PREA AUDIT REPORT ☐ INTERIM ☐ FINAL

COMMUNITY CONFINEMENT FACILITIES

Auditor Information			
Auditor name: Stephen J. Huffman			
Address: 11820 Parklawn Drive, Rockville, Maryland 20852			
Email: stephen.huffman@nakamotogroup.com			
Telephone number: 614-940-4696			
Date of facility visit: May 29, 2015			
Facility Information			
Facility name: Waterloo Residential Correctional Facility			
Facility physical address: 310-314 East 6th Street, Waterloo, Iowa 50703			
Facility mailing address: *(if different from above)*			
Facility telephone number: 319-291-2087			
The facility is:	☐ Federal	■ State	☐ County
	☐ Military	☐ Municipal	☐ Private for profit
	☐ Private not for profit		
Facility type:	☐ Community treatment center ■ Halfway house ☐ Alcohol or drug rehabilitation center	☐ Community-based confinement facility ☐ Mental health facility	☐ Other
Name of facility's Chief Executive Officer: Karen E. Herkelman			
Number of staff assigned to the facility in the last 12 months: 31			
Designed facility capacity: 162			
Current population of facility: 144			
Facility security levels/inmate custody levels: Minimum			
Age range of the population: 18-80			
Name of PREA Compliance Manager: Ross Todd		**Title:**	Executive Officer
Email address: ross.todd@iowa.gov		**Telephone number:**	319-292-1263
Agency Information			
Name of agency: First Judicial District Department of Correctional Services			
Governing authority or parent agency: *(if applicable)* State of Iowa/First Judicial District Department of Correctional Services			
Physical address: 314 East 6th Street, Waterloo, Iowa 50703			
Mailing address: *(if different from above)*			
Telephone number: 319-236-9626			
Agency Chief Executive Officer			
Name: Karen E. Herkelman		**Title:**	District Director
Email address: karen.herkelman@iowa.gov		**Telephone number:**	319-292-1277
Agency-Wide PREA Coordinator			
Name: Ross Todd		**Title:**	Executive Officer
Email address: ross.todd@iowa.gov		**Telephone number:**	319-292-1263

AUDIT FINDINGS

NARRATIVE

The on-site Prison Rape Elimination Act (PREA) compliance audit of the Waterloo Residential Correctional Facility, Waterloo, Iowa was conducted May 29, 2015 by the Nakamoto Group, Inc. certified PREA auditor Stephen J. Huffman. When the auditor arrived at the facility, an "in-briefing" meeting was held with Executive Officer/PREA Coordinator. The introductions and audit process was discussed during the briefing.

The standards used for this audit became effective August 20, 2012. This auditor discussed information contained in the Pre-Audit Questionnaire with the PREA Audit Coordinator prior to the on-site audit visit. As part of the audit, a review of all agency and local facility policies and a tour of the the facility was completed. A total of eighteen residents of the 144 total population were interviewed by the auditor. All residents stated the facility assists them to meet their needs. There were no allegations of sexual abuse/harassment filed by residents during the rating period of the past twelve months.

The average length of stay at the minimum security facility is 2.7 months. The age range of the population is 18-80 years of age. Eligible residents are afforded a furlough program to allow for employment seeking, family visits, recreation, shopping, religious services, vocational training, educational services and counseling sessions. The facility offers various programs like anger management, job seeking skills, education, sex offender continuing care, sex offender group treatment and drug court accountability.

A total of 20 of the 31 employed staff were interviewed including residential officers from all three eight hour shifts and housing units. Six administrative staff were interviewed including Director, Residential Managers, Human Resource Manager, Executive Officer and Executive Officer / PREA Compliance Coordinator. Specialized staff included investigators, incident review team, retaliation monitor, intake and unit staff were interviewed.

The auditor interviewed a representative from the local advocacy center, Riverview Center, and the representative believes the facility has an excellent PREA culture and they periodically meet with facility staff to discuss PREA issues and how the culture can be improved to enhance the safety of the residents and staff. The facility also has two staff trained for assisting the residents with emotional and support services. Waterloo Residential Correctional Facility has a memorandum of understanding with the local hospitals Covenant Medical Center and Allen Memorial Hospital for medical and mental health services.

The auditor concluded, through interviews and review of policy and documentation, that all staff and residents were very knowledgeable concerning their responsibilities involving PREA. During the interviews, the residents stated that staff were respectful and that they felt safe at the facility. All residents stated they would ask staff for assistance if they were being sexually harassed or abused, indicating they have confidence in the facility staff. Staff were able to describe in detail their specific duties and responsibilities, including being a "first responder" if an incident occurred or allegation of sexual abuse/harassment was made.

DESCRIPTION OF FACILITY CHARACTERISTICS

DEPARTMENT OVERVIEW and HISTORY

The Department of Correctional Services within the First Judicial District is one of eight judicial district correctional programs currently existing within the State of Iowa. These are the end result of statewide development of correctional programs with the objectives of providing total services at the community-based level to correctional clients, the court system, and ultimately, the public. The First Judicial District operates its programs as mandated by Chapter 905 of the Code of Iowa. Additionally, a Board of Directors with established By-Laws governs the District. The Board of Directors is comprised of a county supervisor from each county in the district, a judicial appointee, and one citizen advisory representative. The Department of Correctional Services, as it exists in this judicial district, provides the usual historic services and, in addition, some innovative and functional services.

In 1985, the Waterloo Residential Correctional Facility moved from the condemned Ellis Hotel to a newly constructed 56 bed facility at 310 East 6th Street. In March of 1991 an addition was completed to the Waterloo Residential Correctional facility to house the Work Release Center and DCS Administrative Offices. In this transition the Work Release Center expanded from a 20-bed facility to a 64 bed multi-program facility.

Today the Waterloo Residential Correctional Facility operates as one facility with 150 beds. This facility is for male offenders only. The facility population includes offenders who are placed at the facility as a condition of probation, on state work release or as as alternative jail sentence. Federal residents are housed at the facility through a contract with the U.S. Bureau of Prisons. Specialized programming is available for Sex Offenders, Domestic Violence Offenders and Habitual Operating While Intoxicated (321) Program.

SUMMARY OF AUDIT FINDINGS

At the conclusion of the on-site audit, an "out-brief" meeting was held with facility Director, Residential Manager, Executive Officer, Executive Officer/PREA Compliance Coordinator, Residential Supervisor and Administrative Officer. The auditor was provided with extensive and lengthy files prior to the audit for review to support a conclusion of compliance with PREA. The facility staff were found to be courteous, cooperative, knowledgeable and professional. All areas of the facility were found to be clean and well maintained. At the conclusion of the audit, the auditor thanked the Director and staff for their hard work and dedication to the PREA process.

Number of standards exceeded: 1

Number of standards met: 38

Number of standards not met: 0

Number of standards not applicable: 1

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

☐ Exceeds Standard (substantially exceeds requirement of standard)

■ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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

Policy PER 27 pages 1-3 and PER 31 pages 1-7 address this standard. The facility PREA Plan meets zero tolerance as required by the standard. The facility PREA Compliance Coordinator is a Executive Officer who reports directly to the Director. The facility has zero tolerance posting in all areas of the facility and residents receive several PREA zero tolerance documents. Staff receive initial training and annual training, as well as, updates throughout the year.

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.

Not Applicable-The facility does not contract with other entities for the confinement of residents.

Standard 115.213 Supervision and monitoring

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

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

DRS 41 pages 1 and 2 and DRS 46 pages 1 and 2 address this standard. The facility administration including the PREA Coordinator reviews the staffing plans on an annual basis. Interviewing the Director, PREA Coordinator and Resident Managers, indicated compliance with PREA and other safety and security issues are always a primary focus when they consider and review their staffing plan. The auditor reviewed the facility staffing plan and it was determined to be acceptable. The facility has been provided with all necessary resources to support the programs and procedures to ensure compliance with PREA standards. The audit included an examination of all video monitoring systems, inmate access to telephones, review of documentation and staff interviews and rosters. Documentation of unannounced rounds by administrative staff that cover all shifts were reviewed. Interviews with staff confirmed unannounced rounds to all areas of the facility on a weekly basis and conducted with no warning to staff. Fifty-five video cameras are placed throughout the facility with monitoring capabilities. The camera monitoring system is monitored in the main control center. The cameras have recording capabilities and is maintained for fourteen days.

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.

PER 27 pages 1-5, CM 40 pages 1-6 and staff training curriculum address this standard. Cross-gender strip and body cavity searches are prohibited, except in emergency situations and completed by staff of the same gender as the resident and is documented. Staff indicated they received cross-gender pat search training during initial and annual training sessions. Residents, resident officers and administrative staff stated residents are allowed to shower, dress and use the toilet privately without being viewed by the opposite gender. Residents and staff reported that staff of the opposite gender announce their presence before entering the housing areas. Staff were aware of the policy prohibiting the search of trans gender or intersex residents to just determine their genital status.

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.

CM 22 pages 1 and 2 and CM 32 pages 1 and 2 address the requirements of this standard. The facility takes appropriate steps to ensure residents with disabilities and inmates with limited English proficiency have an opportunity to participate in and benefit from facilities efforts to prevent, detect and respond to sexual abuse and harassment. PREA handouts, zero tolerance posting and resident handbooks are in English and Spanish. The auditor reviewed all mentioned documents. Staff interviewed were aware that under no circumstances are resident interpreters or assistants are to be used when dealing with PREA issues. There were no residents with disabilities or with limited English speaking proficiency available for interview.

Standard 115.217 Hiring and promotion decisions

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

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

PER 35 pages 1-4 and PER 16F Employment Application address this standard. The Human Resource Manager was interviewed, and stated that all components of this standard have been met. All employees, contractors, volunteers have had their background checks completed through the National Crime Investigation Center. Staff promotions require a background check before promotion is approved. A tracking system is in place to ensure that updated background checks are conducted every five years. Policy states false information submitted by applicants is grounds for termination. Auditor reviewed employment documentation supporting compliance to this standard.

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 installed 40 additional cameras and windows in bedroom doors during the audit period. The cameras have recording capabilities for 33 days and are monitored in the control center.

Standard 115.221 Evidence protocol and forensic medical examinations

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

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

Facility staff were interviewed concerning this standard and all were knowledgeable of procedures to secure and obtain usable physical evidence when sexual abuse is alleged. Staff were aware who was responsible for conducting investigations. Residents are transported to local Allen Memorial Hospital and Covenant Medical Center for SAFE/SANE exams. The facility has an memorandum of understanding with hospitals. The facility has two trained advocacy staff members. There were no sexual abuse/harassment allegations the past twelve months and there was no SAFE/SANE forensic exams during the audit period.

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.

PER 27 pages 1-5 and PER 52 pages 1-4 address this standard. Administrative and criminal investigations are completed on all allegations of sexual abuse/harassment. Various administrative staff conduct administrative investigations and were interviewed and found to be very knowledgeable concerning their responsibilities. There are eight facility trained investigators who received training through the Moss Group. The Waterloo City Police Department and Iowa Department of Corrections Division of Investigative Services conducts the criminal investigations for the facility. There were no allegations of sexual abuse or harassment during audit period.

Standard 115.231 Employee training

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

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

PER 29F Training Form, PER 31 pages 1-7 and Annual Training Plan address all training required by this standard. The Iowa Department of Corrections provides extensive web-based E-Learning of PREA standards training which all staff successfully complete. Contractors and volunteers are provided training relative to their duties and responsibilities. Annual refresher training including PREA topics is provided to all staff. Staff receive continuous updating throughout the year. Staff acknowledge in writing their understanding of PREA. Staff training files and facility training curriculum was reviewed and contained documentation supporting compliance to this standard. All staff interviewed indicated they had received PREA training.

Standard 115.232 Volunteer and contractor training

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

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

The Annual Training Plan addresses the requirements of this standard. There are three contractors and volunteers who have received PREA training that covered zero-tolerance, reporting and responding requirements. All training is documented and auditor examined training files that confirmed standard compliance. There were no volunteers or contractors available for interview.

Standard 115.233 Resident education

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

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

CM 22 pages 1 and 2 and CM 32 pages 1 and 2 addresse the requirements of this standard. Auditor believes the facility does an good job in educating the inmates in PREA. Residents receive information during the intake process that includes a CM 53F PREA information packet "Prevention of Sexual Misconduct an Overview for Offenders" and CM35F "Protection From Abuse and Offender Grievance Procedure" handout and resident handbook printed in English and Spanish. Facility staff meet periodically with residents concerning PREA standards giving the residents an opportunity to ask questions and present any concerns. There are zero tolerance posters throughout the facility and in each housing unit and a "hot line" telephone number to call the Sexual Abuse Assault or Council on Sexual Assault and Domestic Violence to report abuse or harassment and address for the Iowa Obudsman Office. There are also two trained staff for advocacy services. Interviews with staff and residents, as well as documentation review, support the facility exceeds compliance of the standard.

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.

PER 31 pages 1-7 address this standard. The Waterloo City Police Department or Iowa Department of Corrections Division of Investigative Services perform criminal investigations. Eight facility investigators received PREA specialized investigative training through the Moss Group Training Program and perform administrative investigations. Training records were reviewed confirming the completion of the required training.

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 doesn't employ medical or mental health staff. The facility has memorandum of understandings with the local Allen Memorial Hospital and Covenant Medical Center and the Riverview Center for medical and mental health services.

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.

DRS 45 pages 1 and 2 State of Iowa Sexual Violence Propensity intake screening instrument-(SVP) address the requirements of this standard. All residents are assessed at intake immediately upon arrival at the facility for their risk of being sexually abused or harassed by other residents or being sexually abusive towards other residents. An intake staff member screens all new arrivals within their first 72 hours. They are almost always seen the first day of intake. The staff reviews all relevant information from other facilities and continues to reassess when additional information is received within 30 days of arrival. Residents identified as high risk for sexual victimization or at risk of sexually abusing other residents are referred to the hospital medical and mental health staff for additional assessment. Staff and resident interviews, review of documentation and observation of intake process confirmed this information. There were 584 inmates screened for risk of sexual victimization or risk of sexually abusing other inmates whose length of stay was more than 72 hours. It is unknown the number of inmates screened that were reassessed after 30 days of arrival for possible sexual abuse or victimization based upon additional information received during the audit period. the facility did not track this type of data.

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.

DRS 45 pages 1 and 2 and DRS 46 pages 1 and 2 address compliance of this standard. Policy requires the use of a PREA Objective Screening Instrument (reviewed by auditor) to determine proper housing, bed assignment, work assignment, education and other program assignments with the goal of keeping residents at high risk of being sexually abused / harassed separate from those residents who are at a high risk of being sexually abusive. Housing and program assignments are made on a case by case basis for all residents with continued follow-up and monitoring when needed. There are weekly staff meetings addressing PREA concerns and issues. Staff and resident interviews and review of screening documents confirm compliance of the standard.

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)

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PER 27 pages 1 and 2, CM 32 pages 1 and 2, CM 53F form, grievance policy and resident handbook in English and Spanish address compliance of this standard. A review of documentation and staff/resident interviews indicated that there are multiple ways (including verbally, in writing, anonymously, privately, "hot line" telephone calls and from a third party for residents to report sexual abuse/harassment. Staff document all allegations. There are posters and other reporting documents, on display throughout the facility, observed by auditor, also explain reporting methods. The facility does have a memoranda of understanding with the local advocacy center the Riverview Center to provide all services relevant to this standard and also the facility has two trained facility advocacy staff to address resident concerns.

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.

PER 27 pages 1-5, PER 52 pages 1-4, CM 35F page 1, CM 53 F form, DRS 46 pages 1 and 2 and grievance policy address this standard. Residents may file a grievance; however, all allegations of abuse/harassment when received by staff, would immediately result in an administrative or criminal investigation. The policy allows for an emergency grievance to be completed by the residents. There were no grievances filed involving PREA related issues during the audit period.

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.

CM 53F form and resident handbook address this standard. The facility does have a memoranda of understanding with the local advocacy center; the Riverview Center to provide all services relevant to this standard. The facility has contact information for the advocacy center and two staff are advocacy trained to address resident issues. Auditor made contact with a representative from the Riverview Center and the representative confirmed the facility had a good PREA culture and they have an excellent relationship with the facility.

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)

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PER 27 pages 1-4, website with facility staff telephone numbers, resident handbook, posters, posted addresses of local advocacy center address the requirements of this standard. The resident handbook, various information handouts, PREA packet and facility posters assist in third party reporters on how to report allegations. Posted telephone number of the local advocacy service center allows residents to contact the agency at any time. Staff and resident interviews confirm compliance to this standard.

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.

PER 27 pages 1-5 address this standard. All staff interviewed were well aware of their duty to immediately report all allegations of sexual abuse and harassment and retaliation relevant to PREA standards including third party. This standard of compliance was verified through resident officers and administrative staff interviews and review of policies.

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.

CM 32 pages 1 and 2 and DRS 46 pages 1 and 2 address this standard. All staff interviewed stated their duties and responsibilities if they were aware of a resident being sexually abused or harassed and they would act immediately to protect the resident. The staff interviewed stated they would separate residents, secure scene and protect possible evidence, not allow residents to destroy possible evidence and contact supervisor and medical staff. During the rating period there were no residents determined to be subject to substantial risk of imminent sexual abuse.

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.

DRS 46 page 2 addresses this standard. Policy requires the reporting of any PREA related allegation by an resident that occurred at another facility. There were no allegations received during the rating period stating that sexual abuse occurred at another facility. Policy requires the Director where the resident is currently being housed notify the Director where the resident was previously housed within 72 hours after being notified. The policy requires an investigation be immediately initiated. This standard was verified by reviewing policy and interviewing Director, Residential Manager and Executive Officer/PREA Coordinator.

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.

DRS 46 page 2 addresses this standard. All staff interviewed were very knowledgeable concerning their first responder duties and responsibilities upon learning of a sexual abuse or harassment allegation by a resident. The staff stated they would separate the residents, secure the scene, would not allow residents to destroy any evidence and contact supervisor. The residents would be sent to the local hospital if needed. There were no allegations made by residents during the audit period.

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.

DRS 46 pages 1 and 2, coordinated plan and allegation flow chart address this standard. The documentation was reviewed by the auditor. The policy and plan describes first responders, investigators, facility administration, advocacy center and medical facilities coordination to resolve sexual abuse / harassment incidents.

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.

The Collective Bargaining Agreement between the State of Iowa and (AFSCME) American Federation of State, County and Municipal Employees, Council 61 AFL-CIO complies with this standard. Employees are subject to discipline, including removal, if they engage in any sexual abuse/harassment with a resident. The agreement was examined by the auditor.

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.

PER 27 page1 addresses this standard. The policy prohibits any type of retaliation to any staff person or resident who has reported sexual abuse or harassment or cooperated in any PREA allegation investigation. The Resident Supervisor is designated the retaliation monitor. He was interviewed and he stated he would conduct checks with the resident weekly or as needed up to 90 days or as long as needed to make sure the resident is safe from retaliation or resident is transferred. There have been no cases of retaliation during the rating period.

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.

PER 52 pages 1-4 addresses this standard. Resident Manager,Executive Officer and other administrative staff conduct administrative investigations within the facility and refers criminal investigations to the Waterloo City Police Department or Iowa Department of Corrections Division of Investigation Services who confers with county prosecutor to determine if prosecution will be pursued. There were no criminal prosecutions during this audit period. Per the Director, the facility cooperates fully with any outside agency who initiates an investigation.

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.

PER 52 page 3 addresses this standard. The evidence standard is a preponderance of the evidence in determining whether allegations of sexual abuse or sexual harassment are substantiated.

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.

PER 52 pages 3 and 4 address this standard requiring the resident be informed of the outcome of the investigation. There were no administrative investigations during the audit period requiring resident notification as required by this standard.

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.

PER 15 pages 1-5, Per 27 pages 1-4 and employee handbook address this standard. The facility has not issued any disciplinary sanctions to residents as a result of sexual conduct with other residents or staff. There have not been any reported cases of residents engaging in sex with staff during the audit period. The Collective Bargaining Agreement between the State of Iowa and (AFSCME) American Federation of State, County and Municipal Employees, Council 61 AFL-CIO allows for disciplinary sanctions against staff including termination for sexual abuse/harassment of an resident.

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.

PER 27 pages 1-4 address this standard. During the audit period there were no contractors or volunteers accused of sexual abuse/harassment of an resident. Director interview indicated contractors or volunteers would be terminated immediately if they engaged in sexual abuse or harassment of an resident.

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.

DRS 2F pages 1-6, CM 53F pages 1-4 and CM 32 page 2 address this standard. There were no cases of resident sexual abuse/harassment investigated at the Waterloo Residential Correctional Facility during the audit period. There have been no cases of staff and residents engaging in sex during the audit period. There were no cases of residents having sex with other residents. Policy does not allow consensual sex of any nature. Residents that sexually abuse or harass staff will be disciplined if not consensual. The facility does not discipline residents who make allegations in good faith, even if the investigation does not establish evidence sufficient to substantiate the allegation. Interviews with facility investigators confirm compliance to this standard.

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.

DRS 46 pages 1 and 2 address this standard. The facility has a memoranda of understanding with the local Allen Memorial Hospital and Covenant Medical Center for emergency medical and mental health treatments. The treatment is offered at no financial cost to the residents. There are no facility medical and mental health staff, but there are two trained facility staff for advocacy services at the facility.

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.

DRS 46 pages 1 and 2 address this standard. Services are without financial cost to the resident. The facility has memoranda of understanding with local Allen Memorial Hospital and Covenant Medical Center for ongoing medical and mental health services. This standard compliance was determined by documentation review and administrative staff interviews.

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.

PER 52 page 3 addresses this standard. Administrative and criminal investigations are completed on all allegations of sexual abuse/harassment. Residential Manager, Executive Officers and other supervisory staff perform administrative investigations for sexual abuse/harassment. Three investigators were interviewed and found to be very knowledgeable concerning their responsibilities. There are eight trained facility investigators. The Waterloo City Police Department and Iowa Department of Corrections Division of Investigative Services conducts the criminal investigations for the facility. There were no allegations of sexual abuse or harassment during audit period. All investigations ordinarily will be completed within 30 days. The review team consists of Director, Residential Manager, Executive Officer and PREA Coordinator and all were very knowledgeable concerning their duties for investigating and reviewing incidents. The auditor reviewed the monthly administration meeting minutes, sexual abuse incident form and incident review 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.

PER 52 page 3 addresses this standard. The facility collects accurate uniform data for every allegation of sexual abuse/harassment by using a standardized Iowa Department of Corrections PREA Investigation Data Base Report. The incident-based data collected includes the data necessary to answer all questions from the most recent version of the Survey of Sexual Violence conducted by the Department of Justice. The agency aggregates all data annually and reviews it annually. The auditor reviewed the annual 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.

PER 52 pages 3 and 4 address this standard. The Iowa Department of Corrections and the Waterloo Residential Correctional Facility administration review and assess all sexual abuse/harassment data at least annually to improve the effectiveness of its sexual abuse prevention, detection and response policies, and to identify any issues or problematic areas and take corrective action if needed. The facility PREA Coordinator forwards data to the Iowa Department of Corrections. An annual report is prepared and placed on the departments website. The Annual Report was reviewed by the auditor.

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.

PER 52 page 4 addresses this standard. The facility PREA Coordinator reviews data compiled and issues a report to the Iowa Department of Corrections. The data is securely retained and published on the department website. The reports cover all data noted in this standard, and is retained in a secured file.

AUDITOR CERTIFICATION

I certify that:

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

Stephen J. Huffman June 12, 2015

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Auditor Signature Date