

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

Date of report: November 9, 2017

Auditor Information			
Auditor name: Kayleen Murray			
Address: P.O. Box 2400 Wintersville, Ohio 43953			
Email: kmurray.prea@yahoo.com			
Telephone number: 740-317-6630			
Date of facility visit: August 16-17, 2017			
Facility Information			
Facility name: Volunteers of America of Greater Ohio-Mansfield Residential Re-Entry Program			
Facility physical address: 921 North Main Street, Mansfield, Ohio 44903			
Facility mailing address: <i>(if different from above)</i> Click here to enter text.			
Facility telephone number: 419-524-5013			
The facility is:	<input type="checkbox"/> Federal	<input type="checkbox"/> State	<input type="checkbox"/> County
	<input type="checkbox"/> Military	<input type="checkbox"/> Municipal	<input type="checkbox"/> Private for profit
	<input checked="" type="checkbox"/> Private not for profit		
Facility type:	<input type="checkbox"/> Community treatment center	<input type="checkbox"/> Community-based confinement facility	
	<input checked="" type="checkbox"/> Halfway house	<input type="checkbox"/> Mental health facility	
	<input type="checkbox"/> Alcohol or drug rehabilitation center	<input type="checkbox"/> Other	
Name of facility's Chief Executive Officer: Nicole Chinn			
Number of staff assigned to the facility in the last 12 months: 38			
Designed facility capacity: 120			
Current population of facility: 118			
Facility security levels/inmate custody levels: minimum			
Age range of the population: 18 and up			
Name of PREA Compliance Manager: Nicole Chinn		Title: Program Director	
Email address: Nicole.Chinn@voago.org		Telephone number: 419-524-5013	
Agency Information			
Name of agency: Volunteers of America of Greater Ohio			
Governing authority or parent agency: <i>(if applicable)</i> Click here to enter text.			
Physical address: 1776 East Broad Street Columbus, Ohio 43203			
Mailing address: <i>(if different from above)</i> Click here to enter text.			
Telephone number: 440-717-1500			
Agency Chief Executive Officer			
Name: Dennis Kresak		Title: President/CEO	
Email address: dennis.kresak@voago.org		Telephone number: 440-717-1500x1104	
Agency-Wide PREA Coordinator			
Name: Stacey Seif		Title: Quality Improvement Manager	
Email address: Stacey.Seif@voago.oeg		Telephone number: 419-525-4589x1277	

AUDIT FINDINGS

NARRATIVE

The PREA audit for Volunteers of America of Greater Ohio-Mansfield Residential Re-Entry Program (MRRP) was conducted on August 16-17, 2017 in Mansfield, Ohio. Pre-Audit preparation consisted of a review of the pre-audit questionnaire and all supporting documentation for each of the standards (policies, training curriculum, resident education material, camera views, MOU's, and completed forms). This information was sent to the auditor on a flash drive and then mailed to the P.O. Box on file. On-site the auditor was provided with additional supporting documentation and allowed to review employee files and investigation reports.

During the audit, the auditor was provided a private area in which to complete work and interviews. The auditor conducted formal and information interviews of staff and residents. During the tour, the auditor noted PREA audit notices posted in both resident and staff areas in conspicuous places. The notices included the name and address of the PREA auditor and the date posted was approximately 6 weeks prior to the on-site audit. Also posted throughout the facility were postings that informed residents how to report an allegation, including anonymously, phone numbers and address of the emotional support agency, and for staff a posting of the agency's coordinated response plan.

Ten random residents from the five dorm units were interviewed plus one resident who requested to speak to the auditor. The resident who requested to speak to the auditor identified as being gay and wanted to speak privately concerning some perceived inappropriate, unprofessional behavior. The auditor was able to address the concerns of the resident with agency and facility management staff. The facility was able to develop a plan of action to address the concerns. During resident interviews, they were asked about their experience with PREA education, allegation reporting, communication with staff, safety, restrooms, knock and announcements, grievance procedures, pat downs, PREA posters and other handouts, and the zero tolerance policy. The resident who identified as being gay was also questioned on his concern for the housing unit or dorm and if it is a dorm selected because of his sexual orientation.

Staff interviewed included specialized staff. This includes the PREA Coordinator, Vice President of Program Operations, Director of Compliance and Quality Improvement, Director of Program Operations, Human Resource Manager, Human Resource Generalist, and the Director of Field Operations. The auditor was able to review Ohio Health Med Central Hospital's Sexual Assault Response Network of Central Ohio (SARNCO) MOU and website to confirm the scope of their services provided to residents at the facility. Random staff from each of the three shifts were interviewed. These staff were asked about PREA training, how to report, whom to report, filing out reports, investigations, conducting interviews, follow-up and retaliation monitoring, first responder duties, and the facility's coordinated response plan.

After a brief opening, the auditor toured both the male and female facilities. The tour consisted of examining all dorms, bathrooms, group rooms, outside recreation areas, day rooms, operations post, utility areas, kitchen, and maintenance areas. The auditor gave a closeout that included some of the immediate findings.

DESCRIPTION OF FACILITY CHARACTERISTICS

Volunteers of America of Greater Ohio-Mansfield Residential Re-Entry Program (MRRP) is a halfway house located in Mansfield, Ohio that serves both male felony offenders. The facility is a single level brick building that can house up to 120 offenders. To access the facility, all staff and visitors must be buzzed into the administrative lobby area. Staff can access all areas of the building with a key or electron key card. Visitors entering the building must sign-in at the desk and sign a PREA acknowledgment form. Residents have a separate entrance and must sign in/out at the main control desk. Residents will receive a pat down on camera. Residents who need a urinalysis will be escorted to the UDS bathroom the is located near the dining hall.

The facility has five dorm units including an honor dorm. The honor dorm has its own dayroom and unsupervised recreation yard access. There are eight bunk beds and a bathroom inside the dorm area. The honor dorm bathroom is equipped with two toilet stalls with doors, 1 urinal, and three individual shower stalls with curtains. Residents that identify as transgender or intersex, or residents that need moved due to a PREA allegation will be moved to this dorm. The other four dorm rooms are identically set up. There are fourteen bunk beds set up around the perimeter of the room. Between two dorm rooms is a dayroom that each dorm has access. The dayroom has a TV, games, and exercise equipment. There is a wall of windows that cover all dorm areas out into the hallway and the rooms are set up to provide clear line of site views. All dorms have camera surveillance. Residents are informed that they must dress in the bathroom. At the back of the building is an open recreation yard. A 12ft fence that includes 2ft of barbed wire surrounds the rec yard. The residents that are not housed in the honor dorm, share a bathroom across from the secondary control desk. This bathroom has an open entryway and divided into two sides. One side occupies four toilet stalls with doors and sinks, while the other side contains twelve shower stalls and six urinal stalls. The shower stalls are single use only and have curtains for privacy. The shower near the entrance is disable due to its visibility from the hallway. The resident laundry room, dining hall, and kitchen area all have camera surveillance. Residents that work in the kitchen are supervised by contracted Aramark staff.

The case manager hallway houses staff offices. Each office is equipped with a panic button. Pushing the button will sound an alarm and arm a flashing light. Residents are required to go to the main or secondary post and get permission to enter this area.

The male facility has 52 indoor and outdoor cameras. The electronic monitoring equipment is video only and can record and playback for up to thirty days. Leadership at the facility has the ability to live and playback the cameras at their desk tops. The facility has one head count per shift plus one extra random count. Resident Supervisor staff are required to complete circulations every 15-30 minutes. The facility increases circulations in blind spot areas.

The agency's mission is to "reach and uplift all people and bring them to the knowledge and active service of God. Volunteers of America, illustrating the presence of God through all that we do, serves people and communities in need, and creates opportunities for people to experience the joy of serving others. Volunteers of America measures its success in positive change in the lives of individuals and communities we serve."

SUMMARY OF AUDIT FINDINGS

Volunteers of America of Greater Ohio-Mansfield Residential Re-Entry Program has had six PREA allegations during this audit cycle. The allegations were administratively investigated. Allegations that appeared to involve criminal activity were referred to the legal authority for a criminal investigation.

MRRP staff interviewed indicated that they received formal PREA training during orientation as well as online as part of their annual training. Staff on all three shifts including security and program staff were able to discuss their responsibility as a first responder, how to report or respond to an allegation of sexual abuse, sexual harassment, or retaliation. Staff seemed sure of their education and training and would be capable of responding to any allegation appropriately.

Residents interviewed from both facilities seem well versed on their rights under the PREA standards and knew who and how they could report including anonymously. All residents receive information at intake with the phone number and address of inside and outside agencies that could help and knew the location of posters.

The MOUs Ohio Health and their partnership with SARNCO verify that forensic examinations and crisis services are in place. The agency has been working on getting an MOU with their local legal authority to conduct criminal investigations.

Overall, the auditor was left with the impression that the agency as a whole and the facility specifically take PREA compliance seriously. The agency has implemented policies and practices that allow facility leadership to provide their staff with training and equipment that ensures the safety of all residents.

Number of standards exceeded: 0

Number of standards met: 39

Number of standards not met: 0

Number of standards not applicable: 3

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

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

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

The facility has an agency wide written policy (policy 1700.01) mandating zero tolerance on all forms of sexual harassment, sexual abuse/assault, and sex sexual misconduct. The policy specifically defines what type of behavior is prohibited and the responsibilities of the PREA Coordinator in facilitating the agency's approach to preventing, detecting, and responding to sexual abuse and sexual harassment.

The agency-wide PREA Coordinator is the agency's Quality Improvement Manager. She reports to the agency's Director of Compliance and Quality Improvement. The auditor spoke with both the PREA Coordinator and her supervisor concerning the Coordinator's level of authority to develop, implement, and oversee the agency's efforts to comply with PREA standards. During staff interviews, the PREA coordinator indicated that she has enough time and authority to develop, implement, and oversee the facility's efforts to comply with the PREA standards. The Director of Compliance and Quality Improvement agreed that the PREA Coordinator has great latitude toward implementing policy and procedure where PREA is concerned.

The facility PREA Manager is the Program Director. The Program Director would report any PREA related issue directly to the PREA Coordinator. The Program Director works directly with the PREA Coordinator to ensure facility compliance with PREA standards. The Director indicates that she has ample time to comply with the standards.

Review:
Policy and Procedure
Interview with PREA Coordinator/Quality Improvement Manager
Interview with Director of Compliance and Quality Improvement
Interview with Program Director

Standard 115.212 Contracting with other entities for the confinement of residents

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

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

N/A: The facility is a private agency and does not contract with other agencies for the placement of offenders

Standard 115.213 Supervision and monitoring

- Exceeds Standard (substantially exceeds requirement of standard)

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

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The facility has a staffing plan that provides for adequate levels of staffing, and where appropriate video monitoring equipment to protect residents against sexual misconduct. The staffing plan reviews the facility layout, types of residents housed at the facility, and the number of allegations. Facility management has identified blind spot areas and developed an appropriate response to maintain safety and security of the facility. Movement throughout the facility is limited by areas only assessable with a key fob or staff using electronic lock doors that can be controlled by staff at the main post. Security staff is required to complete one head count per shift plus a random check along with at least one round each hour.

The development of the plan included the input of the PREA Coordinator and the PREA manager, along with the Director of Field Operations. The auditor has reviewed the agency's written policy concerning what information is to be contained in the staffing plan and the number of staff members required to operate each shift. A review of floor plans, camera placement, and identified blind spot areas was conducted by the auditor prior to the audit and during the walk through. During interviews with facility staff, the auditor was informed how staff placement, security mirrors, required head counts and circulations, and video monitoring are used to ensure maximum safety and security. There is a policy requirement to have the staffing plan reviewed annually and updated if necessary.

The facility reports that there have been no deviations to the staffing plan.

- Review:
- Policy and Procedure
 - Facility tours
 - Facility staffing plan
 - Screen shots of each camera angle
 - Interview with PREA Coordinator
 - Interview with Director of Program Operations
 - Interview with Program Director

Standard 115.215 Limits to cross-gender viewing and searches

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

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

The facility does not permit body cavity or strip searches. The facility does conduct pat-down searches but does not allow for cross-gender pat-down searches. Pat-down searches are completed in a secure area in camera view. Security staff are trained during their orientation on how to properly complete a pat-down search. Supervisory staff monitor staff conducting pat-downs live or through camera review and make necessary corrective plans if necessary.

The facility allows for residents to shower, perform bodily functions, and dress in areas not viewable to staff. Because rooms have windows on the doors and a camera, residents are instructed to dress in the bathroom and be completely dressed in all common areas of the facility.

The bathroom in the facility has showers and urinals on one side and toilets and sink on the other separated by a wall. The entrance to the bathroom is open to the main hallway area. The toilet stalls have doors and curtains that allows for security and privacy cover the individual shower stalls. During the tour, it was noted the first shower is nonfunctional due to its visibility to the corridor. The bathroom in the honor dorm has a solid door at its entrance and can only be used by the offenders housed in that dorm. The bathroom in this dorm is equipped with three individual stalls with curtains and toilet stalls with doors and one urinal. Staff coming into the bathroom for security checks; announce themselves before entering the bathroom and shower area.

The facility has not had an incident of incidental viewing.

The facility has not housed a transgender or intersex resident. Facility leadership has stated that they would in fact house a transgender/intersex resident and had an appropriate plan for housing safely. The agency has a policy for professional, respectful transgender/intersex pat downs and has trained staff appropriately.

Review:

Policy and Procedures

Facility tour

Interviews with residents

Interviews with staff

Employee training records

Interview with Director of Field Operations

Interview with Clinical Supervisor

Interview with PREA Coordinator

Interview with Program Director

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

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

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

The agency has a policy that calls for the reasonable accommodations for residents that allows them to be able to benefit from program services. These services are for residents who maybe deaf, blind, intellectual, psychiatric, or speech disabilities, and for residents who may be limited English proficient. The facility identifies residents who may be limited English proficient and works with interpreters from the International Institute of Mansfield and collaborates with other community partners so that residents can benefit from all aspects of the facility's efforts to prevent, detect, and respond to sexual abuse and sexual harassment.

As part of the agency's PREA education program, staff are instructed to ensure that all aspects of PREA are communicated with residents with cognitive, language, or physical disability and how to collaborate with outside agencies for services that facility cannot provide. The facility will use a qualified employee to aid any resident in understanding agency rules, PREA, and other regulations. If a qualified staff member is not available, outside assistance will be used. At no time will another resident be used for interpretive services unless a delay in services could compromise the resident's safety, the performance of first responder duties, or an investigation.

The facility does not currently have a resident that requires these services.

Review:

Policy and procedure

MOU with Mansfield Correctional Institute

Resident case notes

Interviews with staff

Interview with Program Director

PREA Audit Report

Standard 115.217 Hiring and promotion decisions

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

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The agency has a policy that prohibits hiring or promoting anyone who may have contact with the residents and prohibits services of any contractor or volunteer who may have contact with residents who: has engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility, or other institution; has been convicted of engaging or attempting to engage in sexual activity in the community facilitated by force, over or implied threats of force, or coercion or if the victim did not consent or was unable to consent or refuse; or have been civilly or administratively adjudicated to have engaged in the described activity.

The Human Resource Department uses several resources to complete background checks including NCIC/NLETS, ADT, and Asurint at employment. The HR Department will run a report at the beginning of each year and makes a request to one of these agencies annually to ensure that employees will have a background check every five years. Employees who will be working with BOP residents will have to pass a federal background test every five years. Contractors and volunteers will also have a background check conducted.

All successful applicants are notified of the PREA background check requirement as well as the omission of any sexual misconduct reporting is grounds for termination. Employees sign off on receiving this information on a Criminal Offense Disclosure form.

The HR department will review all employee files including performance evaluations any disciplinary action before a promotion can be authorized.

The auditor reviewed ten random employee files. The review included on boarding documentation, reference checks/verifications, structured interview forms, employment application, disciplinary records, training records, background checks, employee policies, employee handbook, and promotions.

The auditor interviewed the Human Resource Generalist concerning their method for ensuring staff receive an initial and five year background check, the process for promotion, ensuring training requirements are met, employee discipline, and the onboarding process.

It was noted by the auditor that the HR Department did not check with past employers, specifically those employed by another correctional facility or institution, to see if the potential employee has ever had a substantiated allegation of sexual abuse while working for that agency or resigned during a pending investigation of an alleged sexual abuse. The agency is also not asking applicants if they have (1) engaged in sexual abuse in a prison, jail, or other institution (2) have been convicted of engaging or attempting to engage in sexual activity in the community facilitated by force, overt or implied, threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse (3) has been civilly or administratively adjudicated to have engaged in the activity described in (1) or (2).

The facility had been doing this, but a recent change in how the agency recruited and completed the onboarding process has changed and this part of the process was left off. The agency has begun using an outside agency to complete employment applications and reference checks and this information was not used by the outside agency.

CORRECTIVE ACTION:

The agency will have to include the required applicant questions either on the actual application or during applicant interviews. The agency will also need to ensure it performs reference checks on applicants who have worked in prior institutions. The check needs to ensure the applicant does not have a substantiated sexual abuse allegation or quit in the middle of a sexual abuse investigation.

FACILITY RESPONSE:

The agency has updated its online application to include requiring internal and external applicants to answer questions required in section (a) (1) (2) and (3) of this standard. The agency has also updated its personnel file checklist to include ensuring all prior institutions were

contacted regarding any substantiated sexual abuse allegations or resignation in the middle of a sexual abuse investigation.

Review:

Policy and procedures

Employee handbook

Employee files

Onboarding documentation

Interview with Human Resource Manager

Interview with PREA Coordinator

*New job application

*New personnel file checklist

Standard 115.218 Upgrades to facilities and technologies

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

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

The facility has not acquired a new building or made any substantial expansion or modification to the existing facility.

Facility management and the PREA Coordinator review the staffing plan annually in order to assess the effectiveness of the facility's security program and if improvements in the electronic monitoring could help in the prevention, detection, and responding to sexual abuse and sexual harassment. No other electronic surveillance system or other monitoring technology has been changed. The facility will address any needs to these areas as the budget allows.

Review:

Policy and procedure

Floor Plans

Facility Tour

Interview with Director of Field Operations

Interview with Program Director

Interview with PREA Coordinator

Standard 115.221 Evidence protocol and forensic medical examinations

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

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The facility conducts administrative investigations into allegations of sexual abuse and sexual assault. If at any time during the investigation the incident appears to be criminal in nature, the PREA investigator will refer the case to the legal authority for a criminal investigation. The facility's legal authority is the Mansfield Police Department who will provide criminal investigatory services. This legal authority will use "A National Protocol for Sexual Assault Medical Forensic Examinations, Adults/Adolescents" techniques that maximize the potential for obtaining usable physical evidence for administrative proceedings and criminal prosecutions.

The facility has a signed MOU with Ohio Health to provide forensic examinations by a qualified practitioner free of charge to victims of sexual abuse. The hospital also collaborates with SARNCO to provide advocate services. The auditor made several attempts to speak with the Coordinator (who signed the MOU) but was unable to get in touch the Coordinator. The auditor was able to review the agency's website and MOU with the facility to confirm that the forensic exam practitioner, emotional supportive services, and mental health services free of charge to victims of sexual abuse.

The SARNCO agency will provide advocate services free of charge to victims of sexual abuse or sexual harassment. The auditor reviewed SARNCO's website to verify the type and scope of services. The website states that the agency would provide advocate services, emotional supportive services, crisis services, hotline number for residents to report sexual abuse or sexual harassment, an address where residents could report sexual abuse and sexual harassment, follow up services, and community referrals all free of charge to the victim.

The facility has four trained emotional support personnel on staff to provide services such as accompany and support the victim through the forensic medical examination process and investigatory interviews if requested by the victim.

Review:
Policy and procedure
MOU with Ohio Health
Review of Ohio Health website
Review of SARNCO website
Interview with PREA Coordinator

Standard 115.222 Policies to ensure referrals of allegations for investigations

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

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

The agency has a policy that regulates an administrative investigation of all allegations of sexual abuse and sexual harassment. The policy ensures that any allegation that appears to be criminal in nature is referred to the legal authority in charge of conducting a criminal investigation. The Mansfield Police Department is the agency that performs criminal investigation into allegations of sexual abuse or sexual harassment that is criminal in nature. The agency's administrative investigation policy and criminal investigation referral policy is posted on the agency's website. The facility has had six allegations during this audit cycle.

Allegation number 1: This was a resident verbal report of resident-to-resident sexual abuse. The allegation was administratively investigated and determined to be substantiated. The allegation was referred to Mansfield Police Department for a criminal investigation. The MPD came to the facility and interviewed the resident. The officer declined to press charges due to lack of evidence.

Allegation number 2: A resident made a third party verbal report of resident-to-resident sexual abuse. The allegation was administratively investigated and determined to be substantiated. The allegation was referred to the Adult Parole Authority who had arresting powers for this residents commitment type. The Mansfield Police Department was also called to assist APA in arresting the resident.

Allegation number 3: A resident made a verbal report of resident-to resident sexual harassment. The allegation was administratively investigated and determined to be unsubstantiated. There was no criminal activity so no criminal investigation referral was made.

Allegation number 4: A resident made a verbal report of resident-to-resident sexual harassment. The allegation was administratively investigated and determined to be substantiated. There was no criminal activity so no criminal investigation referral was made.

Allegation number 5: A resident made a verbal report of staff-to-resident sexual abuse. The allegation was administratively investigated and determined to be unfounded.

Allegation number 6: A resident made a verbal report of resident-to-resident sexual harassment. The allegation was administratively investigated and determined to be unsubstantiated. There was no criminal activity so no criminal investigation referral was made.

During the course of reviewing investigation reports and conducting interviews it was noted by the auditor that the investigator misunderstood the definition of unfounded and unsubstantiated. After a discussion with all investigators, it was made clear that unfounded allegations have proof that the harassment/abuse did not occur. Besides this confusion, the investigations were all handled properly and had the correct outcome.

Review:

Policy and procedure

Agency website

Investigation reports

Interview with PREA Administrative Investigator

Interview with PREA Coordinator

Interview with Program Director

Interview with Human Resource Generalist

Standard 115.231 Employee training

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

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All employees receive facilitated orientation training at employment. This training includes PREA related topics. Refresher or annual training is conducted at the facility through team meetings or online using the Realis Learning System. The CL Supervisor assigns training to staff through the online system and keeps track of completed training. The facility was able to show the auditor the training curriculum and how the staff maintains accountability with PREA trainings.

During staff interviews, it was clear to the auditor that the staff was well trained on the required PREA topics and that the facility leadership regularly reviewed PREA policies with the staff. Staff was able to clearly identify specific training topics and recite things that they learned during the training.

A review of the training topics and interviews with staff made it clear that the staff was not being trained on how to communicate effectively and professionally with residents that may identify as LGBTI or gender non-conforming.

CORRECTIVE ACTION:

The auditor recommended that all staff be trained on how to communicate effectively and professional with residents that identify as LGBTI or gender non-conforming.

FACILITY RESPONSE: The agency has trained the staff on Respectful Communication with LGBTI offenders. The auditor has reviewed the training curriculum and the sign in sheets for the training.

Review:

PREA Audit Report

Policy and procedure
Training records
Training curriculum
Interview with Clinical Supervisor
Interviews with staff
Interview with PREA Coordinator
*Respectful Communication with LGBTI Offenders training curriculum
*Training sign-in sheet

Standard 115.232 Volunteer and contractor training

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

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The agency has a policy requiring appropriate PREA training for all contractors and volunteers who will have contact with residents. The training includes the agency's zero tolerance policy and their responsibilities under these policies. Each volunteer will be provided with the necessary PREA education and must sign an acknowledgement of receiving and understanding the education.

Each visitor who enters the facility must read and sign an understanding of the agency's zero tolerance policies on a PREA acknowledgement form before entering the facility.

At the time of the audit, there were no visitors, contractors, or volunteers in the facility.

Review:

Policy and procedure
Contractor/vendor acknowledgement forms
Visitor acknowledgement form
Interview with Program Director

Standard 115.233 Resident education

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

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All residents receive information at intake on the facility's zero tolerance policy. This information is reviewed with the resident to ensure that each resident knows how to report incidents or suspicions of sexual abuse or sexual harassment, their right to be free from sexual abuse and sexual harassment, and to be free from retaliation for reporting such incidents. If a resident has limited English proficiency or another

disability that prevents normal communication, the facility will work with outside agencies to ensure each resident can benefit from the agency's efforts to prevent, detect, report, and respond to allegations of sexual abuse and sexual harassment.

Orientation group offers a more formal education on the resident's rights under the PREA standards. The Program Director teaches this group to residents. Residents are given handouts on ways to report allegations, reporting phone numbers, location of posters, limits of confidentiality, and other supportive services offered at no cost to the resident. Each resident will take a pre and post exam to show understanding of the material.

On the tour, the auditor noted that PREA posting were in conspicuous areas throughout the facility.

In total, the auditor interviewed 11 residents (10 random and 1 requested). The residents acknowledged receiving PREA education training and informational brochures from the facility. Residents stated that their case manager reviewed the information again when completing their initial PREA assessment. All residents reported feeling safe in the facility and that staff appeared capable of handling a PREA related situation appropriately. No resident had an issue with reporting such incidents to staff or using the anonymous hotline (as evidenced by the types of reporting documented during this audit cycle- five verbal reports to staff and one resident third party verbal report to staff.

Review:
Policy and procedure
Resident PREA education curriculum
Resident pre/post exam
Resident PREA brochure
Resident handbook
Interview with Program Director
Interview with residents
Facility tour
Investigation reports

Standard 115.234 Specialized training: Investigations

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

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

The agency has a policy concerning the specialized training for PREA administrative investigators. All criminal investigations are referred to the local legal authority for investigation. The facility has three staff members that have received appropriate training on how to conduct an administrative investigation. This training was provided by the Moss Group. The training included techniques for interviewing sexual abuse victims, proper use of Miranda and Garity Warnings, evidence collection in a confinement setting, and required evidence to substantiate a case for administrative action or criminal investigation referral.

Review:
Policy and procedure
Training curriculum
Training certificates
Interview with Administrative Investigator
Interview with PREA Coordinator

Standard 115.235 Specialized training: Medical and mental health care

- Exceeds Standard (substantially exceeds requirement of standard)

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

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 facility does not provide onsite medical or mental health services. All residents requesting these services would be referred to community resources. Medical services would be provided to residents by Ohio Health Hospital. The facility has an MOU with this hospital to provide forensic examination services should a resident be sexually abused or assaulted while at the facility. Mental Health or Victim Advocate services would be provided by SARNCO.

Ohio Health Hospital has collaborated with SARNCO and together the agencies have comprehensive education and training on dealing with victims of sexual abuse or sexual assault.

Review:
 Policy and procedure
 MOU with Ohio Health
 Ohio Health website
 SARNCO website

Standard 115.241 Screening for risk of victimization and abusiveness

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

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

All residents are screened within 72 hours from intake to assess risk of vulnerability or abusiveness. The screening tool used includes all required criteria per the standard to accurately assess the resident’s risk. The screening is completed with the resident’s case manager and a rescreening is completed before a resident reaches 30 days in the facility. Case management staff have been trained on how to complete the form and appropriately designate whether a resident is classified as vulnerable or abusive. The Clinical Supervisor will periodically review the assessments to ensure accuracy.

Per policy, a resident cannot be disciplined for refusal to answer questions on the assessment.

Interviews with residents showed that they received the screening at intake from their case manager and a rescreening at a later date.

Interviews with staff showed they understood how to use the screening tool and keep the information confidential while still making arrangements to protect the resident.

Review:
 Policy and procedure
 Risk assessment tool
 Initial assessments
 Reassessments
 Interviews with case managers
 PREA Audit Report

Standard 115.242 Use of screening information

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

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

All residents who receive a classification based on their vulnerability/abusiveness assessment will have their needs addressed. A resident's assessments results will be documented into the facility's SecurManage database system where only staff that are authorized can gain access to this information.

The facility has identified specific beds that allow for clear easy view as vulnerability beds and will place anyone who is assessed as a potential abuser in another dorm. Staff would be aware to ensure the safety and security of residents with a classification but would not know the details of the assessment.

Case management staff are able to refer residents to outside counseling sources to deal with issues related to being assessed as vulnerable or abusive.

The facility has never housed a transgender or intersex resident, but has a plan to house such residents safely, which includes opportunities to shower separately. The residents own views on safety would also be taken into account.

The auditor interviewed case managers and facility leadership who were able to provide a plan for housing safely and showering separately for transgender or intersex residents. They were able to give a clear answer as to how this plan included keeping residents that are at risk for being sexually victimized from those who are at risk to be sexually abusive during work, education, or program assignments.

Review:
Policy and procedure
Case notes
Interview with case manager
Interview with PREA Coordinator
Interview with Clinical Supervisor

Standard 115.251 Resident reporting

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

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

Residents at MRRP have several ways in which to report an allegation of sexual abuse or sexual harassment. Residents are given this information at intake and during orientation group. The facility also has several notices posted in conspicuous areas. The ways to report include an outside agency hot line number and information for advocacy groups.

The residents have access to phones and are allowed to carry cell phones in the facility.

During interviews, all residents were able to list the various ways in which they could report an allegation. These included verbally to staff, written to staff, use of the hotline number, through a third party such as a loved one or victim support group. Residents understood that they had the right to report anonymously and did not have to use the grievance system in order to file an allegation.

Staff interviews verified that staff understood how they could privately report an allegation of sexual abuse or sexual harassment.

During a review of the six allegations at MRRP, residents reported the allegations to staff either directly.

Review:
Policy and procedure
Facility tour
Resident handbook
PREA posters
Investigation reports
Interview with residents
Interviews with staff

Standard 115.252 Exhaustion of administrative remedies

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

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

N/A: The PREA Coordinator and Program Director report that residents do not use the grievance system to make an allegation. If an allegation came in through the grievance system, it would be taken out and treated as a written report.

Standard 115.253 Resident access to outside confidential support services

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

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

The facility has a MOU with Ohio Health to provide victim advocate services or emotional support services related to sexual abuse. The

hospital collaborates with SARNCO to provided residents with their address and hotline number in order to obtain these services or make a sexual abuse or sexual harassment report.

The facility informs residents the limits of confidentiality when using these services during orientation group.

Interviews with residents indicate that they have received the phone number and address of SARNCO and understand that reporting an allegation to the center could result in a mandatory reporting of the allegation.

Review:
Policy and Procedure
Posters
MOU with Ohio Health
Interview with residents

Standard 115.254 Third-party reporting

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

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

The agency has posted on its website ways that anyone can report sexual abuse or sexual harassment on behalf of a resident. Residents are also educated that they may make a third party report on behalf of another resident. The information on how to make a third party report is also posted in the visitation area.

One allegation during this audit cycle was made by a third party report to staff by another resident. This allegation was relayed to the supervisor and an administrative investigation was started.

Review:
Policy and procedure
Agency website
Facility tour
PREA postings
Investigation report

Standard 115.261 Staff and agency reporting duties

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

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

The agency has a policy that requires all staff to immediately report any knowledge, suspicion, or information regarding an incident of sexual abuse, sexual harassment, or retaliation, including third party and anonymous reports. The staff have been given instruction on how to document the report in the SecurManage system, which limits access to that information, and to only share that information with staff in order to make treatment, investigation, or other security decisions. All allegations of sexual abuse or harassment are referred to the PREA Coordinator for investigation.

Staff interviewed, including line staff and facility leadership, understood their duty to report and were trained appropriately on the agency's PREA reporting policies. Staff indicated that they would have no trouble reporting any allegation or suspicion of sexual abuse, sexual harassment, or retaliation even if it was against another staff member.

All staff members who have licensure are required to inform residents of their status and the limits of confidentiality. These staff members maintain their duty report any allegation made to them.

The facility does not accept any resident that is under the age of 18 and does not have a duty to report to child protective services. The State of Ohio does not require institutions or facilities licensed by the state of facilities in which a person resides as a result of voluntary, civil, or criminal commitment to report to adult protective services (Chapter 5101:2-20 and 5101:2-20-01).

Review:
Policy and procedure
Interviews with staff
Investigation reports
State law statute

Standard 115.262 Agency protection duties

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

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

The facility has a plan to protect residents from imminent sexual abuse. The facility has several dorm units that a resident can be moved to in order to facilitate protection. If necessary, Volunteers of America of Greater Ohio has several facilities throughout Ohio. The facility could utilize one of the other facilities if necessary to protect a resident from imminent sexual abuse. The facility also has the ability to place a staff member on administrative leave if a staff is involved in the investigation.

An interview with the PREA Coordinator and Program Director discussed the process for ensuring resident safety and making a move to another facility if necessary. The facility has moved a resident to the honor dorm due to a resident's concern for risk of imminent sexual abuse. The facility has also moved an offender's bed placement or dorm due to an allegation investigation. The dorms in the facility have cameras and vulnerable clients would be placed in a bed with clear views from the camera.

The auditor was left with the impression from the interviews that resident safety was paramount to the staff at MRRP and that any necessary changes that would not jeopardize the safety and security of the facility would be made.

Review:
Policy and procedure
Bed change notice
Investigation report
Interview with PREA coordinator
Interview with Program Director

Standard 115.263 Reporting to other confinement facilities

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

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

The agency has a policy that requires the Program Director to report to the head of another facility any allegation made against that facility within 72 hours of receiving the allegation. The Program Director is responsible for documenting the report. Should a report be made to the facility to MRRP that a resident at another facility is making an allegation toward someone in their agency; the Program Director shall ensure that the allegation is fully investigated.

An interview with the Program Director indicated that the facility has not received a report from another institution. The facility has reported two allegations to the head of another facility.

Review:
Policy and procedure
Interview with Program Director

Standard 115.264 Staff first responder duties

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

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

The agency has a policy requiring all staff be trained on first responder duties. The duties vary from non-security staff to security staff. All staff are supplied the required first responder training. The facility has a detailed response plan and evidence protocol for any incident of sexual abuse. This plan is posted at the staff main post. The protocol includes where to place an alleged abuser when separating from the victim so that the abuse cannot destroy any evidence, preserving evidence until the local legal authority can collect the evidence, requesting that the alleged victim not do anything to destroy evidence including washing, brushing teeth changing clothes, performing bodily functions, smoking, drinking, or eating, reporting allegation to the local authorities and to the Program Director or the manager on call if the Program Director cannot be reached.

Non-security staff are required per policy to contact a security staff member and make a request that the alleged victim not take any action that could destroy evidence.

During staff interviews, both security and non-security staff have acknowledged their training of the first responder duties. The staff was able to specifically identify the steps they are to take as a security or non-security staff (non-security staff also knew all the required steps for security staff) and knew the location of the response plan and evidence protocol.

Review:
Policy and procedure
Agency's response plan and evidence protocol
Investigation reports
Interviews with staff

Standard 115.265 Coordinated response

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

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

The agency has developed a response plan and evidence protocol for any incident of sexual abuse. The plan is listed in required steps and is posted at the security posts. The steps listed are specific and detailed enough for staff to follow in the event of a sexual abuse/sexual assault incident. The list starts with the first responder duties and refers the staff member to call the local authorities and the Program Director or Manager on Call. The Program Director (the administrative investigator) will follow up with the local authorities until completion of the investigation. An administrative investigation will not take place until after the criminal investigation is completed or in conjunction with the local legal authority.

The staff will offer the victim access to a forensic medical exam Ohio Health Hospital, victim advocate services from the SARNCO, and if the advocate services are not readily available a qualified staff member who has been trained as an emotional support person will assist. The advocate will accompany the victim to the medical exam and any investigative interviews. The Program Director or designee will be responsible for the 90 day retaliation monitoring.

Review:
Policy and procedure
Response plan and evidence protocol
Interview with PREA Coordinator
Interview with Program Manager
Interview with staff

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

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

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

N/A: The PREA Coordinator reports that the facility does not have a union or enter into any collective bargaining with employees.

Standard 115.267 Agency protection against retaliation

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

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

The agency has a policy designed to protect residents and staff who report sexual abuse or sexual harassment or cooperate with an investigation from retaliation from other residents or staff. The protection measures include bed moves, dorm moves, facility moves, and administrative leaves for staff. Should a resident or staff member make a request, an emotional support person will be available for services.

The Program Director or designee would be responsible for monitoring the conduct, and treatment of residents or staff who report sexual abuse. The monitoring of residents who report abuse would also include periodic status checks and resident disciplinary records, housing, program changes, or negative performance reviews or reassignments of staff. The monitoring would continue past 90 days if a need is indicated. Monitoring would cease if the allegation has been determined to be unfounded.

The staff at MRTP have placed residents on increased observations, retaliation watch and supplied emotional supportive services to residents during and after allegation investigations.

The auditor was able to interview the Program Director to confirm the retaliation monitoring process and the measures the facility would employ to insure that a resident or staff member would be protected from retaliation.

Review:
Policy and Procedure
Interview with Program Manager
Interview with PREA Coordinator
Investigation reports
Retaliation watch reports

Standard 115.271 Criminal and administrative agency investigations

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

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

The facility conducts administrative investigations but does not conduct criminal investigations. Criminal investigations would be completed by Mansfield Police Department. The facility has completed six administrative investigations for sexual harassment with three allegations being referred to the local legal authority for criminal investigation.

Allegation number 1: This was a resident verbal report of resident-to-resident sexual abuse. The allegation was administratively investigated and determined to be substantiated. The allegation was referred to Mansfield Police Department for a criminal investigation.

The MPD came to the facility and interviewed the resident. The officer declined to press charges due to lack of evidence.

Allegation number 2: A resident made a third party verbal report of resident-to-resident sexual abuse. The allegation was administratively investigated and determined to be substantiated. The allegation was referred to the Adult Parole Authority who had arresting powers for this residents commitment type. The Mansfield Police Department was also called to assist APA in arresting the resident.

Allegation number 3: A resident made a verbal report of resident-to resident sexual harassment. The allegation was administratively investigated and determined to be unsubstantiated. There was no criminal activity so no criminal investigation referral was made.

Allegation number 4: A resident made a verbal report of resident-to-resident sexual harassment. The allegation was administratively investigated and determined to be substantiated. There was no criminal activity so no criminal investigation referral was made.

Allegation number 5: A resident made a verbal report of staff-to-resident sexual abuse. The allegation was administratively investigated and determined to be unfounded.

Allegation number 6: A resident made a verbal report of resident-to-resident sexual harassment. The allegation was administratively investigated and determined to be unsubstantiated. There was no criminal activity so no criminal investigation referral was made.

The facility has three trained administrative investigators. The Program Manager currently handles all MRRP's administrative investigations. The Program Manager's training was developed and facilitated by the Moss Group.

The auditor sat with the PREA Coordinator and the PREA Investigator to review the process for how the investigator completes an investigation. The investigator discussed the review of any camera footage if available, interviewing the alleged victim, witness, and abuser, and review if there has been previous complains made against the suspected abuser. At no time does the investigator use the resident's status as a resident or staff member to determine credibility. The facility does not use a polygraph examination as part of an administrative investigation. All allegations will receive an administrative investigation regardless of whether the alleged victim or abuse is no longer employed or in the control of the agency.

All allegations are documented on the facility's Unusual Incident Report. The report is comprehensive in the information it collects from the beginning to the disposition of the allegation. If a Sexual Abuse Review Team meeting and retaliation monitoring in necessary, the investigator will denote the time of the SART meeting and who is responsible for retaliation monitoring.

The PREA Coordinator confirmed the retention schedule of for as long as the person is incarcerated or employed with the agency plus five years. The Program Manager is responsible for maintaining contact with the legal local authority when the investigation has been referred for criminal investigation.

Review:

Policy and Procedure

Investigation Reports

PREA administrative training certificate

Interview with PREA Coordinator

Interview with PREA Investigator

Standard 115.272 Evidentiary standard for administrative investigations

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

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

Agency policy states that the facility will use preponderance of evidence or lower for determining whether allegations of sexual abuse or

sexual harassment are substantiated.

During the course of reviewing investigation reports and conducting interviews it was noted by the auditor that the investigator misunderstood the definition of unfounded and unsubstantiated. After a discussion with all investigators, it was made clear that unfounded allegations have proof that the harassment/abuse did not occur. Besides this confusion, the investigations were all handled properly and had the correct outcome

Review:

Policy and procedure

Investigation Reports

Interview with PREA Coordinator

Interview with Administrative Investigators

Standard 115.273 Reporting to residents

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

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

The agency has a policy for notifying a resident of the outcome of an investigation with the options being substantiated, unsubstantiated, or unfounded. The standard only calls for the notification in the case of sexual abuse, however the agency will make the notification any time there is an allegation if possible.

The Unusual Incident Report denotes whether a resident was notified and the date of notification or if there was no notification given. If the facility was unable to notify the resident, the reason is noted on the form.

The alleged victim in the allegation will receive notification on the disposition and if applicable, notify the resident if the staff member is no longer posted within the facility; the staff member has been indicted on a charge related to the sexual abuse within the facility; or if the staff member has been convicted on a charge related to sexual abuse within the facility. If the abuser is another resident, the facility will notify the alleged victim if the abuser has been indicted on a charge related to sexual abuse within the facility or the agency learns the abuser has been convicted on charges related to sexual abuse within the facility. The resident will sign the document and been given a copy.

The auditor reviewed notification forms from the various administrative investigations.

Review:

Policy and procedure

Investigation reports

PREA investigation outcome notification form

Interview with PREA Investigator

Standard 115.276 Disciplinary sanctions for staff

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

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

The agency has a policy that subjects employees to discipline up to and including termination for violating the agency's sexual abuse and sexual harassment policies with termination being the discipline for employees who engage in sexual abuse. The facility had one allegation of staff sexual abuse during this audit cycle but the allegation was determined to be unfounded.

All staff interviewed understood that anyone engaging in sexual harassment will be disciplined according to agency policy and that they would be terminated for participating in sexual abuse. Staff indicated that they are required to report any suspicion to their immediate supervisor and that they would not have any issue reporting a coworker for violation of the zero tolerance policy.

The auditor reviewed agency policy, the employee handbook, and interviewed the PREA Coordinator and Human Resource Generalist to confirm the disciplinary process for employees found to have substantially engaged in sexual harassment or sexual abuse against residents. All agency leadership stated that any employee found to have engaged in sexual harassment will be immediately terminated from the facility and employees found to have engaged in sexual abuse will be immediately terminated and law enforcement would be notified.

Review:

Policy and procedure

Investigation report

Interview with PREA Coordinator

Interview with Human Resource Generalist

Interview with random staff

Standard 115.277 Corrective action for contractors and volunteers

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

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

The facility has not had a report of sexual abuse or sexual harassment against a volunteer or contractor during this audit cycle. The agency's policy states that any allegation of sexual abuse would be reported to law enforcement and any relevant licensing body. The facility would prohibit any further interaction between contractors or volunteers with residents if there is a violation of the agency's sexual abuse or sexual harassment policies. All contractors and volunteers sign an acknowledgement of the policies.

Review:

Policy and Procedure

Interview with PREA Coordinator

Standard 115.278 Disciplinary sanctions for residents

- Exceeds Standard (substantially exceeds requirement of standard)
- Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

- Does Not Meet Standard (requires corrective action)

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

The facility has an appropriate policy that disciplines residents for a substantiated allegation of sexual abuse or sexual harassment or for a criminal finding of guilt for sexual abuse or harassment. The facility has had five allegations against resident during this audit cycle. All resident that have been found to have violated that agency's zero tolerance policy have been unsuccessfully terminated from the facility. Allegations that have been referred for a criminal investigation have not resulted in a guilty finding.

The resident handbook clearly defines the agency's rule violations and the possible sanctions. Each resident is given a handbook at intake and staff reviews the handbook, specifically the disciplinary policies, with each resident. The Program Manager also reviews these policies with residents during orientation group.

During resident interviews, all residents stated that they received a handbook at intake and that staff reviewed the disciplinary policies with them. Each resident was able to identify the sanctions that accompany a substantiated allegation of sexual abuse or sexual harassment or a criminal finding of guilt.

Review:
Policy and procedure
Resident handbook
Orientation curriculum
Interview with Program Manager
Interview with residents

Standard 115.282 Access to emergency medical and mental health services

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

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

The agency has a policy requiring the facility to have a MOU with a medical and mental health facility to ensure that victims of sexual abuse receive timely, unimpeded access to emergency medical treatment and crisis intervention services, the nature and scope of which are determined by medical and mental health practitioners according to their medical judgement. The facility is also required to provide timely information about and timely access to emergency contraception and sexually transmitted infections prophylaxis. All services are to be provided to the resident free of charge.

The facility has MOU's with Ohio Health to provide emergency medical services to any sexual abuse victim in the facility and Ohio Health's agreement with SARNCO to provide Crisis Intervention services to victims of sexual abuse. These services have been verified to be free of charge to the resident. A trained emotional support employee will take preliminary steps to help the victim if no qualified medical or mental health practitioners are on duty at the time of the report.

The facility has not used Ohio Health for forensic medical examination during this audit cycle. The facility has offered victims of sexual harassment and sexual abuse emotional supportive services. Some clients have received services from the community and others requested to use staff as support personnel.

Review:
PREA Audit Report

Policy and procedure
MOU with Ohio Health
Interview with PREA Coordinator
Interview with Clinical Supervisor
Ohio Health website

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

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

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

The agency has a policy to offer medical and mental health evaluations and treatment if needed to residents who have been victimized by sexual abuse in any prison, jail, lockup, or juvenile facility. If needed, the resident will receive follow up services, treatment plans, and continued care upon a transfer or placement in another facility or released from custody.

All victims of sexual abuse while incarcerated will be offered tests for sexually transmitted infections. The facility does not house female offenders.

These services would be provided by Ohio Health and SARNCO, both community facilities. These services will be offered free of charge to the victim regardless of whether the victim names the abuser or cooperates with the investigation.

Any known resident on resident abuser will be offered treatment when deemed appropriate by a mental health practitioner within 60 days of learning of such history.

The facility has not had a resident who was victimized while in a prison, jail, lockup, or juvenile facility. The facility has not had any known resident on resident abusers.

Review:
Policy and procedure
MOU with Ohio Health
Ohio Health website
SARNCO website
Interview with PREA Coordinator

Standard 115.286 Sexual abuse incident reviews

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

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

corrective actions taken by the facility.

The agency has a policy requiring a Sexual Abuse Review Team review all substantiated and unsubstantiated allegations of sexual abuse within 30 days from the conclusion of the investigation. The team will include the PREA Coordinator, Program Manager, Clinical Supervisor, and PREA investigator. Other staff members will be asked to provide input include line staff and medical and mental health practitioners.

The team will review whether there needs to be a change to policy or practice in order to better prevent, detect, or respond to sexual abuse; consider if the sexual abuse was motivated by race, ethnicity, gender identity, LGBTI identification, status or perceived status, gang affiliation, or any other group dynamics; any physical barriers that enabled the abuse; adequacy of staffing levels; and need for augmented monitoring technology.

The team will document their findings in a report and make any recommendations for improvement. The report will be submitted to the facility head and PREA compliance manager.

The facility will document how they implemented the recommendations or reasons for not doing so.

CORRECTIVE ACTION:

The current review form the SART team completes does not include the consideration of whether the incident or allegation was motivated by race; ethnicity; gender identity; lesbian, gay, bisexual, transgender, intersex, or gender non-conforming status or perceived status; or gang affiliation; or was motivated or otherwise caused by other group dynamics at the facility. The review should also include an assessment of the adequacy of staffing levels in that area during different shift.

FACILITY RESPONSE:

The facility has developed a new SART review form. The new form includes an assessment of the motivation for the allegation, which includes all the above status. The form also includes an assessment of staffing vulnerabilities.

Review:

Policy and procedure
SART checklist
SART team debriefing
Interview with PREA Coordinator
*New SART checklist form

Standard 115.287 Data collection

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

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

The Program Director and PREA Coordinator are responsible for collecting data for every allegation of sexual abuse at the facility. The facility is using a standardized instrument and includes definitions. The information is aggregated annually and documented in an annual report which is posted on the agency's website. The data collected is enough to answer all questions on the most recent version of the Survey of Sexual Violence conducted by the Department of Justice. The PREA Coordinator will retain all information collected for at least 10 years.

Review:

Policy and procedure
Annual report
Agency website
PREA Audit Report

Standard 115.288 Data review for corrective action

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

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

The agency has a policy for developing an annual PREA report which documents how the facility assess and improves the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training. The report identifies problem areas and corrective action taken. The report has relevant information for the facility and the agency as a whole.

A review of the report shows that the facility documented this information as well as a comparison of the current year’s data and corrective actions with those from prior years and includes an assessment of the agency’s progress in addressing sexual abuse.

The report is posted on the agency’s website and does not include any identifying information that could jeopardize the safety and security of the facility.

Review:
Policy and procedure
PREA annual report
Interview with PREA Coordinator
Interview with Director of Compliance and Quality Improvement

Standard 115.289 Data storage, publication, and destruction

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

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

The PREA Coordinator is responsible for the collection and secure retention of all data collected pursuant to standard 115.287. The data collected will be retained for 10 years. The Coordinator takes all collected information from each facility under the Volunteers of America of Greater Ohio umbrella and creates an annual report which is published on the agency’s website after approval from the Executive Vice President.

The report does not contain any personal identifiers or any information that could jeopardize the safety and security of any facility.

Review:
PREA Audit Report

Policy and procedure
PREA annual report
Agency website
Interview with PREA Coordinator

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.

Kayleen Murray

November 9, 2017

Auditor Signature

Date