PREA AUDIT REPORT ☐ INTERIM ■ FINAL

ADULT PRISONS & JAILS

Auditor Information				
Auditor name: Bobbi Pohlman-Rodgers				
Address: PO Box 4068, Deerfield Beach, FL 33442				
Email: bobbi.pohlman@us.g4s.com				
Telephone number: 954-818-5131				
Date of facility visit: 03/24/2015				
Facility Information				
Facility name: Halifax Correctional Unit 23				
Facility physical address: 1200 Farm Road, South Boston, VA 24558				
Facility mailing address: *(if different from above)*				
Facility telephone number: 434-572-2683				
The facility is:	☐ Federal	■ State	☐ County	
	☐ Military	☐ Municipal	☐ Private for profit	
	☐ Private not for profit			
Facility type:	■ Prison	☐ Jail		
Name of facility's Chief Executive Officer: Jerry R Townsend				
Number of staff assigned to the facility in the last 12 months: 90				
Designed facility capacity: 248				
Current population of facility: 247				
Facility security levels/inmate custody levels: Level 1				
Age range of the population: 20-65				
Name of PREA Compliance Manager: David Dishman			**Title:**	Correctional Officer
Email address: david.dishman@vadoc.virginia.gov			**Telephone number:**	434-272-4146
Agency Information				
Name of agency: Virginia Department of Corrections				
Governing authority or parent agency: *(if applicable)*				
Physical address: 6900 Atmore Drive, Richmond, VA 23225				
Mailing address: *(if different from above)*				
Telephone number: 804-674-3119				
Agency Chief Executive Officer				
Name: Harold Clarke			**Title:**	Director
Email address: harold.clarke@vadoc.virginia.gov			**Telephone number:**	804-674-3119
Agency-Wide PREA Coordinator				
Name: Elisabeth Thornton			**Title:**	Operations Manager
Email address: elisabeth.thornton@vadoc.virginia.gov			**Telephone number:**	804-887-8085

AUDITFINDINGS

NARRATIVE

On March 24 - 25, 2015, the Halifax Correctional Unit 23 underwent a PREA audit. Bobbi Pohlman-Rodgers was the DOJ Certified auditor who conducted the audit. An entrance was held. Present were the Warden, Central Region PREA Analyst, PREA Compliance Manager, ACA Compliance Officer, PREA Investigator (LT), Human Resource OSS, one Counselor, Health Authority, Sr. Fiscal Technician, Chief of Security, one Lieutenant and one Captain. Immediately after the entrance, a tour of the facility was conducted.

During the tour, the auditor noted that PREA Audit Notices were posted in areas accessible to both inmates and staff. Additionally, PREA reporting information was posted in areas easily assessable to inmates.

The auditor interviewed 9 specialized staff positions. The Agency Head and PREA Coordinator were previously interviewed. Ten random staff were interviewed and included staff on all shifts. Ten inmates were selected for interview and included one inmate who reported prior victimization.

There were no allegations of sexual abuse or sexual harassment in the past 12 months.

DESCRIPTION OF FACILITY CHARACTERISTICS

Halifax Correctional Unit 23 is a Level 1 facility that was opened in 1955. The facility houses a maximum of 247 male inmates. There are 8 housing units and one segregation unit. The main building consists of 2 housing dorms on the 2nd floor. There are two toilets and 1 sink with privacy. The 1st floor contains a day room with a private area that hosts 11 showers and 8 toilets. There are also two multi-use sinks - long sinks that can accommodate a number of users. In 2014 a privacy wall was installed to block the view of the showers from the open day room. There are two phones for inmate use that will allow calls to an outside agency that accepts PREA calls. Additionally, there is law library, inmate clothing/property, laundry, 2 classrooms, barber shop, supply closet, dining hall, and 3 counselor offices. As the kitchen and bakery are on the lower level of the building, the agency installed mirrors in 2013 to assist in the supervision of inmates in these areas.

There is an Education/Visitation Annex next to the main building. This building contains 4 cameras, 1 inmate bathroom, 1 staff bathroom, 2 visitor bathrooms, computer storage and two offices.

The second housing building consists of segregation (4 cells), and 6 dorms. The north side contains 3 dorms and the south side contains 3 dorms. Each dorm contains bathrooms and showers which offer privacy to inmates, a phone with appropriate PREA reporting information. There is an ice room, storage rooms, recreational officer office, multi-purpose room, library, barber, counselor offices, and staff bathrooms. The control rooms for these dorms overlook shower areas, however the view is appropriately blocked from direct staff observation in the event a female staff is assigned to this post.

Exterior buildings include a laundry room, wash house and pump house. There is also a large exterior recreation area for inmate use. The facility has a textile industry which is located in a large building on the opposite side of the recreation area. A variety of clothing and sheets are made in this facility. There are currently 48 inmates employed in this industry.

The facility also hosts 3 large greenhouses and over 10 acres of working field. The facility has produced over 720,000 heads of cabbage. Additionally, there is a Agribusiness New Initiative for Bore (Meat) Goats.

The agency offers GED classes to inmates with testing quarterly. Currently, they have an average of 5 inmates who take the GED test each quarter.

SUMMARY OF AUDIT FINDINGS

The agency is committed to the protection of inmates from sexual abuse and sexual harassment. This is reflected in their policy, procedures and practices as identified through document review and both staff and inmate interviews.

Prior to the on-site audit, the facility provided the Pre-Audit Questionnaire and a flash drive with all agencies policies and sample documents. The agency provided additional documents as requested during the on-site audit and immediately after the audit.

There are MOU's in place and a hospital has been identified that provides SANE services. Inmates have access to reporting allegations of sexual abuse and sexual harassment to both internal and external call centers. There are numerous posters and other material available that describe how to report sexual abuse and sexual harassment. Interviews with inmates noted that they have received education on PREA and how to report allegations.

Many thanks to Warden Townsend and his staff for their warm welcome and openness to this process. Special thanks to Correctional Officer and PREA Manager Dishman and Regional PREA Analyst Rose Durbin for their assistance.

Number of standards exceeded: 4

Number of standards met: 37

Number of standards not met: 0

Number of standards not applicable: 2

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.

There is a written policy addressing zero tolerance toward sexual abuse and sexual harassment. Policy 038.3 addresses this in detail and was last revised on 03/09/2015. This policy outlines the implementation of the agency's approach to the preventing, detecting, and responding to sexual abuse and harassment. Policy 130.1 addresses the rules of conduct between employees and inmates and became effective on 8/2/13. This policy defines prohibited behaviors and mirrors the Prison Rape Elimination Act definitions.

Elisabeth Thornton, the state agency PREA coordinator, is in a dedicated position and reports sufficient time and authority to the development and implementation of agency efforts in PREA compliance. She has three regional PREA analysts to provide additional over-site of all state correctional facilities.

David Dishman is the Facility PREA Compliance Manager. He reports that he has enough time to conduct his regular duties and his PREA duties.

Interviews with both Warden Townsend and PREA Coordinator Elisabeth Thornton confirm the Virginia Department of Corrections stand on sexual abuse and sexual harassment and their commitment to enforcing the zero tolerance policy.

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.

There is one contracted prison in the Virginia Department of Corrections. Policy 260.1 identifies that all contracts for the confinement of DOC offenders shall include requirements of the entity's obligation to adopt and comply with PREA standards, as well as provide for the agency contract monitoring to be conducted.

Operated by the GEO Group, Inc. is the Lawrenceville Correctional Center. The last contract amendment was in March 2014 and included a requirement to adapt and comply with PREA standards. Additionally, the contract requires state agency monitoring of PREA compliance. Per conversation with the PREA analysts, this will occur as mock audits each year.

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.

Policy 401.2 requires all facilities shall have a staffing plan that takes into consideration all 11 requirements of the PREA standard; requires documentation and justification of deviations of the plan; and requires an annual review of the existing staffing plan and all post audits. This facility staffing plan identifies assigned posts and emergency/relief posts. Also identified are the six reasons for most deviations of the staffing plan: staff on short term disability; staff attending mandated training; positions held for budgetary purposes; staff scheduled PTO; call-ins; and transportation trips and time adjustments for staff overtime. Deviations are documented on the Duty Roster each day and each shift. The last review of the staffing plan was conducted on January 15, 2015 by Warden Townsend.

Policy 401.3 addresses the requirement of the Facility ADO's to conduct and document unannounced rounds intermittently during the month. Policy 401.1 addresses staff are prohibited from alerting other staff of supervisory rounds. A review of the logbook indicates that unannounced rounds are conducted weekly. The Fire Safety/Sanitation/PREA Inspection Sheet offers another level of unannounced checks in addition to the normal logbook entries.

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 not applicable at Halifax Correctional per memo from Elisabeth Thornton, dated 02/12/2013. Memo states that all youthful offenders are housed only at Sussex I State Prison.

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.

Policy 445.1 addresses cross-gender strip searches which are prohibited unless there is an immediate threat to the safe, secure, orderly operation of the facility, and there is no other available alternative. Policy 445.1 addresses the limits of cross-gender frisk searches for female inmates. This does not apply to this facility as this is a male facility. This policy also notes that only medically trained professionals are permitted to conduct body cavity searches. All cross-gender searches shall be documented on an Internal Incident Report as per policy 445.1.

Policy 401.1 notes procedures and practices to enable inmates to shower, perform bodily functions, and change clothing without non-medical staff or staff of the opposite gender viewing, except in exigent circumstances or where viewing is incidental to routine cell checks. This process includes the announcing of opposite gender staff onto the housing unit, as well as documenting the announcement in the central control logbook. A review of the logbook shows documented announcements.

Each shower and toilet areas are protected from viewing by staff. All staff and inmates report the announcement of female staff when they enter a housing unit. This was also seen during the auditor's tour. Additionally, all announcements are well documented.

Policy 720.2 allows only for the identification of the trans-gender or inter-sex inmates genital status to be determined through means other than a strip search by non-medical staff.

Policy 445.1 addresses cross-gender frisk searches and searches of trans-gender and inter-sex inmates. All staff have been trained on performing searches on trans-gender and inter-sex inmates. Trans-gender and inter-sex offenders have the opportunity to express their preference of the gender of the staff conducting searches of their person in writing, which will then be reviewed by an interdisciplinary treatment team. Confirmation of staff training was provided through training documentation.

Standard 115.16 Inmates 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.

Policy 038.3 addresses the agency's commitment to provide inmates with disabilities, or who are limited English proficient, appropriate means to participate in all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment. This commitment prohibits the use of offender interpreters or readers except in limited circumstances where an extended delay in obtaining an effective interpreter could compromise the inmate's safety, the performance of first-response duties or the investigation of the inmate's allegations.

The agency has access to information in Braille through the Virginia Correctional Enterprises Braille at Fluvanna Correctional Center for Women for blind or low vision inmates. They recently entered into a MOU with Vernacular Language Services for the provision of telephonic language interpretation. They also have an MOU with Purple Language for deaf interpreter services.

Signs and orientation material is presented in English and Spanish. There are systems in place to provide staff assistance for limited English proficient inmates, as identified. The agency would, if necessary, have these documents interpreted into other languages as the need arose. Documents provided show that an interpreter was present during inmate education for one inmate with limited English.

A memo signed by the Warden stated that no offenders with disabilities was held from 2012-2014.

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.

Policies 030.3, 040.1, 260.1, 101.1, 057.1 and 170.1 address all components of the standard. Policy 030.3 confirms the commitment to not hire or promote any person who has engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility or other institution; or has been civilly or administratively adjudicated to have engaged or has been convicted of engaging or attempting to engage in sexual activity in the community facilitated by force, overt, or implied threats of force, or coercion, or if the victim did not consent or was unable to consent. The agency considers sexual harassment in determination of hiring or promoting of employees or enlisting the services of a contractor. This policy also addresses required background screenings to be conducted prior to any new staff having contact with inmates or before enlisting the services of any contractor who many have contact with inmates. There is a provision for background checks to be completed every five (5) years. As per the HR staff, this practice just began in 2014 and a review found that the facility has completed a background check on 100% of the staff and contractors.

Policy 040.1 and 260.1 confirms the failure of a staff, or a contractor, to report when charged or found liable in any civil or disciplinary proceedings of having engaged or attempted to engage in sexual activity by force as noted in the standard. Additionally they must also report any charges or convictions of a criminal offense or moving traffic violation. Failure to report or material omissions regarding charges or convictions of sexual abuse or sexual harassment is grounds for termination

Policy 101.1 requires employees to complete an Employee Self-Assessment during their annual Performance Evaluation that addresses the above behaviors. Policy 057.1 requires Virginia DOC to provide information on substantiated allegations of sexual abuse or harassment involving an employee to any institutional employer who provides a written request. Policy 170.1 allows for the direct questioning of an applicant or employee about previous misconduct.

Hiring and promotions policies and practices include specific interview questions as required by the standard, and has a commitment to not hire or promote any person who has engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility or other institution; or has been civilly or administratively adjudicated to have engaged or has been convicted of engaging or attempting to engage in sexual activity in the community facilitated by force, overt, or implied threats of force, or coercion, or if the victim did not consent or was unable to consent. The agency considers sexual harassment in determination of hiring or promoting of employees or enlisting the services of a contractor, prior to any inmate contact an initial background check is completed.

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.

There were upgrades to both the facility and the video surveillance equipment in the last 12 months. Changes made to the structure were based on an analysis of the facility and included a wall to separate the living area from the showers and a metal plate behind the mailboxes to provider further sight separation from the shower area. Additionally, convex mirror were installed in various areas of the kitchen to allow for supervision of blind areas. The annex building was updated to include doors on the bathroom areas. The additional cameras were installed in consultation with the facility to provide better supervision of certain areas.

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)
- ☐ 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 Virginia DOC is responsible for investigating allegations of sexual abuse. Policy 030.4 requires the use of a uniform evidence protocol that is developmentally appropriate for youth. The Sexual Assault Victim Search/Evidence Collection Protocol shall be followed for all investigations into allegations of sexual abuse.

Policy 720.7 allows for the facility to offer a victim a forensic medical examination that is performed by a SAFE or SANE examiner at no cost to the victim. It also requires a victim advocate to be provided upon request. The agency has an MOU with Action Alliance for the whole state of Virginia that provides for the training of internal victim advocates. Victim advocates are on-call and do not respond to their own work location. There are seven in the Eastern Region that respond as per a 2015 posted schedule. Advocates may, as requested, accompany victims at forensic exams, during investigations and may also include follow-up visits or communications with the victim. The facility utilizes Lynchburg General Hospital for forensic examinations through the Forensic Nurse Examiners of Centra Health . The facility reports no forensic medical exam were required or conducted in the past 12 months.

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.

Policy 030.4 addresses administrative and criminal investigations. The DOC Special Investigations Unit (SIU) conducts administrative and criminal investigations after an internal investigation at the facility level has definitely determined the allegations is not unfounded. SIU have statutory authority to conduct investigations. They will confer with the Commonwealth Attorney's Office which has the authority to prosecute.

The agency conducts both administrative and criminal investigations. Criminal investigations are conducted through the Special Investigations Unit (SIU), who will confer with the Commonwealth Attorney's Office regarding prosecution. As per a memo from the Warden, there were no allegations in the past 12 months and therefore no investigations were required.

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.

Policy 160.1 requires all new staff to receive PREA Orientation which includes all ten items identified in the standard prior to assuming any job duties within a unit.

Policy 350.2 requires annual training of all staff in PREA, which includes all ten items as identified in the standard.

Agency training for employees includes all ten required items of the standard. The facility reports that 100% of the staff have been trained. Staff interviews confirm training and the training topics. A review of a sample of staff training files confirms PREA training has been completed within the past 12 months.

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.

Policy 160.1 requires all volunteers and contractors that have contact with inmates are trained on their responsibilities under the agency's sexual abuse and sexual harassment policies and procedures. And, at a minimum, will be notified of the zero –tolerance policy and how to report. The agency shall maintain documentation of the training or confirmation of receiving the zero-tolerance policy and how to report.

All volunteers and contractors that have contact with inmates are trained on their responsibilities under the agency's sexual abuse and sexual harassment policies and procedures. And, at a minimum, will be notified of the zero –tolerance policy and how to report. The agency maintains documentation of the training or confirmation of receiving the zero-tolerance policy and how to report. Fifty-one volunteers are noted in a memo from the Major in 2014. Four of the volunteers are specific to the facility and signed copies of the training roster show they have completed the required training. An interview with a contractor/volunteer confirmed training.

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.

Policy 038.3 requires all inmates upon admission be given the Sexual Assault Awareness and Prevention brochure (English or Spanish), and that within ten (10) days of arrival shall receive comprehensive education including the "PREA: What You Need to Know" and "Breaking the Silence of Offender Sexual Abuse". The inmate is required to sign the Training form at the completion of the video and the facility maintains a copy n the inmates Institutional Record.

Policy 810.2 requires all inmates having been transferred to receive a copy of the brochure. If there is no documentation of having received the PREA comprehensive training completed at a prior DOC facility, the facility shall repeat the education with the inmate. Once completed, a copy will be placed in the inmate's Institutional Record.

The facility offers each inmate a handbook that details sexual abuse and sexual harassment reporting at intake.

All inmates are provided PREA information (Sexual Abuse Brochure) on admission to the facility, as well as a comprehensive education within 10 days of their arrival. There were 171 new inmates to the facility who received a copy of the brochure upon intake, 169 inmates who received comprehensive education within 10 days, and 24 inmates who were in the facility prior to August 2012 and received the PREA education prior to August 2013.

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.

Policy 030.4 and 350.2 require SIU investigators to receive additional training regarding PREA; specifically, techniques for interviewing sexual abuse victims; proper use of Miranda and Garrity warnings; Sexual abuse evidence collection in confinement settings; and criteria and evidence required to substantiate a case for administrative action or prosecution. This is a two and one half day training that covers all material as required and additional material. Additionally, this training covers not only PREA investigative courses, but all PREA standards.

SIU Investigators and the facility PREA investigator have completed the 2-1/2 day training as required by the standard and policy and this training is documented. An interview with the investigator and a copy of the training roster confirmed this 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.

Policy 160.1 requires medical and mental health care practitioners to receiving training mandated for employees or for contractors and volunteers depending upon the practitioner's status.

Policy 701.1 requires all full and part-time medical and mental health staff who work regularly in a DOC facility receive specialized training in the detection and assessment of signs of sexual abuse and sexual harassment, preservation of physical evidence of sexual abuse, effective and professional response to sexual abuse and sexual harassment victims, and the reporting of allegations or suspicions of sexual abuse and harassment. Training sign-in sheets confirm training.

All medical and mental health practitioners have received initial mandated training as confirmed by training records and interviews. Specialized training is also completed and documented. No forensic examinations are conducted on site. These are conducted at the hospital.

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.

Policy 810.1 requires an initial assessment be completed within 72 hours by the reception center staff. Any inmate who scores as a High Risk Sexual Victim (HRSV) and/or High Risk Sexual Aggressor (HRSA) will be referred to the facility Senior QMHP for follow-up. The policy also requires a 30-day reassessment based upon any additional and relevant information that may have been received. This policy identifies that sensitive information is not disseminated outside of the persons who are identified in policy and that no inmate will be disciplined for refusing to answer a question or for not disclosing complete information. Policy 810.2 mirrors 810.1 in these areas for transferred inmates.

Policy 730.2 identifies that an inmate's risk level shall be reassessed when warranted due to a referral, request, incident of sexual abuse, or receipt of additional information that bears on the inmate's risk of sexual victimization or abusiveness. When identified as HRSV or HRSA, the QMHP will meet with the inmate within 14 days of identification as HRSV or HRSA to notify inmates of available medical and mental health treatment and programming that is available.

Policy 861.1 requires any inmate convicted of a sexual assault and any victims shall be referred to their Counselor for reassessment of the inmate's risk of sexual victimization or abusiveness.

The screening tool considers all identified criteria as per the standard with the exception of civil immigration purposes. Virginia DOC does not hold ICE inmates. The agency uses a scoring system to identify a known victim, potential victim or a non-victim, as well as a known sexual aggressor, potential sexual aggressor or a no current indicator of sexual aggressor. The initial screening considers prior acts, convictions and history of prior institutional violence or sexual abuse for HRSA, and all other required components of the standard for HRSV classification.

Identification of HRSV or HRSA is determined through an objective screening tool. For HRSA, the PREA Coordinator stated that the automatic HRSA trigger question is "Does the offender have a history of institutional sexual disciplinary offense." Additionally, the questions "regardless of conviction; history of any physical or sexual violence within past 10 years", and "The most serious current offense for classification (1st question/the system does pull from listed offense, is current offense assaultive, is current offense sexual in nature" are all weighted in the determination of classification for HRSA.

A review of a random sample of inmate records indicates that all inmates are screened for risk of victimization and aggressive behavior. Interviews with inmates confirms that the screening included the inmate's perception of risk.

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.

Policy 425.4 identifies the steps taken by the facility to utilize the Classification Assessment as a tool to make individualized determinations of housing and bed assignments while keeping the goal of separating high risk victims from high risk sexual aggressors. This policy also addresses the placement of trans-gender or inter-sex inmates on a case-by-case basis keeping in mind the inmate's views to their own safety as well as the safety of the facility.

Policy 730.2 requires mental health staff to conduct 6 months reviews of any trans-gender or inter-sex inmate to ensure appropriate housing and programming is in place.

Policy 841.2 identifies the steps for work placement by the Work Program Assignment Reviewer for inmates who are identified as HRSA or HRSV.

Policy 038.3 addresses trans-gender and inter-sex inmates being allowed to shower separately from other inmates.

Cell assignment is made using the VACORIS system which allows for the identification of inmates with similar criminal and institutional histories to be seen side by side on the computer screen. Housing decisions are made by the cell assignment committee.

There is also a Gender Dysphoria Disorder Committee that makes housing decisions for trans-gender or inter-sex inmates; decisions are based strictly on the inmate's view of their safety and the safety of the facility.

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.

Policy 425.4 allows for special housing for inmates who are identified as HRSV or who alleged to have suffered sexual abuse with the victim's consent and unless there are no other alternative means of separation from likely abusers. The facility may hold an inmate only up to 24 hours in special housing only if an assessment was not completed immediately upon arrival or new information obtained.

Policy 830.5 allows for HRSV offenders, or offenders alleged to have suffered sexual abuse, to be placed in segregation with their consent, unless there are no other alternative means of separation. The placement of an inmate under this policy requires clear documentation of the basis and normally would not extend beyond 30 days. Reviews by mental health staff of inmates under this policy are done weekly for 8 weeks, and then every thirty days if needed.

Policy allows for special housing for inmates who are identified as HRSV or who alleged to have suffered sexual abuse with the victims consent, or when there is no alternative placement available to separate the victim from the subject.

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.

Policy 038.1 identifies staff accepts allegations of sexual abuse or sexual harassment that are made verbally, in writing, anonymously, and from third parties and shall prepare an Internal Incident Report.

Policy 801.6 offers the inmates the use of the Offender Request where a report of sexual abuse or sexual harassment and retaliation by other inmates or staff can be reported privately.

Policy 803.3 identifies that inmates have the ability to use a dedicated hot line when the inmate telephones are available by dialing #55.

Policy 866.1 identifies the Offender Grievance Procedure is one of the internal methods available for inmates to privately report sexual abuse/harassment, retaliation or staff neglect/violation of responsibilities.

The facility accepts multiple ways for inmates to report sexual abuse or sexual harassment which includes an Offender Request, Offender Grievance, or the Hot-line. There is a MOU established with Action Alliance which allows inmates to dial #55 on the inmate phones and privately and anonymously report to an outside agency. Contact with Action Alliance was made and the auditor was informed that all calls are then forwarded back to the state agency PREA Coordinator's office for follow-up only if agreed upon by the caller. Action Alliance staff did report that they maintain a list of calls that is provided quarterly to the state agency. During interviews, both staff and inmates confirmed that the various methods of reporting are known, including contacting the outside abuse agency.

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.

Policy 866.1 addresses the all components of the PREA standard regarding exhaustion of administrative remedies. The policy addresses: staff are not to respond to grievances written about them; inmates are not disciplined for filing in good faith; an informal complaint process is not required prior to filing a grievance; and there is no time limit on grievances regarding an allegation of sexual abuse. The grievance system allows for third-party reporting and assistance in completion of grievance paperwork. Responses to regular grievances are based on level. The total time allowed for the final agency decision is 70 days (Level I – 30 days; Level 2 – 20 days; Level 3 – 20 days) with an extension of a 30 day period at each level that requires the inmate be notified of the delay.

The policy also addresses emergency grievances for alleging a substantial risk of imminent sexual abuse. The policy requires notification to both the Facility Unit Head and the PREA Compliance Manager. A first response within eight (8) hours is expected from the ADO or Shift Commander.

Inmates have access to both the grievance system and the emergency grievance system without stipulations of using the informal process first. Grievances are not turned into nor answered by a staff who is the subject of the grievance. Grievances are handled within required time frames. Emergency grievances of a substantial risk of imminent sexual abuse are addressed within eight (8) hours. All delays of the responses required documentation. Third party persons are allowed to assist.

There were zero emergency grievances filed that alleged substantial risk of imminent sexual abuse filed in the past 12 months.

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.

The agency has an MOU with Action Alliance to provide confidential support services. Information for inmates is provided through brochures which list the mailing address and two phone numbers (800 number and #55). The handbook identifies monitoring of these through the description of telephone calls and mail; and instructions on how to call them on the phone is posted in each pod. Interviews with inmates confirms the availability of access.

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.

The agency offers four ways of third-party reporting of sexual abuse and sexual harassment. The Virginia DOC website identifies the e-mail of the Director for electronic correspondence, the e-mail of the PREA Grievance Office for electronic correspondence, a phone number to the Confidential Reporting Hot-line, and forms in both Spanish and English that can be printed, filled out and mailed. Inmate and staff interviews note that they are aware of third-party reporting.

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.

Policy 038.3 requires all employees, volunteers or contractors to immediately report any knowledge, suspicion or information regarding an incident of sexual abuse or sexual harassment, retaliation for reporting or staff neglect/violation of responsibilities that may have contributed to an incident or retaliation. This policy also addresses the prohibition of revealing information to a person who is not a part of investigation, treatment or management of the particular incident or victim/subject.

Policy 720.2 requires all medical and mental health professionals at initiation of services to disclose their duty to report and the limitations of confidentiality.

Policy 038.3 requires that all allegations of sexual abuse and sexual harassment be reported to the facility designated investigator for initial investigation and notification to the PREA analyst.

All employees, volunteers or contractors to immediate report any knowledge, suspicion or information regarding an incident of sexual abuse or sexual harassment, retaliation for reporting or staff neglect/violation of responsibilities that may have contributed to an incident or retaliation. The policy addresses confidentiality of the information and with whom information may be shared. This was verified through staff interviews.

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.

Policy 425.4 requires immediate referral and consult with the Facility Unit Head regarding action to be taken when an inmate is at substantial risk of imminent sexual abuse or further victimization.

The agency has in place steps to take in the event an inmate is at substantial risk of imminent sexual abuse or further victimization, that includes a mental health consultation, and the Facility Unit Head to determine housing interventions or other actions as identified. It is clear through interviews with both staff and inmates that the agency will immediately relocate a potential victim. There were no incidents of substantial risk to any inmates during the prior 12 months.

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.

Policy 030.4 requires the Facility Unit Head to ensure an investigation is initiated when an inmate reports prior sexual abuse at another facility.

Policy 038.3 requires the head of the facility to immediately notify the head of the facility or the appropriate office of the agency when an alleged prior abuse had occurred.

The policies meet the requirement of the standards in regards to reporting prior institutional sexual abuse to the facility head or appropriate office of the agency when identified. There was one allegation of an inmates being abused while located at another facility. There were no reports that an inmate had alleged abuse while at this 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.

Policy 030.4 identifies steps to be taken immediately when there is an allegation of sexual abuse that includes separating the victim from the subject, preserving and protecting the scene, and ensuring both the victim and the subject do not take any actions that could destroy physical evidence upon their bodies.

Policy 075.1 identifies the presence and use of the facility specific checklist that details out steps for any responder to include the above noted steps and further includes moving the victim to the medical department for assessment and treatment and to notify mental health. If the first person to respond is not a trained first responder, they are to protect and separate the victim from the subject and notify administration.

Policies detail all required steps of the standard. A facility specific checklist is available that includes all steps identified above, as well as notification requirements to the investigator, Unit Head, ADO, the taking of photographs and transport to local hospital for forensic evidence collection. This check list identifies those persons responsible for specific tasks and requires each person to sign off that the task has been completed. Staff interviewed are aware of the necessary steps for responding to an allegation of sexual abuse, and documents indicate that all staff were trained. There were no incidents where an allegation was made.

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.

Policy 075.1 details the presence and use of the facility specific checklist for responding to an allegation of sexual abuse.

The facility has a Sexual Assault Checklist that details all the steps to be taken in the event of an allegation of sexual assault. Additionally, the facility has a PREA Management Plan that is specific to the facility that details all steps to be taken in the event of an allegation of sexual assault, including the transport of the inmate and the PERK (Physical Evident Recovery Kit) and the name of the specific hospital that provides for forensic examinations. Staff were trained on the facility specific plan.

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.

Collective bargaining in Virginia is prohibited by §40.1-57.2.

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.

Policy 075.5 identifies the Crisis Response Team as the emotional support service for staff who fear retribution or retaliation for reporting or cooperating with sexual abuse or sexual harassment investigations.

Policy 130.1 provides protection measure for inmates and staff who report sexual abuse or sexual harassment or who cooperate with an investigation or who may fear retaliation by other inmates or staff.

Policy 038.3 provides multiple protection measures that mirror the standard, as well as monitoring of the conduct and treatment of offenders or staff who have report sexual abuse or cooperated in an investigation each month for 90 days, or longer if necessary. This policy also includes the requirement of periodic status checks for inmates.

The agency has identified services, protections, and monitoring for any staff or inmate who reports sexual abuse or sexual harassment, or who cooperates in an investigation. There is a Grievance Officer who confirms there are protective measures in place. There were no reported retaliation incidents.

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.

Policy 830.5 provides provisions for the use of segregation only in the event that the victim requests or when it has been determined that there is no other available means of separation from the likely abuser. Any use of segregation for this purpose requires an Institutional Classification Authority Hearing report which documents the details of reasons for the use of segregation. This policy limits the use of segregation for this purpose to not ordinarily exceed 30 days. Additionally, mental health will recommend appropriate release from segregation or transfer to a Protective Custody Unit.

Policy 425.4 requires the use of a Special Housing Review Report for any inmate placed in segregation that continues to be maintained in this unit. In addition, the segregation area may be used for no longer than 24-hours in the event that a move is deemed necessary prior to an assessment being completed.

The agency has a method of providing post-allegation protective custody that may use segregation as an intermediate tool pending release or transfer to a Protective Custody Unit. There were no inmates held in protective custody due to sexual abuse allegations.

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.

Policy 030.4 identifies that allegations of sexual abuse and sexual harassment are investigated by the agency internal SIU investigators who have receive specialized training; and that such investigations shall be conducted promptly, thoroughly, and objectively. This policy also details the collection of evidence, interviews with alleged victim and suspected perpetrators and witnesses and shall review prior complaints and reports involving the same suspected perpetrator. The policy also addresses credibility of the alleged victim, suspect or witnesses and includes that all efforts are documented in a written report. Those allegations where the investigation identifies potential criminal conduct shall be referred for prosecution. It also addresses the departure of the alleged abuser is not a reason to stop the investigation.

The policy complies with all aspects of the standard. There is a system in place to conduct investigations of sexual abuse and sexual harassment once identified by the Facility PREA Investigator. There were no investigations conducted as there were no allegations made at this facility.

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.

Policies 130.1, 135.1 and 861.1 state that a preponderance of evidence presented at the hearing shall be sufficient to support a finding of guilt in an investigation.

The policies meet the requirement of the standard. The Facility PREA Investigator stated the same during the interview.

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.

Policy 030.4 requires the SIU to notify the Facility Unit head as to the determination of any allegation.

Policy 038.3 requires that at the conclusion of an investigation the investigator in charge shall inform the offender as to the determination using the Offender PREA Allegation Letter, and requires notification of certain information if the allegation was against staff or another inmate as per the standard.

There were no investigations at this facility and therefore, no reporting to inmates was required.

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.

Policy 130.1 details consequences of staff and inmate relationships. In the event of sexual misconduct, termination is the presumptive disciplinary action for those who engage in sexual abuse. Additionally, if the staff resigns before conclusion and eventual termination, the incident shall be reported to any relevant licensing bodies and law enforcement agencies, unless the activity was clearly not criminal.

Policy 135.1 advises staff of the requirement for any violation of the sexual abuse or sexual harassment policies to be reported to any relevant licensing bodies and to law enforcement agencies, unless the activity was clearly not criminal.

The agency policies comply with the PREA standards. There was no allegations at this facility and therefore, no disciplinary sanctions were taken against staff.

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.

Policy 027.1 details possible grounds for volunteer dismissal if they fail to comply with DOC procedures, federal or state laws, or unit rules. Any volunteer who engages in sexual abuse shall be prohibited from contact with inmates and shall be reported to any relevant licensing bodies and to law enforcement agencies, unless the activity was clearly not criminal. It additionally allows for remedial measures in case of other violations of agency sexual abuse or sexual harassment policies by a volunteer.

Policy 130.1 details possible grounds for volunteer or contractor dismissal if they fail to comply with DOC procedures, federal or state laws, or unit rules. Any volunteer who engages in sexual abuse shall be prohibited from contact with inmates and shall be reported to any relevant licensing bodies and to law enforcement agencies, unless the activity was clearly not criminal. It additionally allows for remedial measures in case of other violations of agency sexual abuse or sexual harassment policies by a volunteer or contractor.

The agency policy meets all of the requirements of the standard in regards to corrective action for contractors and volunteers. There were no reported corrective actions taken towards volunteers or contractors as noted in a memo from the warden.

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.

Policy 820.2 requires inmates who are found guilty of a disciplinary or criminal offense for sexual abuse shall be offered therapy, counseling or other interventions if they are offered at the facility. Offenders that do not comply with required services as noted previous shall be charged in accordance with Policy 861.1 or .2.

Policy 861.1 details the Disciplinary Hearing Procedure that encompasses the requirements of the standard in full. There is consideration given based on the identification of any mental disabilities or mental illness and the requirement of participation in various therapy or counseling sessions. If the investigation finds that an unfounded allegation was made in good faith, the inmate cannot be disciplined. All findings of consensual sexual contact between an inmate and a staff member shall not result in inmate discipline.

The policies contain all requirements of the standard. There were no allegations at this facility and therefore there were no disciplinary sanctions issued against an inmate.

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.

Policy 730.2 identifies the process for the QMHP to follow up with an inmate who is identified as HRSA or HRSV during the assessment. Any information obtained during the screening related to a sexual victimization or abusiveness that occurred in an institutional setting is limited to those staff necessary to direct treatment plans and security and management decisions. Additionally, all practitioners are required to obtain informed consent from inmates before reporting information about a prior sexual victimization that did not occur in an institutional setting.

The policies meet all requirements of the standard including the need for follow-up referrals, privacy of information, and informed consent. Interviews with specialized staff confirm the requirement for informed consent. Per the memo from the warden, there were no instances where an inmate alleged prior victimization. Interviews with random inmates did not identify any prior victimization.

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.

Policy 075.1 requires that if no medical or mental health staff is on duty when there is an allegation, that the first responders shall take preliminary steps to protect the victim and contact the facility's designated medical and mental health practitioner. Note that all staff are trained as first responders.

Policy 720.4 requires emergency services to be provided regardless if the victim identifies the subject or cooperates with any portion of the investigation.

Policy 720.7 provides for emergency services in a timely, unimpeded manner; as well as the requirements for emergency contraception and STD treatment. All of this is offered at no cost to the inmate.

All agency policies provide for the requirements of this standard. There are provisions in place additionally to address any needs at a later date as per the interview with medical and mental health staff.

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.

Policy 720.7 requires the medical and mental health evaluation and treatment, as appropriate to all inmates who have been victimized in any institutional setting. This shall include assessment, treatment plans, follow-up services and referrals. These services shall be provided at a level consistent with community care. Victims of sexual abuse while incarcerated shall be offered STD testing and treatment as appropriate. All treatment services offered under this policy shall be free of charge to the victim regardless of the identification of the perpetrator or cooperation in any investigation.

Policy 720.4 addresses the requirement that all emergency and ongoing treatment for victims of sexual abuse while incarcerated shall be offered free of cost to the victim.

All policies address the components of the standard. Interviews with medical and mental health staff indicate that these services are available at no cost to the inmate. The Sexual Assault Response Checklist is used for allegations of abuse at the housing facility includes a referral to the mental health staff for evaluation. Additionally, the Sexual Assault Assessment is completed by the QMHP and details the necessity of further services and treatment as identified during the evaluation.

There were no instances of an allegation of sexual abuse.

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.

Policy 038.1 requires a Review Team shall be convened to review all instances of sexual abuse and sexual harassment. The review shall begin as soon as possible after completion of the investigation, and a formal report shall be submitted within seven days. The policy addresses members of the review team and the specifics as required by the standard.

The policy addresses all requirements of the standard. There is a specific form, Report of Incident Review, which is required to be completed and contains all elements of the standard. No review of documents was available as there had been no noted allegations of sexual abuse.

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.

Policy 038.3 addresses the collection of accurate and uniform data for every allegation of sexual abuse at facilities under their direct control. The collection shall also include any privatized facility that is contracted by the agency.

The state agency collects information from all facilities regarding allegations of sexual abuse utilizing a standardized instrument. This system for collection of information is used to assist in the preparation of the DOJ Survey of Sexual Violence as well as assisting the agency in addressing trends and the need for corrective action.

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.

Policy 038.3 identifies a data review process with corrective action. The review includes identifying problem areas, taking corrective action on an on-going basis, and preparing an annual report of its findings and corrective actions for each facility – and as a whole for the agency. Policy requires a comparison of the current data with prior years, and that this report is made public through the agency website. Redaction of certain information is made along with a statement about the nature of the material redacted.

The policy addresses all requirements of the standard, including identification of corrective actions for each facility as well as the agency as a whole. This report is available on the agency website.

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.

Policy 025.3 addresses retention of records for 10 years after the date of the initial collection and that data must be under the direct control of the agency.

All indicators are that the data collected is maintained with the direct control of the agency and that records are maintained for the appropriate number of years.

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.

Bobbi L Pohlman-Rodgers — April 27, 2015

Auditor Signature — Date