PREA AUDIT REPORT ☐ INTERIM ☐ FINAL

COMMUNITY CONFINEMENT FACILITIES

Auditor Information				
Auditor name: Glynn Maddox				
Address: 11820 Parklawn Drive, Rockville, Maryland 20852				
Email: Glynn.Maddox@nakamotogroup.com				
Telephone number: 478-278-8022				
Date of facility visit: May 4, 2016				
Facility Information				
Facility name: West Union Residential Facility				
Facility physical address: 500 South Pine Street, West Union, Iowa 52175				
Facility mailing address: *(if different from above)*				
Facility telephone number: 563-422-5758				
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: Mark Smith				
Number of staff assigned to the facility in the last 12 months: 2				
Designed facility capacity: 48				
Current population of facility: 41 (38 male and 3 female)				
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:**	319-292-1265	
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 B				
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: Ken Kolthoff		**Title:**	District Director	
Email address: kenneth.kolthoff@iowa.gov		**Telephone number:**	319-292-1265	
Agency-Wide PREA Coordinator				
Name: Ross Todd		**Title:**	Executive Officer	
Email address: ross.todd@iowa.gov		**Telephone number:**	319-292-1265	

AUDIT FINDINGS

NARRATIVE

The on-site Prison Rape Elimination Act (PREA) compliance audit of the West Union Residential Facility, West Union, Iowa was conducted May 4, 2016 by the Nakamoto Group, Inc. certified PREA auditor Glynn Maddox. When the auditor arrived at the facility, an "in-briefing" was held with the Executive Officer/PREA Coordinator, the Residential Manager, and the Residential Supervisor, to discuss the audit process and schedule of activities. 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 entire facility was completed. There were no allegations of sexual abuse filed by residents during the rating period of the previous twelve months. There was one case of sexual harassment during the previous 12 months. That case is currently under investigation.

The average length of stay at the minimum security facility is 4.4 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 District Director (Agency Head), the Residential Manager (Facility Director), the Residential Supervisor, the Human Resources Manager, and the Executive Officer/PREA Compliance Coordinator were interviewed concerning their duties and responsibilities related to the PREA. Specialized staff interviewed included an Investigator, an Incident Review Team member, the Retaliation Monitor, two Staff who Perform Screening for Risk of Victimization and Abusiveness, two Intake Staff and five Unit Staff (Residential Officers-randomly selected from the three, eight hour shifts were also interviewed). Staff were able to describe in detail their specific duties and responsibilities, including serving as a "first responder" if an incident occurred or allegation of sexual abuse was made.

The facility capacity is 48 beds. There were 41 residents (38 male residents and 3 female residents) assigned to the facility on the day of the compliance audit. Many of the residents were off-site at work at their jobs. Six randomly selected residents (four male and two female) from the various housing wings of the facility were interviewed by the auditor. In addition there was one openly Gay resident interviewed. There were no Disabled or Limited English Proficient Residents nor were there any Lesbian,Transgender or Intersex Residents assigned to the facility at the time of the compliance audit. All residents stated the facility assisted them in meeting their needs. 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 staff.

The auditor concluded, through interviews and review of policy and documentation, that all staff and residents were very knowledgeable concerning their responsibilities involving PREA.

DESCRIPTION OF FACILITY CHARACTERISTICS

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.

The residential facility located in West Union is a single story facility, having been opened in 1992 after being newly constructed. It is located in the southeast section of the city, and the area surrounding the facility might be termed residential in nature. When the facility opened, the designated capacity was 32 male residents. As of June 2000, the designated capacity had increased to 40 male residents and 8 female residents. Female residents are housed on a separate wing from male residents. The facility population includes offenders who are assigned on state work release status, or as a condition of probation or parole. Federal residents are also housed at the facility through a contract with the U.S. Bureau of Prisons. Staff may monitor the majority of the facility from the one control center by line of sight. There are 15 security cameras with recording capabilities to enhance monitoring of residents. These cameras are also monitored from the control center.

SUMMARY OF AUDIT FINDINGS

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

Number of standards exceeded: 1

Number of standards met: 37

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.

Personnel Policy (PER) 27 pages 1-3 and PER 31 pages 1-7 address this standard. The facility PREA Compliance Coordinator is an Executive Officer who reports directly to the District Director (Agency Head). The Agency's zero tolerance against sexual abuse is clearly established and the policy also outlines the agency's approach to preventing, detecting and responding to sexual abuse and sexual harassment allegations. Zero tolerance posters are displayed throughout the facility. Both facility staff and residents are provided with a variety of opportunities to become aware of the PREA. A review of training records and staff interviews confirmed that staff who have regular or frequent contact with residents, receive PREA related training during new employee training, on e-learning and annually at personal safety training. The PREA Coordinator was interviewed and advised that he has sufficient time and authority to coordinate efforts to comply with PREA standards.

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.

District Residential Services Policy (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. Interviews with the District Director, PREA Coordinator and the Residential Manager, indicated compliance with PREA and other safety and security issues are always a primary focus when they consider and review the 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, resident access to telephones, review of documentation, staff interviews and rosters. Documentation of unannounced rounds by administrative staff that covered all shifts was reviewed. Interviews with staff confirmed unannounced rounds to all areas of the facility on a weekly basis are conducted with no warning to staff. Fifteen video cameras are placed throughout the facility with monitoring capabilities. The camera monitoring system is monitored in the control center. The cameras have recording capabilities and footage is maintained for approximately 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, Case Management Policy (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 to be documented. Staff stated they received cross-gender pat search training during new hire training and annual personal safety training sessions. Residents, residential officers and administrative staff stated residents are allowed to shower, dress and use the toilet privately without being viewed by staff of the opposite gender. Residents and staff stated that staff of the opposite gender announce their presence before entering the housing areas. During the tour of the facility, staff were observed making announcements of their presence when entering housing areas of the opposite gender. Staff were aware of the policy prohibiting the search of Transgender or Intersex residents in order to 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 the facilities efforts to prevent, detect and respond to sexual abuse and sexual harassment. PREA handouts, zero tolerance postings 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 to be used in residents making allegations of sexual abuse or sexual harassment. 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 addresses this standard. The Human Resources Manager was interviewed, and stated that all components of this standard have been met. All employees, contractors and volunteers have had their background checks completed through the National Crime Information Center. Staff promotions require a background check before the 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.

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 a total of 15 security cameras strategically located to cover all common areas of the facility. All have recording capabilities and are monitored at the control center. A window was added to the door to the kitchen and a window was added to two janitorial closets to enhance monitoring during the previous 12 months.

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 to be transported one of two local hospitals for SAFE/SANE exams. The facility has an memorandum of understanding with the two hospitals, Finley Hospital and Mercy Medical Center. There were no sexual abuse allegations in the past twelve months and there for there were 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 and or sexual harassment. Trained administrative staff from the district office conduct administrative investigations and were interviewed and found to be very knowledgeable concerning their responsibilities. There are eight trained investigators who received training from the Moss Group. The West Union Police Department and Iowa Department of Corrections, Division of Investigative Services conducts criminal investigations for the facility. There were no allegations of sexual abuse during the previous 12 months. There was one case of resident on resident sexual harassment during the previous 12 months. That investigation was initiated on 04/02/2016 and the administrative investigation was on-going at the time of the compliance audit. The alleged perpetrator had been removed from the facility.

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 the 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 the PREA. Staff training files and facility training curriculum was reviewed and contained documentation supporting compliance to this standard. All staff interviewed stated 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 two volunteers who have received PREA training that covered zero-tolerance, reporting and responding requirements. All training is documented and the auditor examined training files that confirmed standard compliance. There were no volunteers available for interview on the day of the compliance audit.

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 addresses the requirements of this standard. 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 a 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 the address for the Iowa Ombudsman Office. Interviews with staff and residents, as well as documentation review, support the facility exceeding compliance to 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 West Union Police Department or Iowa Department of Corrections Division of Investigative Services would perform criminal investigations. Eight investigators received PREA specialized investigative training from the Moss Group 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.

Not Applicable-There are no medical or mental health staff on site.

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 on the day of intake. The staff review all relevant information from other facilities and continues to reassess when additional information is received within 30 days of arrival. Staff and resident interviews and a review of documentation confirmed this information.

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.

District Residential Services Policy (DRS) 45 pages 1 and 2 and DRS 46 pages 1 and 2 address compliance to 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 or sexually 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 a review of screening documents confirm compliance of this 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)

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 and 2, CM 32 pages 1 and 2, CM 53F form, grievance policy and the resident handbook in English and Spanish address compliance to this standard. A review of documentation and staff and 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 or sexual harassment. Staff stated they would immediately document all allegations. There are posters and other reporting documents, on display throughout the facility, observed by auditor, that also explain reporting methods. The facility does have a memorandum of understanding with a local victim advocacy center, the Riverview Center, to provide all services relevant to this standard.

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 the grievance policy address this standard. Residents may file a grievance, however, all allegations of sexual abuse or sexual 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 previous 12 months.

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 the resident handbook address this standard. The facility does have a memorandum of understanding with the local advocacy center, the Riverview Center, to provide all services relevant to this standard. The facility provides contact information for the advocacy center.

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, the facility's website with staff telephone numbers, the resident handbook, posters and posted addresses (local advocacy center) address the requirements of this standard. The resident handbook, various information handouts, a PREA packet and facility posters assist third party reporters on how to report allegations. The 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/or sexual harassment and retaliation relevant to PREA standards including any third party reports. This standard of compliance was verified through residential officer and administrative staff interviews and a 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 sexually harassed and they would act immediately to protect the resident. The staff interviewed stated they would separate residents, secure the scene, protect possible evidence, not allow residents to destroy possible evidence and immediately notify a supervisor. During the previous 12 months 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 Residential Manager where the resident is currently being housed to notify the Residential Manager or Facility 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 the District 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 sexual 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 immediately notify a supervisor. The residents would be sent to the local hospital if needed. There were no allegations made by residents during the previous 12 months.

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 and sexual harassment incidents. Staff interviews were consistent with policy.

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 the American Federation of State, County and Municipal Employees, Council 61 AFL-CIO (AFSCME) complies with this standard. Employees are subject to discipline, including removal, if they engage in any sexual abuse or sexual 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 page 1 addresses this standard. The policy prohibits any type of retaliation to any staff person or resident who has reported sexual abuse or sexual harassment or cooperated in any PREA allegation investigation. The Residential Supervisor is designated the Retaliation Monitor. He was interviewed and stated he would conduct checks with a resident on a regular basis for at least 90 days or beyond if needed to ensure the resident is safe from retaliation. 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. The Residential Manager, the Executive Officer and other administrative staff from the District conduct administrative investigations within the facility and refer criminal investigations to the West Union Police Department or Iowa Department of Corrections, Division of Investigation Services, who confer with the county prosecutor to determine if prosecution will be pursued. There were no criminal prosecutions during this audit period. Per the Residential Manager, the facility would cooperate fully with any outside agency in 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. It requires that the resident be informed of the outcome of the investigation. There were no administrative investigations completed 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 the 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 previous 12 months. The Collective Bargaining Agreement between the State of Iowa and the American Federation of State, County and Municipal Employees, Council 61 AFL-CIO (AFSCME) allows for disciplinary sanctions against staff including termination for the sexual abuse and/or sexual harassment of a 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 or sexual harassment by a resident. The Residential Manager stated that contractors or volunteers would be terminated immediately if they engaged in sexual abuse or sexual harassment of a 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 investigated at the West Union Residential Facility during the previous 12 months. There was one case of sexual harassment under investigation at the time of the compliance audit. The alleged perpetrator had been removed from the facility. Policy does not allow consensual sex of any nature. 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. An interview with a facility investigator confirmed 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 memorandum of understanding with Palmer Lutheran Health 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.

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 memorandum of understanding with the Riverview Center and Palmer Lutheran Health 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 and sexual harassment. The Residential Manager, the Executive Officer and other trained administrative staff perform administrative investigations for sexual abuse and sexual harassment. An investigator from the District office was interviewed and found to be very knowledgeable concerning their responsibilities. There are eight trained facility investigators within the District. The West Union Police Department and Iowa Department of Corrections Division of Investigative Services conduct criminal investigations for the facility. There were no allegations of sexual abuse or harassment during the previous 12 months. All investigations ordinarily will be completed within 30 days. The review team consists of the District Director, the Residential Manager and the Executive Officer/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 West Union Residential Facility administration reviews and assesses all sexual abuse and sexual 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 department's 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.

Glynn Maddox — May 28, 2016

Auditor Signature — Date