

PAP #02-01-115 and #04-01-101 mandate that decisions regarding appropriate transgender or intersex housing in either male or female facilities and programming assignments are determined on a case-by-case basis. Placement decisions will ensure the offender's health and safety, and will consider whether placement would present management or security problems. It requires offenders be reassessed at least twice a year to review any threats to safety experienced by the offender. Policy states that transgender and intersex offender's own views are seriously considered when determining housing placement and programming assignments. The facility has not housed any transgender or intersex offenders in the last 12 months.

Staff responsible for risk screening stated that transgender and intersex offender's views of their own safety would be taken into consideration in housing placement and programming assignments and that they would be allowed to shower separately from other offenders.

Living units were toured and in most of the housing units, modifications had been made to allow transgender and intersex offenders to shower separately from other offenders. In the units that hadn't been modified, the facility is working on making the modifications. During random discussions with staff, they indicated that if the offender requested to shower separately, it would be allowed.

Policy mandates the agency not place Lesbian, Gay, Bi-sexual, Transgender, or Intersex (LGBTI) offenders in dedicated facilities, units, or wings solely on the basis of such identification or status. The PREA Coordinator confirmed that the agency has no consent decrees, legal settlements, or legal judgements for the purpose of protecting such offenders.

In reviewing the housing assignments for LGBTI offenders, it was noted by the audit team that they are not housed in a specific area, they are housed in various units within the facility. Through interviews with gay offenders, the audit team confirmed that gay offenders have never been put in a housing area only for gay offenders.

#### **Standard 115.43 Protective custody**

- 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 PAP #02-01-115 and #02-01-111, Use and Operation of Adult Offender Administrative Restrictive Status Housing, were conducted by the audit team. The team also reviewed the intake screening process.

Policy basically mirrors Standard 115.43 and prohibits placing offenders who are at high risk for sexual victimization in involuntary segregated housing unless an assessment of all available alternatives has been made and a determination has been made that there is no available alternative means of separation from likely abusers. It mandates offenders, who are placed in segregated housing for the purpose identified in standard provision 115.43(a), shall have access to programming, education & work opportunities to the extent possible and requires that restrictions be documented and include the 3 areas as identified in standard provision 115.43(b). Policy mandates that offenders will be reviewed every 7 days for the first 2 months of assignment and then every 30 days thereafter, to ensure that for each such offender there exists a continuing need for separation from the general population.

In practice, if an offender is placed in segregated housing, any limitations will be documented on the offender record maintained in the housing unit. Offenders assigned in segregated housing are not allowed to have a work assignment. Over the past 12 months there have been no offenders who were identified to be at risk of sexual victimization, held in involuntary segregation.

During the interview with the Superintendent, he confirmed that policy #02-01-115 does not allow offenders who are at high risk of sexual victimization to be placed in segregated housing unless all other alternatives have been eliminated. If alternate housing is not identified, the offender may be placed in segregated housing for less than 24 hours, while appropriate housing is identified. They have the ability to transfer the offender to another facility pretty quickly. He further stated the policy requires that if an offender is placed in segregated housing, he is monitored every 7 days for the first 60 days and then every 30 days thereafter. The length of time the offender is retained depends on the case and the length of the investigation.

Intake staff interviews confirmed that screening assessments are conducted immediately upon arrival. Housing assignments are made based on information from the SVAT and other case factors.

Staff who supervises offenders in segregated housing told the audit team that offenders who are placed in segregated housing for protection or after having alleged sexual abuse have access to limited privileges and programs. They have access to education which is completed, in cell. Offenders assigned to segregated housing are not allowed to work. The time retained in segregation depends on the length of time the investigation takes and the ability to transfer the alleged victim to another institution. 30 day reviews are conducted by the facility PREA committee.

During the tour, it was noted that there were no offenders currently housed in segregated housing due to victim concerns. The counseling staff provided a sample for a non-PREA offender who was reviewed every 30 days to determine the continued need for retention.

**Standard 115.51 Inmate 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.**

PAP #02-01-115, the Inmate Orientation Handbook and the PREA Brochure were reviewed by the audit team.

PAP #02-01-115 requires the facility to provide multiple internal ways for offenders to privately report sexual abuse/harassment, retaliation by other offenders or staff for reporting sexual abuse/harassment, and staff neglect or violations of responsibilities that may have contributed to such incidents. Policy further mandates the facility to provide at least one way for offenders 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 offender reports of sexual abuse/harassment to agency officials, allowing the offender to remain anonymous upon request. The standard further requires that offenders 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. Through discussion with the PREA Coordinator, IDOC, does not house offenders detained solely for civil immigration reasons.

PAP #02-01-115 requires staff to accept reports made verbally, in writing, anonymously, and from 3<sup>rd</sup> parties and to promptly document any verbal reports. Policy mandates the facility to provide a method for staff to privately report sexual abuse and sexual harassment of offenders. This is accomplished through the chain of command or by contacting the Executive Director of PREA.

During random staff interviews, staff indicated they would accept the report from the offender and document on a SIR. They shared that offenders can report several different ways including reporting to any staff, calling the number on the poster, using #80, using the kiosk, and telling family. Staff who was interviewed stated that they can privately report sexual abuse or harassment of offenders. In most cases, staff believed they could report to a supervisor, and it would be kept private.

Offenders reported, through the random interviews, that there are several ways to report. These include use of the kiosk, use the telephone number from the poster, call #80, tell family, or tell staff.

Review of the Inmate Handbook indicates internal reporting mechanism for offenders is by: 1) writing an offender grievance and giving it to a staff member; 2) placing the grievance with outgoing mail in any housing unit; 3) mailing the grievance directly to the institution; 4) family reports; or 5) submitting the report on kiosk. In addition, the Inmate Handbook allows offenders to privately report by dialing #80 or the public number which is monitored and recorded. PREA posters, written in both English & Spanish, provide a number which can be called confidentially.

During the tour, the team noted posters providing reporting information in English and Spanish, we observed reporting instructions on the kiosk, and were shown brochures that are provided to offenders. The audit team tested the numbers posted and all work, as expected. Posters provided contact information for an entity outside of the IDOC who will take reports and forward immediately to the Headquarters PREA Coordinator for response. We saw copies of these reports that had been forwarded to the Headquarters PREA Coordinator.

**Standard 115.52 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.**

PAP #02-01-115 and #00-02-301, Offender Grievance Process, were reviewed by the audit team. The auditor obtained an offender grievance form from staff for review.

The agency has an administrative policy for dealing with offender grievances regarding sexual abuse. Offender grievances alleging sexual abuse or sexual harassment are forwarded to the PREA Compliance Manager and the I&I Office. This establishes that the agency has administrative procedures where offenders can fill out a form articulating an issue they wish to grieve; submit their completed grievance form to a designated staff member for review and response. The response is provided in writing on the grievance form and within a specified timeframe. The policy establishes timeframes for responding to emergency allegations. The auditor was told there have been no grievances filed in the last 12 months which alleged sexual abuse or sexual harassment.

Policy mandates that the agency will not impose a time limit on when an offender may submit a grievance regarding an allegation of sexual abuse. Agency does not require an offender to use any informal grievance process or to otherwise attempt to resolve with staff, an alleged incident of sexual abuse. Review of inmate handbook reveals reports of sexual abuse allegations may be made at any time using the Grievance Suggestion Form. There is nothing to restrict the agency's ability to defend against an offender lawsuit on the grounds that the applicable statute of limitations has expired.

Policy mandates a final decision on the merits of any portion of a grievance alleging sexual abuse shall be issued within 90 days of the initial filing of the grievance. Computation of the 90 day time period shall not include time consumed by offenders in preparing any administrative appeal. The agency may claim a 70 day extension to respond and offender must be notified in writing of any such extension and provided date in which decision will be made. At any level of the process, including final level, if the offender does not receive a response within the time allotted for reply, including any properly noticed extension, the offender may consider the absence of a response to be a denial at that level.

Policy states that 3<sup>rd</sup> parties are permitted to assist offenders in filing request for administrative remedies relating to allegations of sex abuse and shall be permitted to file such requests on offenders' behalf. If a 3<sup>rd</sup> party files such a request on behalf of an offender, 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. If the offender declines to have the request processed on his or her behalf, the agency shall document the offender's decision.

The standards require establishment of procedures for filing an emergency grievance alleging that an offender is subject to a substantial risk of imminent sexual abuse. The standard requires initial response within 48 hours and issuance of the final agency decision within five calendar days. The agency policy indicates initial response within two business days and final response within five business days. The facility has a policy outlining the grievance process; however, it is not in compliance with the standards. Over the past 12 months, no emergency grievances have been filed.

The audit team tried to interview several offenders who had made an allegation of sexual abuse. Two were no longer housed at this facility. Three refused to be interviewed. We were able to interview one offender. He indicated that he had not been told anything about his report. Upon follow up, it was determined the allegation was made in 2014. The allegation was related to an unclothed body search where the offender felt the search was inappropriate. The review by the institution found the search to be appropriate and the incident was not considered a PREA incident.

The following corrective measure(s) are recommended to bring the agency/facility into compliance with this standard.

1. The agency should modify PAP #00-02-301 to clarify initial response is required within 48 hours and final response within five calendar days of receiving the emergency grievance.

Through the corrective action period, ED 16-20 was issued and reflects the necessary changes to policy regarding timeframes for initial and final response times for offender grievances which contain allegations of sexual misconduct. The changes will be incorporated in AP 00-02-301, "Offender Grievance Process" upon next annual review.

Based on the additional information provided, this standard has been met.

### **Standard 115.53 Inmate 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.**

PAP #02-01-115, PREA posters, PREA pamphlets, the Inmate Orientation Handbook, the MOU for Alternatives, Inc., and the Professional Services Agreement with the Indiana Coalition Against Domestic Violence (ICADV).

PAP #02-01-115 mandates each facility to provide offender access to outside victim advocates for emotional support services related to sexual abuse by providing offenders mailing addresses and telephone numbers, including toll-free hotline numbers where available, or local, state, or national victim advocacy or rape crisis organizations, and, for persons detained solely for civil immigration purposes, immigrant services agencies.

Policy mandates each facility to inform offenders prior to giving them access, of the extent to which such communications will be monitored and to the extent to which reports of abuse will be forwarded to authorities in accordance with mandatory reporting laws. Also included in the policy, counselors from victim advocacy groups shall be allowed access to the offender as a special visit arranged through the PREA Compliance Manager in accordance with PAP #02-01-102, "Offender Visitation." The reason for this visit shall be kept confidential and limited to the coordinator.

Policy further requires the facility to maintain or attempt to enter into an MOU or other agreements with community service providers that are able to provide offenders with confidential emotional support services related to sexual abuse. The facility maintains copies of agreements and provided copies to the auditor for review.

Offender information sheet and brochure entitled "Sexual Assault Reporting and Counseling Services Information Brochure" provides contact numbers for the rape crisis center.

Random offender interviews provided information that about half of the offenders interviewed indicated that they knew about outside victim advocates that would be available to talk with them. Of the offenders who knew, they

indicated there were posters around the institution that provide the contact information and telephone number.

The audit team tried to interview several offenders who had made allegations of sexual abuse. Two were no longer housed at this facility. Three refused to be interviewed. We were able to interview one offender. He indicated he had seen a telephone number on the posters in the unit. He also indicated his family called the number and reported his situation. The offender also told the auditor that he does not talk to people at the facility and he does not come out of his cell. He further indicated that he could communicate in a confidential way with the people on the poster and he felt they would listen to him.

The audit team observed posters in the housing units which provided contact information for the outside victim advocate. We were told that some of the posters were out of date and needed to be updated.

The audit team contacted the victim advocate at ICADV and was told that they have been receiving calls from the facility and that the process has worked well. When the call is received, it goes to a voice mail or to the Victim Advocate's cellular phone.

No corrective action is recommended; however, as a best practice, it is recommended that the posters around the institution be updated to reflect current contact information for the ICADV.

#### **Standard 115.54 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.**

PAP #02-01-115 and a Visitor Information Brochure were reviewed by the audit team.

Policy mandates establishment of a method to receive 3<sup>rd</sup> party reports of sexual abuse/harassment and distribute public information on how to report sexual abuse and sexual harassment on behalf of an offender.

The auditor reviewed the IDOC website and found the required information.

The facility provided the auditor with a copy of the Visitor Information Brochure. The brochure was reviewed and the required information was included.

#### **Standard 115.61 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.**

PAP #02-01-115 and the PREA Duty to Report for Medical and Mental Health Staff form were reviewed by the audit team.

PAP #02-01-115 mandates all staff to immediately report any knowledge, suspicion, or information regarding an incident of sexual abuse/harassment that occurred in a facility, whether or not it is a part of the agency. This includes any retaliation against any offender or staff who reported such an incident and any staff neglect or violation of responsibilities which may have contributed to an incident or retaliation. Policy prohibits staff from revealing any information related to a sexual abuse report to anyone other than to the extent necessary to make treatment, investigation, other security, and management decisions.

Policy requires medical and mental health practitioners to report sexual abuse pursuant to standard provision 115.61(a), and to inform offenders of the practitioner's duty to report, and the limitations of confidentiality, at the initiation of services, unless precluded by federal, state, or local law. Policy mandates each facility to report all allegations of sexual abuse/harassment, including 3<sup>rd</sup> party and anonymous reports, to the facility's designated investigators.

Interviews with staff at all levels of this facility indicate that all PREA related reports go to the facility PREA investigators.

During random interviews with staff, it was confirmed that staff is aware of this requirement and could explain how they would report an allegation of sexual abuse. They further stated that the information they received from the victim should remain confidential, with them only notifying their supervisor and medical staff.

During interviews with medical and mental health staff, the auditor heard mental health and medical staff express their understanding of the policy and duty to report. They explain to the offender the limitations of confidentiality prior to the initiation of services.

The Superintendent informed the audit team that his facility does not house offenders under the age of 18. If the offender is considered a vulnerable adult, the institution would report to the appropriate agency, as required in state law. All allegation of sexual abuse or sexual harassment are reported to designated investigators at the facility. The facility currently does not have any offenders who have been identified as a vulnerable adult.

The PREA Coordinator confirmed that the facility does not house offenders under the age of 18. If the offender is considered a vulnerable adult, the institution would contact the Department of Aging. In addition, a "potential victim" flag would likely be attached to the offender's record.

The agency provided a copy of the medical informed consent form which is provided to offenders prior to the initiation of services in accordance with the policy.

#### **Standard 115.62 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.**

PAP #02-01-115 was reviewed by the audit team.

PAP #02-01-115 requires immediate action to be taken to protect the offender when it is learned that said offender is subject to a substantial risk of imminent sexual abuse.

In past 12 months, one instance occurred where the facility determined that an offender was subject to substantial risk of imminent sexual abuse. Actions were immediately taken to ensure the offender's safety and those actions were documented in the SIR. An investigation was completed and appropriate disciplinary action was taken.

During the interview, the Commissioner's Designee indicated that if he received such information, he would notify the facility where the offender is housed. Direct that the offender be placed in protective custody while an investigation is completed into the threat. If the perpetrator is identified, he would be placed in disciplinary segregation pending completion of the investigation. The victim would only be retained in segregation until alternate housing could be identified.

During the interview with the Superintendent, he stated that if he received such an allegation, he would immediately move the offender to a place where he would be safe until the investigation was concluded.

Through random staff interviews, they indicated that if they received such a threat, they would separate the offender, notify the supervisor, and ensure the offender was safe. These actions would be taken immediately.

#### **Standard 115.63 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.**

PAP #02-01-115 was reviewed by the audit team.

PAP #02-01-115 requires the facility that receives an allegation of an offender being sexually abused while confined at another facility, to notify the other facility or appropriate office of the agency where the alleged abuse occurred within 72 hours of receiving the allegation. Policy further requires that allegations received from other

facilities/agencies be investigated in accordance with the PREA standards and PAP #02-01-115.

During the interview with the Commissioner's Designee, he stated any such allegation received is referred to the Director of Investigations. Contact is made with the PREA Compliance Manager and an investigator is assigned to conduct the review.

During the interview with the Superintendent, he indicated an investigation would be initiated. His staff will be directed to work with the other agency to gather all information and create a response.

In the past 12 months, no allegations have been received by PCF which indicated an offender was abused while confined at another facility.

**Standard 115.64 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.**

PAP #02-01-115 and all SIRs and Investigatory Reports, from the last year, were collected and reviewed by the audit team.

Policy requires that, upon learning that an offender was sexually abused, the first staff member to respond to the report shall be required to separate the victim and abuser, preserve and protect the crime scene, request that the victim not take any action which may destroy physical evidence, and ensure the alleged perpetrator does not take any action to destroy evidence. Policy further mandates that non-sworn staff, acting as first responders, request the alleged victim not take any actions that could destroy physical evidence and then notify custody staff, as soon as possible.

Security staff first responders stated they would provide emotional support to the offender, gather initial information to give the investigator, secure the crime scene, and separate/secure the victim in a dry cell so no washing facility or restroom was available. They would also notify their supervisor. Non-security staff first responders would notify custody staff and ask the alleged victim not to destroy any evidence. Through random staff interviews, staff stated they would secure the offender, separate from the perpetrator, call the supervisor for further direction, and notify the investigator. All information would be kept confidential except for staff who have a need to know.

The audit team tried to interview several offenders who had made allegations of sexual abuse. Two were no longer housed at this facility. Three refused to be interviewed. We were able to interview one offender. He indicated that he reported the incident to staff and that nothing was done. Upon follow up, it was determined the allegation was made in 2014. The allegation was related to an unclothed body search where the offender felt the search was inappropriate. The review by the institution found the search to be appropriate and the incident was not considered a PREA incident.

**Standard 115.65 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.**

PAP #02-01-115 and the Pendleton Correctional Facility, Directive 13A, Sexual Abuse Response Team policies and procedures were reviewed.

Both statewide and local policy establishes the coordination to be followed in response to an incident of sexual abuse, among staff first responders, medical and mental health practitioners, investigators, and facility leadership.

Facility leadership and line staff understood the response that is required when allegations of sexual abuse are made and were able to adequately describe their role, if appropriate.

The Superintendent stated that the facility has a local procedure #13A which describes the coordinated actions to be taken by staff of various disciplines in response to an incident of sexual abuse.

During the site visit, we observed response to an allegation of sexual abuse which was prompt. This observation along with staff interviews and policy review allowed the audit team to determined PCF is in substantial compliance with this standard.

**Standard 115.66 Preservation of ability to protect inmates 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.**

There is no collective bargaining within the IDOC; therefore, this standard is N/A.

**Standard 115.67 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.**

PAP #02-01-115 was reviewed by the audit team and requires protection for all offenders and staff who report sexual abuse/harassment or cooperate with sexual abuse/harassment investigations from retaliation by other offenders or staff. Policy establishes multiple protection measures such as housing changes or transfers for offender victims or abusers, removal of alleged staff or offender abusers from contact with offenders or staff who fear retaliation for reporting sexual abuse or sexual harassment or for cooperating with investigations. Items the agency monitors include offender disciplinary reports, housing or program changes, or negative performance reviews or reassignments of staff. The agency continues monitoring beyond 90 days if a continuing need is identified. Policy establishes that in the case of offenders, such monitoring includes periodic checks. Policy further states that if any other individual who cooperates with an investigation expresses a fear of retaliation, the department shall take appropriate measures to protect that individual against retaliation.

Auditor observed that this process was newly put in place beginning in December 2015/January 2016.

During the interview with the Commissioner's Designee, he stated that the facility will use the protection against retaliation process to follow-up with victims and those who report. Staff will take appropriate action if there appears to be retaliation. Once follow-up is completed, the documents are maintained in the offender's packet. If retaliation is suspected or confirmed, possible actions may include additional monitoring, transfer of housing or work location and possible discipline for the individual who is retaliating.

The Superintendent, during his interview, shared that the different measures used to protect offenders and staff from retaliation include separating the victim and perpetrator, change in housing or work assignment, monitoring of grievances or complaints. For retaliation by staff, the case is assigned to an investigator. For retaliation by offenders, evidence is collected and the offender is held accountable through the disciplinary process. The facility has recently implemented follow-up monitoring that will meet the standard.

Staff assigned to the Facility PREA Committee has been designated to monitor for possible retaliation within the facility. The auditor observed that this process was newly implemented beginning in December 2015/January 2016. During the site visit, the 11 reported PREA cases were reviewed and the protection against retaliation process was initiated for those that hadn't already been done. Minimal information was contained in the investigatory files, as protection against retaliation was not consistently used until January 2016.

In one PREA case reviewed, the auditor noted possible retaliation. The facility took action to rehouse the abuser to mitigate further retaliatory behavior. Follow up was not accomplished as required by the standards; although follow up was done with the offender during the audit and the offender reported no further concerns.

The following corrective measure(s) are recommended to bring the Agency/Facility into compliance with this Standard.

1. A new Protection Against Retaliation process has been implemented. During the corrective action period, the new process will be monitored to ensure consistent application.

During the corrective action period, the process used to monitor for retaliation is occurring. PCF staff provided

completed documents demonstrating they are following the process for allegations of sexual violence and staff sexual misconduct.

Based on the additional information provided, this standard has been met.

#### **Standard 115.68 Post-allegation protective custody**

- 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.**

PAP #02-01-115 was reviewed by the audit team.

Policy states that any use of segregated housing to protect an offender who is alleged to have suffered sexual abuse shall be subject to the requirements outlined in standard 115.43.

The facility reports that no offenders who allege to have suffered sexual abuse were held in involuntary segregated housing in the past 12 months for more than 24 hours awaiting completion of assessment. No involuntary housing placements or assignments have been made over the past 12 months.

The Superintendent stated that the requirements of 115.43 are complied with.

Staff who supervise offenders in segregated housing shared that offenders who are placed in segregated housing for protection or after having alleged sexual abuse have access to limited privileges and programs. They have access to education which is completed, in cell. Offenders assigned to segregated housing are not allowed to work. The time retained in segregation depends on the length of time the investigation takes and the ability to transfer the alleged victim to another institution. 30 day reviews are conducted by the facility PREA committee.

The site visit and record review revealed that the facility has not had offenders retained in segregated housing who allege they have suffered sexual abuse.

#### **Standard 115.71 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.**

PAP #02-01-115 and #00-01-103, SIRs and investigative case files, training records and certificates, SART training curriculum, investigative reports, and the Records Retention and Disposition Schedule were reviewed by the audit team.

PAP #00-01-103 mandates that investigations of sexual abuse and sexual harassment be done promptly, thoroughly, and objectively for all allegations, including third-party and anonymous reports. It requires all investigators to receive specialized training for conducting sexual abuse investigations in confinement settings. Investigators are required to gather and preserve direct and circumstantial evidence, including any available physical and DNA evidence and any available electronic monitoring data, interview alleged victims, suspected perpetrators, and witnesses, and review prior complaints and reports of sexual abuse involving the suspected perpetrator. The policy states that special attention shall be paid to all interviews, including compelled interviews; however, it does not mandate investigative staff to consult with prosecutors prior to conducting compelled interviews.

Policy mandates credibility of an alleged victim, suspect, or witness be assessed on an individual basis and not determined by the person's status as an offender or staff. A voice stress analysis exam is never to be used on an offender as a condition for proceeding with an investigation of a sexual abuse or sexual harassment report.

Policy mandates administrative investigations shall include efforts to determine whether staff actions or failures to act contributed to the abuse and shall be documented in written reports that include a description of the physical and testimonial evidence, the reason behind credibility assessments and investigative facts & findings.

PAP #00-01-103 mandates criminal investigations be documented in a written report that contains a thorough description of physical, testimonial, and documentary evidence & attaches copies of all documentary evidence where feasible. The substantiation standard for sexual abuse and sexual harassment administrative investigations is preponderance of evidence. Substantiated cases that appear to be criminal in nature are referred for prosecution.

Policy requires that 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.

Interviews with investigative staff revealed that investigations are initiated immediately upon receiving a report of sexual abuse. Allegations made by third party or anonymously are handled the same as other allegations. Investigative staff indicated they have received specialized training in compliance with this standard and 115.34. Training participation was verified through review of training certificates. During the interview, the investigators explained the response process would include separating the victim and perpetrator, medical review, interview of the victim, securing and preserving the crime scene. The assigned investigator would collect the evidence or supervise the collection. He would work together with state police to complete investigation and reports. Evidence would include body fluids, clothing, bedding, photos of the scene, video evidence. In addition, they would look at past cases in the database for information. If the suspect has been identified, they would conduct an interview with the suspect. Investigatory staff indicated that credibility is determined through interviews, evidence and witness statements. Offenders would not be required to submit to a polygraph examination as a condition for proceeding with the investigation. Evaluations related to determining whether staff actions or failures to act contributed to the abuse are included in the investigation and disciplinary actions taken. Written reports are completed on all sexual abuse and harassment allegations. Criminal investigations are documented in a written report that contains all information which has been gathered. Cases are referred when they are substantiated. Referral is made to the Indiana State Police. Investigative staff stated that the investigation is continued on both staff and offender allegations, if the victim or suspect leaves custody or the employment of the agency, and is

referred for prosecution, if warranted.

The one offender interviewed that alleged sexual abuse indicated he was not subjected to any truth telling device.

The agency conducts both administrative and criminal sexual abuse investigations for sexual harassment, sexual abuse, and staff sexual misconduct. I&I staff at the facility conduct all investigations to include third party and anonymous reports. If the allegation is criminal, the state police can be contacted to assist.

Completed SIRs demonstrate that all allegations were investigated promptly, when the allegation was received from either the victim, a third party, or anonymously.

11 allegations of sexual abuse/harassment were alleged during the past twelve months. The PREA Compliance Manager provided SIRs for all allegations. During the on-site review, additional investigative reports were reviewed and collected. It was noted that documented investigation reports were not available in 4 of the 11 cases.

The SART training curriculum was provided evidencing specialized training as described in standard 115.34 and was described during interviews with investigative staff. The curriculum did not include Garrity. Garrity is included in the on-line NIC training that investigators complete. The PREA Compliance Manager confirmed that investigative staff receive SART training and on-line NIC training which meet this provision of the standard. Certificates indicating completion of other specialized trainings were also provided to the audit team.

Investigative files reviewed included allegations against staff. The reports document a similar investigative process for allegations against staff and offenders. The investigative reports contained no documented assessment of credibility based on status as offender or staff. It was noted that allegations against staff and offenders did not consistently include reports evidencing findings, and whether staff actions or failure to act contributed to the abuse. Investigative files reviewed documented reviews of video monitoring data but did not include information regarding reviews of prior reports and complaints.

No cases were referred for prosecution in the past 12 months. No investigative reports reviewed involved offenders that had transferred or were no longer in custody or staff that no longer worked for the facility.

The Record Retention and Disposition Schedule (RRDS) requires an offender's packet to be retained for 10 years past the date of discharge. It requires retention of staff personnel files for one year after the employee leaves the state government agency or at the conclusion of any litigation, whichever is later. Then transfer to the records center, along with a contents-list for each box, at which time they will become the property of the State Personnel Department. The records to be transferred include records relating to disciplinary notices, grievances and complaints. The RRDS does not address retention of investigatory files or referrals for criminal charges related to PREA allegations against staff.

The following corrective measure(s) are recommended to bring the Agency/Facility into compliance with this Standard.

1. In the SIR or other investigative report, document all reviews conducted of prior reports and complaints of sexual abuse involving the suspected perpetrator.
2. Clarify local policy to provide direction for contacting the prosecutor prior to conducting compelled interviews.
3. Train investigative staff regarding consistent thorough documentation of the actions taken during the investigation, to include: evidence collected, SAFE/SANE contacted, Victim Advocate contact and presence for investigative interviews (when required), a clear description of what led to the findings, and whether staffs actions or failure to act contributed to the abuse.
4. Develop or amend RRDS for investigatory files or referrals for criminal charges related to PREA allegations against employees/staff.

- Investigative Reports should clearly articulate that either evidence was identified/gathered or no evidence was present. Reports should provide a description of the items of physical, testimonial and documentary evidence.

During the corrective action period in response to items 1, 3 and 5, the facility initiated a checklist to assist investigative staff in ensuring that investigative reports include all required and pertinent information. Training of staff was conducted into the use of this checklist. To address item 2, the facility investigative staff contacted the Prosecutor's Office regarding conducting compelled interviews. The Prosecutor's Office has provided written direction to the facility and a copy was provided to the auditor. Through discussion with the PREA Coordinator and facility investigative staff about item 4, it was discovered that the I&I policy contains the mandated language for retention of investigative records and referrals for criminal charges. These records are not forwarded to an off-site retention facility; therefore, the mandate has not been added to the official Record Retention Schedule. The auditor learned that investigative files are maintained at the facility.

In conducting a review of investigations initiated during the corrective action period, it is noted that the investigations being conducted are being documented in a more thorough manner and the actions taken demonstrate an understanding of the PREA standards.

Based on the additional information provided, this standard has been met.

**Standard 115.72 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.**

PAP #02-01-115 and investigative case files were reviewed by the audit team.

PAP #02-01-115 mandates the agency impose no standard higher than the preponderance of evidence in determining whether allegations of sexual abuse or sexual harassment are substantiated.

Investigative staff interviews confirmed that no standard higher than a preponderance of evidence is utilized when determining whether allegations are substantiated.

A review of administrative investigative case files also confirmed compliance with the provision of this standard.

**Standard 115.73 Reporting to inmates**

- 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.**

PAP #02-01-115 and SIRs were reviewed by the audit team.

PAP #02-01-115 requires following an investigation into an offender's allegation that he or she suffered sexual abuse or sexual harassment by another offender or staff in a department facility, the PREA Compliance Manager shall inform the offender in writing as to whether the allegation has been determined to be substantiated, unsubstantiated, or unfounded. Policy requires that following an offender's allegation that a staff member has committed sexual abuse against the offender, unless the agency has determined that the allegation is unfounded, the agency informs the offender of the four bullets in this provision. Policy further mandates that following an offender's allegation that he has been sexually abused by another offender in an agency facility, the agency subsequently informs the alleged victim whenever the agency learns the alleged abuser has been indicted on a charge related to sexual abuse within the facility or convicted on a charge related to sexual abuse within the facility. All notifications or attempted notifications shall be documented. In the past 12 months, there have been no notifications to offenders pursuant to this standard.

The interview with the Superintendent revealed that current practice is to provide notification for substantiated and unsubstantiated cases, but not for unfounded cases.

Through interviews with investigative staff, the auditor found that one investigator believed the offender would be notified verbally of the outcome of the investigation during a follow-up interview and this would be documented in the paperwork. Other investigative staff reported that the offender is notified per the requirements in policy.

In the past 12 months, 11 investigations of alleged offender sexual abuse/sexual harassment were completed by the facility. Of the completed investigations, six offenders were notified of the results of the investigation. Copies of these notifications were not provided to the auditor for review; however, some copies were contained in the investigatory files maintained by the I&I Office.

The form used for this notification was reviewed and contains all of the required criteria.

The following corrective measure(s) are recommended to bring the Agency/Facility into compliance with this Standard.

1. Provide training to investigators on provisions of this standard and the requirement to retain a copy of the notification in the investigatory case file for audit purposes.
2. Document the notification to the offender in written reports.
3. Retain a copy of the notification to the offender in an investigative case file or file that pertains to the allegation along with all other documents pertaining to the allegation.
4. Provide training to investigative staff on the process regarding PREA case document retention that is consistently applied for all allegations.

Through the corrective action period to address items 1 and 4, staff were provided training regarding the mandate to notify the offender of the outcome of the investigation into sexual misconduct and copies of sign-in sheets were provided to the auditor. PCF places all information about the case in a centralized location to allow access for those who need it. To address items 2 and 3, the auditor was provided copies of Outcome Notification Reports which have been issued to the offenders. Through an e-mail, the auditor was informed that copies of these notifications

will be retained as part of the case file.

Based on the additional information provided, this standard has been met.

**Standard 115.76 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.**

PAP #02-01-115 and #04-03-103, Information and Standards of Conduct for Departmental Staff, were reviewed by the audit team.

Policy states that staff is subject to disciplinary sanctions up to and including termination for violating agency sexual abuse or sexual harassment policies and that termination shall be the presumptive disciplinary sanction for staff who has engaged in sexual abuse. The policy does not differentiate between lesser and more significant levels of staff misconduct and states that staff is subject to disciplinary sanctions up to and including termination for violating agency sexual abuse or sexual harassment policies.

Over the past 12 months there has been one staff disciplined short of termination for violation of agency sexual abuse/harassment policies. No staff members from PCF were terminated or resigned prior to termination for any violation, since no conclusion provided for criminal and administrative investigation identified in standard provision 115.76(b).

**Standard 115.77 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.**

PAP #02-01-115 was reviewed by the audit team.

Policy mandates any contractor or volunteer who engages in sexual abuse shall be prohibited from contact with offenders and shall be reported to law enforcement agencies, unless the activity was clearly not criminal, and to

relevant licensing bodies.

Interview with the Superintendent stated the facility conducts an investigation into allegations against a contractor or volunteer. If the allegations are substantiated, the contractor is removed from being allowed to enter the grounds. Information is provided to the contract agency and the case is referred for prosecution.

Over the past 12 months, no contractors or volunteers were reported to law enforcement agencies or relevant licensing bodies for engaging in sexual abuse of offenders.

**Standard 115.78 Disciplinary sanctions for inmates**

- 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.**

PAP #02-01-115 and #02-01-101, Disciplinary Code for Adult Offenders, Report of Disciplinary Hearing

Policy states offenders will be subject to disciplinary sanctions pursuant to a formal disciplinary process following an administrative finding that the offender engaged in offender on offender sexual abuse or following a criminal finding of guilt for offender on offender sexual abuse. The policy mandates that sanctions against offenders are to be commensurate with the nature and circumstances of the abuse committed, the offender’s disciplinary history, and the sanctions imposed for comparable offenses by other offenders with similar histories. Should the facility offer therapy, counseling or other interventions designed to address and correct underlying reasons or motivations for the abuse, the facility shall consider whether to require the offending offender to participate in such interventions as a condition of access to programming or other benefits. At this facility, participation in this type of counseling is not made a condition of access to programming or other benefits.

Policy states that the agency may discipline an offender for sexual contact with staff only upon a finding that the staff member did not consent to such contact and that 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. Policy states the agency may, in its discretion, prohibit all sexual activity between offenders and may discipline offenders for such activity.

Mental Health Staff shall conduct a mental health evaluation of the known offender abuser within sixty (60) days of learning of such abuse history and offer treatment when deemed appropriate.

Through an interview with the Superintendent, offenders are subject to discipline based on the level of violation. Penalties might include placement in restricted housing, loss of good time credit, and prosecution. If the offender has a mental health history, mental health staff will be involved in the discussion about penalty.

During Medical and Mental Health Staff interviews, the auditors were told the facility offers limited therapy, counseling and other interventions to address/correct underlying reasons for abuse. They do not require participation in interventions as a condition to access other programming or benefits. If an allegation is of actual

sexual abuse, the victim shall be referred to the facility's health care staff for examination and evaluation.

One substantiated case of sexual conduct against another offender was adjudicated during this rating period, in which earned time credit was lost and a demotion of classification was imposed.

**Standard 115.81 Medical and mental health screenings; history of sexual abuse**

- 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.**

PAP #02-01-115 was reviewed by the audit team.

PAP #02-01-115 mandates that if screening indicates that an offender has experienced prior sexual victimization, whether it occurred in an institutional setting or in the community, staff shall ensure that the offender is offered a follow-up meeting with a medical or mental health practitioner within 14 days of the intake screening. It states that information related to sexual victimization and abusiveness that occurred in an institutional setting be strictly limited to medical and mental health practitioners and other staff, as necessary, to inform treatment plans, work, education, and program assignments, or as otherwise required by federal, state, or local law.

Policy mandates medical and mental health staff obtain consent from offenders before reporting information about prior sexual victimization that did not occur in an institutional setting, unless the offender is under the age of 18. Offenders are made aware of this process and there is a form used to obtain the required consent.

Offender interviews confirmed follow-up mental health interviews are being conducted within the required 14 days. During the interview with the offender who disclosed sexual victimization at risk screening, he was asked about being sexually abused and asked if he wanted to meet with a doctor. He met with the doctor the next day.

Interviews with staff who perform risk screening related that offenders who indicate they have previously perpetrated sexual abuse are offered a follow-up meeting with a medical and/or mental health practitioner within the required 14 days. There are no secondary mental health/medical materials as the documentation is loaded directly on the computer that only medical staff have access to. Documentation is maintained in the automated system. Access is limited to staff in certain classifications.

One of the Mental Health Staff interviewed were unsure about the requirement to obtain informed consent before releasing information to custody staff about previous sexual abuse. PCF does not house offenders under the age of 18.

No corrective action recommended; however, as a best practice it would be beneficial to provide additional on-the-job training regarding informed consent and the process to be used by appropriate staff.

**Standard 115.82 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.**

PAP #02-01-115 and the Sexual Assault Manual (01/15/2014) were reviewed by the audit team.

Policy mandates treatment services 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. Offender victims of sexual abuse shall 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 judgement. Medical and mental health staff completes required documentation, which is secured electronically in medical computers where only medical and mental health staff have access.

Per the Sexual Assault Manual, initial assessment shall take place in a quiet closed place, immediately following the assault. Medical and mental health staff interviews revealed that staff responds immediately when noticed of an incident of sexual abuse. The treatment is based on their professional judgement. Offender victims of sexual abuse while incarcerated are offered timely information about and timely access to emergency contraception and sexually transmitted infections prophylaxis, in accordance with professionally accepted standards of care where medically appropriate.

The audit team tried to interview several offenders who had reported sexual abuse. Two were no longer housed at this facility. Three refused to be interviewed. We were able to interview one offender, who indicated he was not seen by medical staff after he reported the incident to security staff. He further indicated that he was not provided information about or access to emergency contraception or sexual transmitted infection prophylaxis. Based on the nature of the allegation made by the offender, there would be no reason to offer medical screening or prophylaxis.

Security staff and non-security staff, first responders stated that notification will be made verbally via the telephone or radio, to the medical or mental health staff who are on duty when they are informed of an incident of sexual abuse. They also stated that if no qualified medical or mental health practitioners are on duty at the time a report of recent abuse is made, security staff first responders take preliminary steps to protect the victim per standard 115.62, and immediately notify the appropriate medical and mental health staff and supervisory staff.

During the tour, the team leader received a report of sexual abuse. The team reported the alleged incident to the facility staff and immediate action was taken to address the situation.

**Standard 115.83 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.**

PAP #02-01-115 and the Sexual Assault Manual were reviewed by the audit team.

PAP #02-01-115 mandates each facility to offer medical and mental health evaluation and, as appropriate, treatment to all offenders who have been victimized by sexual abuse. The Sexual Assault Manual that was provided goes into detail about the process to be followed by staff. Policy requires the evaluation and treatment of offenders who have been victimized, to include as appropriate, follow-up services and referrals for continued care following their transfer to, or placement in, other facilities and upon the offender's release. Policy mandates that victims of sexual abuse while incarcerated shall be offered tests for sexually transmitted infections as medically appropriate and that treatment services are to 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. Mental health evaluations are required for all known offender-on-offender abusers within 60 days of learning of such abuse history. Treatment should be offered when deemed appropriate by mental health practitioners.

During the site visit, random staff was asked about medical and mental health services being offered. Staff stated offenders who make a report are referred to medical as soon as possible.

During interviews with medical and mental health staff, the auditors learned that offenders are provided with treatment, screening, and follow-up mental health services, as determined appropriate by mental health staff. Staff also indicated that an assessment is provided but follow-up services are limited.

One offenders who reported sexual abuse was interviewed and he indicated that he did not see medical staff after the incident was reported. He also stated he was not offered tests for sexually transmitted diseases. Based on the nature of the allegation made by the offender, there would be no reason to offer testing.

There is no mention in the policy about providing services consistent with the community level of care; however, the policy indicates that the offender will have access to a forensic exam at the designated medical center and to victim advocates who work in a community rape crisis center. Based on this, the auditor feels this standard has been met.

#### **Standard 115.86 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.**

PAP #02-01-115 and PREA Committee Meeting minutes were reviewed by the audit team.

PAP #02-01-115 mandates that the Superintendent of each facility shall establish a Facility PREA Committee comprised of upper-level management officials, with input from line supervisors, investigators, and medical or mental health practitioners. The Facility PREA Committee is responsible 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 determined to be unfounded. Such review shall ordinarily occur within 30 days of the conclusion of the investigation. Policy mandates the Facility PREA Committee to consider all six criteria as outlined in standard provision 115.86(d).

Facility PREA Committee meeting minutes document the date the investigation was completed and the date the Facility PREA Committee occurred, to demonstrate the meeting occurred within the required 30 days. They include a list staff who were present.

The auditor reviewed several sessions of the Facility PREA Committee meeting minutes and found that discussion of the six criteria and how the areas of concern were being addressed and corrected were not documented.

Interviews with the PREA Compliance Manager and Facility PREA Committee members indicated that the committee does go over each of the criteria of this provision and submits the minutes to the Superintendent. The PREA Compliance Manager and Assistant Superintendent ensure any modifications recommended are completed.

The following corrective measure(s) are recommended to bring the agency/facility into compliance with this standard.

1. Develop a format for the Facility PREA Committee to utilize that ensures each criteria of this provision is adequately addressed. Ensure the committee's assessment and recommendations are clearly documented.
2. Document how the findings and recommendations are implemented or the reasons for not doing so.

During the corrective action period, the auditor was provided with several copies of Sexual Abuse Incident Reviews and PREA Committee Meeting minutes. Upon completing a review of these documents, it is noted that all required information is contained within these documents. The reviews are conducted timely and are being thoroughly completed.

Based on the additional information provided, this standard has been met.

#### **Standard 115.87 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.**

PAP #02-01-115 and the Survey of Sexual Violence documents were reviewed by the audit team.

PAP #02-01-115 mandates the agency to collect accurate, uniform data for every allegation of sexual abuse at facilities 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 Victimization (SSV-IA) conducted by the Department of Justice. All data is aggregated annually and displayed on the agencies website. The policy requires the facility to maintain, review, and collect data for all allegations. The PREA Compliance Manager maintains a record of all reports of sexual abuse at the facility. Each individual Sexual Incident Report (SIR) is submitted to the PREA Coordinator and discussed at the next Facility PREA Committee meeting.

The PREA Coordinator stated that contracted facilities have access to the agency's SIR system. This is the system utilized to collect the PREA data. The information is then compiled and reported to the Department of Justice, annually.

The audit team was provided with the agency's Survey of Sexual Victimization. They also reviewed the agency's website and observed previous Surveys of Sexual Victimization posted there.

**Standard 115.88 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.**

PAP #02-01-115, the Agency's Website and the 2013 and 2014 Sexual Assault Prevention Program Annual Report were provided and reviewed by the audit team.

PAP #02-01-115 mandates annually, the Superintendent and the PREA Compliance Manager, as well as any other designated staff, shall conduct an evaluation of the efforts of the facility to eliminate sexual abuse and ensure compliance with this policy and administrative procedure. This evaluation shall include a comparison of the current year's data and corrective actions with those from prior years and provide an assessment of the facility's progress in addressing the sexual abuse program and procedural changes shall be made at the facility based upon this evaluation. The report shall include a comparison of the current year's data and corrective action with those from prior years and shall provide an assessment of the department's progress in addressing sexual abuse. The facility's annual report must be approved by the PREA Coordinator and made readily available to the public through the department's public website.

The PREA Coordinator indicates the agency reviews data collected pursuant to 115.87 and assesses the effectiveness of the sexual abuse prevention, detection, and response policies, practices, and training. The agency prepares an annual report and posts the information on the website. The only information redacted from the agency report is personal identifying information. All other information is included in the annual report.

Through the interview with the Superintendent, the auditor was informed that each allegation is reviewed by the Facility PREA Committee and that information is provided to the PREA Coordinator for the annual review. Any issues identified during the Facility PREA Committee are addressed at that time.

The PREA Compliance Manager indicated all SIR information is provided to the PREA Coordinator for annual review.

The audit team was provided with 2014 Sexual Assault Prevention Program Annual Report which compares data from the past two years. The annual report was reviewed by the audit team and no personal identifying information was included.

**Standard 115.89 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.**

PAP #02-01-115 was reviewed by the audit team.

PAP #02-01-115 mandates the agency to ensure that data collected pursuant to standard 115.87 are securely retained and to make all aggregated sexual abuse data from facilities under its direct control readily available to the public at least annually through its public website. The policy requires the department to remove all personal identifiers from aggregated sexual abuse data before making said data publicly available. Agency website information provides no personal identifiers. The Executive Director of PREA is required to maintain sexual abuse data collected pursuant to standard 115.87 for at least 10 years after the date of the initial collection unless federal, state, or local law requires otherwise.

The PREA Coordinator indicates the data is maintained in a secure data system backed up as required per departmental policy.

A review of the website demonstrates aggregated sexual abuse data from facilities under its control to the public is posted, as required. Information displayed on the agency website, contains no personal identifiers. No federal, state or local law was provided by the agency to indicate there was a law in place to require a data maintenance procedure which would supersede standard provision 115.89(d).

**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.

Nancy Hardy

9/1/2016

---

Auditor Signature

---

Date