

# PREA AUDIT: AUDITOR'S SUMMARY REPORT

## COMMUNITY CONFINEMENT FACILITIES

[Following information to be populated automatically from pre-audit questionnaire]		
Name of facility:	Southeast Missouri Behavioral Health – Aquinas Campus	
Physical Address:	5536 Highway 32 Farmington, MO	
Date report submitted:	August 18, 2016	
<b>Auditor Information</b>		
Address:	1319 Vista Campo, Jefferson City, MO 65109	
E-Mail:	Mrush2112@icloud.com	
Telephone number:	573-338-4577	
Date of facility visit:	December 16 <sup>th</sup> -18 <sup>th</sup> , 2015	
<b>Facility Information</b>		
Facility mailing address: (if different from above) P.O. Drawer 459, Farmington, MO 63640		
Telephone number:		
The facility is:		
<input type="checkbox"/> Military	<input type="checkbox"/> County	<input type="checkbox"/> Federal
<input checked="" type="checkbox"/> Private for profit	<input type="checkbox"/> Municipal	<input type="checkbox"/> <b>State</b>
<input type="checkbox"/> Private not for profit		
Facility Type:	Community Confinement	
Name of PREA Compliance Manager:	Matthew Ernst	Title: Program: Director
E-Mail Address:	MErnst@semobh.org	Phone Number: 573-756-5749
<b>Agency Information</b>		
Name of agency: Southeast Missouri Behavioral Health		
Governing authority or parent agency: (if applicable)		
Physical address: 5536 Highway 32, Farmington, MO 63640		
Mailing address: (if different from above) P.O. Drawer 459, Farmington, MO 63640		
Telephone Number:		
<b>Agency Chief Executive Officer</b>		
Name: Jason Gilliam	Title: Chief Executive Officer	
E-Mail Address: <a href="mailto:hgilliam@semobh.org">hgilliam@semobh.org</a>	Telephone Number: 573-756-5749	
<b>Agency-Wide PREA Coordinator</b>		
Name: Matthew Ernst	Title: Director of community Corrections	
E-Mail Address: mernst@semobh.org	Telephone Number: 573-756-5749	

# AUDIT FINDINGS

## NARRATIVE:

Certified PREA Auditor, Vevia Sturm, conducted a PREA compliance audit at Southeast Missouri Behavioral Health's Aquinas Campus (SEMOBH) on December 16th through December 18th, 2015. On November 4<sup>th</sup>, the Notice of Audit was posted throughout the facility. The auditor received no staff or resident correspondence due to this posting.

During the pre-audit phase, the auditor completed an in depth review of the facility's pre audit questionnaire and documentation. Correspondence between the auditor and PREA Coordinator occurred throughout the pre audit phase.

The auditor arrived at the Aquinas Campus on December 16<sup>th</sup> to begin the onsite portion of the audit. An entrance meeting was held with facility administrators. Following the meeting, the auditor was provided a roster of staff and residents to allow for randomized interview selection.

Immediately following the meeting, the auditor toured the facility than began staff and resident interviews. The auditor conducted interviews with 10 random residents and 4 specialized residents, as well as, 6 random staff and 6 specialized staff. SEMOBH does not house youthful residents.

It was evident during the onsite audit that SEMOBH was still in the infancy stages of implementing PREA standards into the policies and practices of the facility. An exit meeting was held on December 18<sup>th</sup> and involved a detailed discussion of the standards that was found to be not in compliance. The auditor worked with the facility to develop corrective action plans for each deficient standard.

## DESCRIPTION OF FACILITY CHARACTERISTICS

SEMOBH Aquinas Campus is a for profit community confinement facility located in Farmington, Missouri. SEMOBH contracts with the Federal Bureau of Prisons (BOP) for the confinement of both male and female residents. The Community Reentry Services (CRS) program provides services to approximately 85 male and female clients residing both onsite and in the community. On the day of the audit there were 63 federal residents living onsite. Offenders referred by BOP are on supervision or they are referred on inmate status. The length of stay in CRS varies, with the majority of residents living onsite approximately 6 months. During the 6-month period, the residents work toward successful transition back to the community.

In addition to the BOP program, the Aquinas Campus houses a Department of Mental Health funded social detoxification drug and alcohol treatment program (DMH SA). The residents in the DMH SA program are community members admitted for substance abuse detoxification and treatment.

There are two housing units on the Aquinas Campus, A Building, referred to as "The Inn", and B Building. The Inn is a 50 bed male housing unit that houses only federal residents and is staffed by male staff.

B Building contains the administrative offices, dining area, and a housing unit consisting of two wings. B Building houses both male and female residents from both CRS and the DMH SA. On the date of the audit, federal offenders occupied only 13 beds in B Building. CRS and DMH SA residents reside in the same wing but dine separately.

While the residents from the two programs reside in B Building and have access to each other, the substance abuse program was not included in this audit since it is funded by the Department of Mental Health and residents are not federal offenders.

#### **SUMMARY OF AUDITO FINDINGS:**

The initial report was forwarded to SEMOBH on January 22, 2016. The report showed 32 standards required corrective action. On July 18, 2016, the auditor received the final documentation needed to demonstrate compliance with the standards.

Number of standards exceeded: 0

Number of standards met: 39

Number of standards not met: 0

Number of standards not applicable: 4

<b>115.211</b>	<b>ZERO TOLERANCE OF SEXUAL ABUSE AND SEXUAL HARASSMENT; PREA COORDINATOR</b>
<input type="checkbox"/> Exceeds Standard (substantially exceeds requirement of standard) <b>XX</b> Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period) <input type="checkbox"/> Does Not Meet Standard (requires corrective action) <input type="checkbox"/> Does Not Apply	
<b>Auditor comments, including corrective actions needed if does not meet standard</b>	
<p>Agency policy #30-006 addresses staff-on-resident sexual abuse but does not address staff-on-resident sexual harassment, or resident-on-resident sexual abuse or sexual harassment. The agency does not have a policy mandating zero tolerance toward <i>all forms</i> of sexual abuse or sexual harassment as defined by Code of Federal Regulation 115.6. In addition, the agency does not have a policy outlining how it will implement the agency's zero-tolerance approach to preventing, detecting, or responding to sexual abuse or sexual harassment. The agency has designated a PREA Coordinator.</p> <p><b>Corrective Action Period:</b></p> <p>During the Corrective Action Period (CAP), the agency developed policy 70-074 Prison Rape Elimination Act (PREA), which mandates zero tolerance toward all forms of sexual abuse and sexual harassment as defined by Code of Federal Regulation 115.6. The policy clearly outlines how the facility has implemented the zero tolerance approach to sexual abuse and sexual harassment into the practices of the facility.</p>	

<b>115.212</b>	<b>CONTRACTING WITH OTHER ENTITIES FOR THE CONFINEMENT OF RESIDENTS</b>
<input type="checkbox"/> Exceeds Standard (substantially exceeds requirement of standard) <input type="checkbox"/> Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period) <input type="checkbox"/> Does Not Meet Standard (requires corrective action) <b>XX</b> Does Not Apply	
<b>Auditor comments, including corrective actions needed if does not meet standard</b>	
<p>The agency does not contract for the confinement of residents.</p>	

<b>115.213</b>	<b>SUPERVISION AND MONITORING</b>
<input type="checkbox"/> Exceeds Standard (substantially exceeds requirement of standard) <b>XX</b> Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period) <input type="checkbox"/> Does Not Meet Standard (requires corrective action) <input type="checkbox"/> Does Not Apply	
<b>Auditor comments, including corrective actions needed if does not meet standard</b>	

SEMOBH provided the auditor with the staffing plan and documentation showing the agency staff plan was reviewed quarterly. SEMOBH's contract with the BOP outlines the minimum mandatory staffing requirements that include at least two positions (one male and one female if the facility is co-ed), 7-day post, 24-hours a day, dedicated only to supervision of federal offenders.

A review of CRS staffing plan shows 1<sup>st</sup> and 2<sup>nd</sup> shift is staffed with 12.6 staff and 3<sup>rd</sup> shift has 9.8 staff. The Inn houses all male offenders and is staffed by male staff. Building B, which houses male and female offenders, has both male and female staff assigned on each shift.

SEMOBH CSR staff is dedicated only to the supervision of federal offenders in the CSR program.

<b>115.214</b>	<b>YOUTHFUL RESIDENTS</b>
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- 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)
- XX** Does Not Apply

**Auditor comments, including corrective actions needed if does not meet standard**

The CRS does not house youthful residents.

<b>115.215</b>	<b>LIMITS TO CROSS GENDER VIEWING AND SEARCHES</b>
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- Exceeds Standard (substantially exceeds requirement of standard)
- XX** Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- Does Not Meet Standard (requires corrective action)
- Does Not Apply

**Auditor comments, including corrective actions needed if does not meet standard**

The CRS does not conduct cross gender pat searches. The facility conducts no body cavity searches. Staff and offender interviews support this. Offenders are allowed to keep bedroom doors closed and all staff knock and announce before entering bedrooms. All bathrooms afford privacy for dressing, toileting and showering. The Inn is a male dorm with male staff; periodically a female staff person will tour the dorm however, at the time of the audit, female staff was not announcing their presence when entering the dorm.

The SEMOBH policies do not address transgender and intersex residents and staff is not trained in how to conduct pat searches of transgender or intersex residents.

**Corrective Action Period:**

Agency policy 70-074 was revised to show, "Staff members of the opposite gender shall announce their presence when entering an offender housing unit (i.e. female staff member entering The Inn).

The BHT [Behavioral Health Technician] will make an announcement over the intercom system "WE HAVE A FEMALE IN THE BUILDING" and document the announcement in the Shift Pass Down Log." The agency also provided a written directive to all staff outlining the agency's expectation regarding cross gender announcements.

To demonstrate compliance, the agency provided logs documenting cross gender announcement are now being made when a female staff member enters The Inn.

Agency policy 70-074 shows "SEMOBH prohibits male staff from pat searching female residents except in exigent circumstances." During the corrective action period the agency revised policy to include, "The agency trains Community Reentry Services and Behavioral Health Technician staff in how to conduct cross-gender pat-down searches and searches of transgender and intersex residents, in a professional and respectful manner, and in the least intrusive manner possible consistent with security needs." SEMOBH provided the auditor with documentation demonstrating staff received training and the appropriate method to pat search transgendered or intersex residents.

115.216

**RESIDENTS WITH DISABILITIES AND RESIDENTS WHO ARE LIMITED ENGLISH PROFICIENT**

Exceeds Standard (substantially exceeds requirement of standard)

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

Does Not Meet Standard (requires corrective action)

Does Not Apply

**Auditor comments, including corrective actions needed if does not meet standard**

The CRS had not established a procedure or practice to provide disabled offenders or offenders that do not speak English equal opportunity to participate in or benefit from all aspects of the agency's effort to prevent, detect and respond to sexual abuse and harassment. Staff was unable to verbalize how they would communicate with a disabled offender or an offender with limited English. Staff was not aware that offender interpreters could not be utilized in the event of an alleged sexual abuse. The facility does not have a contract with an interpreter or a plan to ensure effective communication with residents who are limited English proficient.

During intake, residents were given documents that contain PREA information. Staff did not verbally provide basic PREA information during intake. **Recommendation:** Staff should provide PREA Information verbally and in writing at intake. Train staff to be sensitive to possible disabilities.

**Corrective Action Period:**

SEMOBH revised policy 70-074 to show offenders will not be utilized as interpreters following an allegation of sexual abuse. In addition, the policy shows "The agency takes reasonable steps to ensure meaningful access to all aspects of its efforts to prevent detect, and respond to sexual abuse and sexual harassment to offenders who have limited English proficiency, including providing interpreters who can interpret effectively, accurately and impartially." SEMOBH provided the auditor with a copy of the PREA brochure and poster in Spanish.

In addition, if interpretive services are needed, the agency utilizes Interpretive Language Center in St. Louis, Mo. For Spanish speaking residents, the agency will utilize bilingual staff person.

115.217

**HIRING AND PROMOTION DECISIONS**

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

**Auditor comments, including corrective actions needed if does not meet standard**

The agency and the CRS program utilized Department of Mental Health’s Code of State Regulations when hiring which does not appear meet the standard. At the time of the audit, if an applicant had a history of documented perpetration of sexual abuse the applicant would have had to apply and receive a waiver from DMH before they could be considered for employment. This practice does not meet the criteria outlined in this standard. The standard shows facilities cannot hire or promote anyone with a history of engaging in sexual abuse in an institutional setting [defined by 42 U.S.C. 1997]; convicted of engaging or attempting to engage in the community by force, implied threat of force or coercion or has been civilly or administratively adjudication to have engaged in such behaviors.

In addition, the facility only required applicants to provide the names and addresses of their last 4 employers, not all institutional employers as outlined in this standard. The facility required the applicants to provide a list of references and the facility contacted the references provided. The facility did not contact past institutional employers as required by this standard.

The standard requires agencies to ask applicants and employees who may have contact with residents about previous history of engaging in sexual abuse in an institutional setting; convictions of engaging or attempting to engage in sexual abuse the community by force, implied threat of force or coercion or history of civilly or administratively adjudicated acts of engaging in such activity.

The agency conducts background checks before hire and each year in the employee’s birth month.

***Corrective Action Period:***

SEMOBH revised their PREA policy and practice to comply with requirements of this standard. Agency policy 70-074 shows the agency will not hire or promote anyone with a history of engaging in sexual abuse in an institutional setting [defined by 42 U.S.C. 1997]; convicted of engaging or attempting to engage in the community by force, implied threat of force or coercion or has been civilly or administratively adjudication to have engaged in such behaviors.

SEMOBH developed an interview supplement form to be used during the interview process. The form requires the interviewer to obtain answers to the following questions:

1. Have you previously worked in a prison, jail lockup, community treatment center, juvenile facility, halfway house, restitution center, mental health facility, alcohol or drug rehabilitation center or other corrections institution?
2. Have you been accused of, convicted of, or civilly or administratively adjudicated for engaging or attempting to engage in sexual activity in the community facilitated by force, threats of force, or coercion, or if the victim did not consent or was unable to consent?

The form also requires applicants to list all previous institutional employers. The agency's Human Resources Department contacts all institutional employers and asks questions regarding the applicant's history of sexually abusive behaviors and investigations during employment.

SEMOBH provided documentation showing they are complying with each subset of this standard.

<b>115.218</b>	<b>UPGRADES TO FACILITIES AND TECHNOLOGY</b>
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- Exceeds Standard (substantially exceeds requirement of standard)  
**XX Meets Standard** (substantial compliance; complies in all material ways with the standard for the relevant review period)  
 Does Not Meet Standard (requires corrective action)  
 Does Not Apply

**Auditor comments, including corrective actions needed if does not meet standard**

The agency has not made any substantial modification to the Aquinas Campus since August 20, 2012.

<b>115.221</b>	<b>EVIDENCE PROTOCOL AND FORENSIC MEDICAL EXAMINATIONS</b>
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- Exceeds Standard (substantially exceeds requirement of standard)  
**XX Meets Standard** (substantial compliance; complies in all material ways with the standard for the relevant review period)  
 Does Not Meet Standard (requires corrective action)  
 Does Not Apply

**Auditor comments, including corrective actions needed if does not meet standard**

SEMOBH did not have a policy to support this standard. Staff reported the facility would refer allegations that appear to be criminal in nature to the St. Francois Sheriff's Department however; a facility staff person would conduct administrative investigations, however, staff had not received PREA Specialized Investigator training.

The facility did not have an evidence collection protocol. The facility has not had an incident within the last year that would require a forensic exam, but if needed, staff reported they would transport the victim to the area hospital for the exam. The facility had not attempted to enter into an MOU with the local advocacy center to provide advocacy services to alleged victims of sexual abuse during the forensic exam and the investigative process.

**Corrective Action Period:**

SEMOBH developed an evidence collection protocol, which contains guidelines concerning evidence collection, maintenance and disposal for department staff when collection, receiving and storing evidence for use in investigations.

The agency provided the auditor with a memo from Parkland Health Center confirming the hospital offers all victims of sexual abuse access to forensic medical exams, without financial cost to the victim, where evidentiary or medically appropriate. The memo shows all exams are performed by a SANE or SAFE when possible. If a SAFE or SANE cannot be made available, other qualified medical practitioners would perform the exam.

The agency provided the auditor with a memo from SEMO Family Violence Council that shows the Family Violence Council offers sexual assault advocacy to victims of sexual assault in the counties they serve which includes St. Francois County. The services include supporting the victim during the medical examination and follow up which would include crisis intervention and emotional support.

SEMOBH provided the auditor with a letter from the Sheriff showing the sheriff's department will investigate sexual abuse allegation at SEMOBH as outlined in the PREA standards.

<b>115.222</b>	<b>POLICIES TO ENSURE REFERRALS OF ALLEGATIONS FOR INVESTIGATIONS</b>
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- 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)
- Does Not Apply

**Auditor comments, including corrective actions needed if does not meet standard**

The agency did not have a policy to support this standard. In the last 12 months the facility has investigated one allegation of sexual abuse. This standard requires that the agency/facility have a policy that mandates that allegations of sexual abuse and sexual harassment be referred for investigation to an agency with the legal authority to conduct criminal investigation, unless the allegation does not involve potential criminal behavior. The policy must describe the responsibilities of both the agency and the investigative entity.

***Corrective Action Period:***

Since the onsite audit, SEMOBH's has revised policy 70-074 to support this standard. The policy shows "Allegations that appear to be criminal in nature will be referred to the St. Francois County Sheriff's Department for investigation. All administrative investigations will be conducted by an agency staff member who has received PREA Specialized Investigator Training."

During the CAP, the agency received one Staff Sexually Misconduct allegation that was investigated by a staff person who had completed PREA Specialized Investigations Training. The allegation was unfounded.

115.231	EMPLOYEE TRAINING
<input type="checkbox"/> Exceeds Standard (substantially exceeds requirement of standard) <b>XX</b> Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period) <input type="checkbox"/> Does Not Meet Standard (requires corrective action) <input type="checkbox"/> Does Not Apply	
<b>Auditor comments, including corrective actions needed if does not meet standard</b>	
<p>The Aquinas Campus has two separate programs, the federal reentry program, which this report addresses, and a substance abuse program that is unrelated to the federal reentry program. Residents from both programs are housed in “B Building” therefore staff assigned to both programs work in the building and have access to all residents.</p> <p>While onsite the auditor randomly selected 5 training records to determine if staff assigned to the federal reentry program had received training. Of the 5 training records reviewed, 3 had not received any type of PREA training.</p> <p>In addition, the standard requires the agency to document, through employee signature or electronic verification that staff understood the training they received.</p> <p><b>Corrective Action Period:</b></p> <p>During the CAP, all staff who may have contact with federal residents completed training including the staff assigned to the DMH SA program. SEMOBH provided training records to demonstrate the training was completed.</p>	

115.232	VOLUNTEER AND CONTRACTOR TRAINING
<input type="checkbox"/> Exceeds Standard (substantially exceeds requirement of standard) <b>XX</b> Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period) <input type="checkbox"/> Does Not Meet Standard (requires corrective action) <input type="checkbox"/> Does Not Apply	
<b>Auditor comments, including corrective actions needed if does not meet standard</b>	
<p>SEMOBH did not have a policy that supported this standard. At the time of the audit, the facility had contracted vendors and one volunteer AA facilitator that entered the facility unescorted. Neither the unescorted vendors nor facilitator received PREA information prior to entering the facility.</p> <p><b>Corrective Action Period:</b></p> <p>During the CAP, the CRS developed a Visitor / Vendor Acknowledgement Form. The form outlines confidentiality for the clients at SEMOBH and the agency’s Zero Tolerance policy on issues pertaining to sexual abuse and sexual harassment. In addition, the form provides visitors and</p>	

vendors with avenues to report sexual abuse or sexual harassment. The agency now requires all visitors and vendors who enter the facility to read and sign the form each year. The forms are kept in a binder in the clerical station under the direction of the Assistant Director.

**115.233**

**RESIDENT EDUCATION**

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

**Auditor comments, including corrective actions needed if does not meet standard**

At the time of the audit, offenders were given, the “Sexually Abusive Behavior Prevention and Intervention” handout from the Federal Bureau of Prisons. The handout appears to have been developed for use within a federal prison. Staff reported they do not provide the residents with verbal information regarding the agency’s zero tolerance policy, their right to be free from sexual abuse or harassment or how to report upon intake. The facility had PREA posters in English posted in the housing units. The facility did not have PREA educational materials available in formats accessible to all resident such as limited English proficient, deaf, visually impaired or residents with limited reading skills. The facility shows the PREA video, “What you need to Know”, during orientation.

***Corrective Action Period:***

During the CAP, SEMOBH revised their PREA brochure to fit their agency. The brochure now reflects the agency’s Zero Tolerance stance for all forms of sexual abuse and harassment as well as, how to report and who will investigate allegations of sexual abuse or harassment.

During orientation, which is within 3 days of intake, residents are given the PREA brochure, which is reviewed with them verbally. Should a resident require interpretive services, the agency will utilize Interpretive Language Center. Following the orientation, residents sign an acknowledgement showing they received a copy of the Prison Rape Elimination Notice.

**115.234**

**SPECIALIZED TRAINING: INVESTIGATIONS**

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

**Auditor comments, including corrective actions needed if does not meet standard**

Staff reported that the agency would refer all sexual abuse and harassment allegations that appear to be criminal to the local Sheriff’s Department; however, a facility staff person would conduct administrative investigations. This standard requires that agency staff that conduct sexual abuse investigations receive specialized PREA investigator training that includes techniques for

interviewing sexual abuse victims, proper use of the Garrity warning, sexual abuse evidence collection in confinement settings and the criteria and evidence required to substantiate a case for administrative action. The agency does not have a staff person trained to conduct sexual abuse investigations.

**Corrective Action Period:**

Since the onsite audit, several federal reentry staff has completed the Relias PREA: Investigation Protocols training. Case Managers, the Social Services Coordinator and the Community Reentry Services Director were trained to conduct administrative sexual abuse investigations. The agency provided the auditor with documentation to demonstrate staff received the training.

Policy has been revised to show "...the agency shall ensure that, administrative investigations are conducted by SEMOBH staff who have received PREA Specialized Investigator Training." "The agency maintains documentation that agency investigators have completed the required specialized training in conducting sexual abuse investigations."

**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)
- XX** Does Not Apply

**Auditor comments, including corrective actions needed if does not meet standard**

The agency does not employ medical or mental health staff.

**115.241 SCREENING FOR RISK OF VICTIMIZATION AND ABUSIVENESS**

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

**Auditor comments, including corrective actions needed if does not meet standard**

The agency provided a copy of their assessment. The assessment considered all the criteria listed in 115.241 (d) however; the assessment was a list of questions. The questions were not scored and did not require a date. Staff interviewed reported they would hand the assessment to the resident to be completed. Staff stated that approximately 30 days later, they go over the assessment again with the resident but the review was not documented.

During the onsite audit, the auditor reviewed 10 randomly selected resident files. Of the 10 reviewed, 8 had an undated assessment in the file, 2 did not. Since the initial assessments were

not dated, the auditor was unable to ascertain if the assessments were completed in the timeframe required by the standard. In addition, the auditor could not locate documentation confirming that a follow-up review was conducted within 30 days as required by this standard.

**Corrective Action Period:**

Since the onsite audit, the agency has revised PREA policy 70-074 to show CRS residents will be assessed within 72 hours of arrival at the facility using an objective screening instrument called the Sexual Violence Assessment Tool. The Sexual Violence Assessment Tool which was implemented during the CAP covers all the criteria required by this standard.

In addition to the 72-hour assessment, the agency's PREA policy shows residents are reassessed within 30 days of intake. The agency provided the auditor with documentation demonstrating the Sexual Violence Assessment Tool had been implemented within the agency as required by this standard as well as documentation showing staff received training on how to utilize and score the assessment.

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)
- Does Not Apply

**Auditor comments, including corrective actions needed if does not meet standard**

Staff reported that if there were an indication that a resident may be at risk of victimization, the resident would be housed in B Building that she believed to be a more secure area due to the presence of staff and the layout of the unit.

As noted previously in this report, the CRS residents and DMH SA residents reside in B Building. The residents from both programs have access to each other. At the time of the audit, the agency was only assessing the federal reentry residents to determine their risk level. The agency was not attempting to determine if the substance abuse residents had a propensity for perpetration that could place their most vulnerable CRS residents at risk of victimization. Staff reported that while they attempt to keep federal CRS residents and the DMH SA residents in separate rooms, at times there is a need to room them together.

The agency did not have a policy that addressed transgender and intersex residents. The standard requires the agency to make individualized housing assignments for transgender and intersex residents and that the resident's own views with respect to their safety be considered.

**Corrective Action Period:**

Since the audit, the agency began using the Sexual Violence Assessment Tool to inform housing, bed, work education and programming assignment with the goal of keeping separate those residents at high risk of being sexually abusive from those at high risk of victimization.

While the agency makes every effort to keep federal reentry resident and DMH SA residents in separate living areas if there is a need to place in the same room, the agency makes individualized determinations about how to ensure the safety of each resident.

To assist in assessing DMH SA clients the agency added additional questions to the Mental Health Screening form regarding history of past confinement, history of victimization and abusiveness. An affirmative answer to the questions regarding victimization or abusiveness requires the Director of Community Reentry Services to be notified.

Agency policy 10-036 Initial Assessment Interpretive Summary shows, "At the Aquinas location, Prison Rape Elimination Act Screening questions will be asked and the Director of Community Reentry Services will be notified of any client with an affirmative answer."

In addition, policy 70-074 has been revised to show how the facility will work with transgender and intersex residents, which includes giving consideration to the transgendered resident's own views of safety.

**115.251**

**RESIDENT REPORTING**

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

**Auditor comments, including corrective actions needed if does not meet standard**

At the time of the audit, the facility had a PREA brochure that informed the residents they could report sexual abuse or harassment to a staff member, probation /parole agent or the facility's PREA Coordinator. The brochure showed residents could report verbally, in writing, anonymously or by third party. The brochure did not inform the residents how someone could make a third party report. The agency provided a poster that informed the residents that they could report allegations of sexual abuse to the Southeast Missouri Behavioral Health, Risk Management Department. While this reporting avenue is outside of the facility, it is not outside the agency therefore, it is not considered an outside entity as required by this standard.

***Corrective Action Period:***

The facility's PREA posters now include the St. Francois Co. Sheriff's Department Crime Tip Hotline (573) 431-7314 Ext. 101 as the outside reporting entity for residents which is displayed throughout the facility. The Sheriff Department has agreed to immediately forward allegations of sexual abuse or harassment back to the facility. The agency's PREA policy 0-074 was revised to show the facility would accept report of sexual abuse or harassment made verbally, in writing, anonymously and third party reports. Family and friends can also report allegations to the St. Francois County Sheriff's Department.

**115.252**

**EXHAUSTION OF ADMINISTRATIVE REMEDIES**

- Exceeds Standard (substantially exceeds requirement of standard)

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

Does Not Meet Standard (requires corrective action)

Does Not Apply

**Auditor comments, including corrective actions needed if does not meet standard**

The agency had a policy for addressing resident grievances, policy 30-004 Client Rights and Grievance Procedures. The policy did not contain the specific timelines outlined in this standard in regards to grievances containing allegations of sexual abuse.

As required by this standard, the agency's procedure did not indicate a timeline associated with submitting a grievance. The policy indicated that residents would receive a response to a grievance within 48 hours; however, if the resident was displeased with the response, the policy contained no other timeframes for resolution. The policy did not include a procedure for filing an emergency grievance.

***Corrective Action Period:***

Since the audit, the agency has revised policy 70-074 Prison Rape Elimination Act (PREA) to support this standard. During the CAP, the agency received on grievance that was investigated and the resident received a response within the required time period.

**115.253**

**RESIDENT ACCESS TO OUTSIDE CONFIDENTIAL SUPPORT SERVICES**

Exceeds Standard (substantially exceeds requirement of standard)

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

Does Not Meet Standard (requires corrective action)

Does Not Apply

**Auditor comments, including corrective actions needed if does not meet standard**

At the time of the audit, the facility had not attempted to enter into an MOU with the local advocacy agency. Residents were not provided with access to outside victim advocates for emotional support services related to sexual abuse. The facility must attempt to enter into a MOU with the local advocacy agency, if the agency is unable to do so, the facility should provide the resident population the address and toll free phone numbers to national advocacy agencies.

***Corrective Action Period:***

The agency provided a memorandum from Southeast Missouri Family Violence Council that shows they offer Sexual Assault Advocacy as one of their many services. The memo confirms that they will provide advocacy to victims within their catchment area, which includes SEMOBH. SEMO Family Violence Council provides support to the victim through the medical examination and ongoing crisis intervention and emotional support services.

115.254

THIRD-PARY REPORTING

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

**Auditor comments, including corrective actions needed if does not meet standard**

The agency or facility has not established a method to receive third-party reports of sexual abuse and sexual harassment as required by this standard. In addition, this standard requires the agency to publicly distribute information on how to report resident sexual abuse or sexual harassment on behalf of a resident.

**Corrective Action Period:**

The agency included their third party report avenue in their FY 2016 annual report, which shows, "The agency provides multiple internal ways for offenders and third party reporters to privately report sexual abuse and sexual harassment, retaliation by other offenders or staff for reporting sexual abuse or sexual harassment, and staff neglect which may have contributed to such incidents. All allegations of sexual abuse or sexual harassment may be reported verbally, in writing, anonymously, or by third party through the agency's Administration Department as well as the St. Francois Co. Sheriff's Department Crime Tip Hotline (573) 431-7314 Ext. 101. Staff shall accept reports made verbally, in writing, anonymously, or by third parties and shall document all reports."

The agency has received no third party report during the CAP.

RECOMMENDATION: Agency should ensure third party reporting avenues are readily available to family and friends by having the number easily accessible on the website and/or posted in the lobby of the facility.

115.261

STAFF AND AGENCY REPORTING DUTIES

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

**Auditor comments, including corrective actions needed if does not meet standard**

Staff interviewed reported policy mandates that they report all suspicion, knowledge or information regarding sexual abuse or harassment. In addition, they were aware that any such information would be considered confidential and should only be revealed if there is a need to know.

115.262	AGENCY PROTECTION DUTIES
<input type="checkbox"/> Exceeds Standard (substantially exceeds requirement of standard) <b>XX Meets Standard</b> (substantial compliance; complies in all material ways with the standard for the relevant review period) <input type="checkbox"/> Does Not Meet Standard (requires corrective action) <input type="checkbox"/> Does Not Apply	
<b>Auditor comments, including corrective actions needed if does not meet standard</b>	
<p>Staff interviewed reported they would take immediate action should they learn a resident was at imminent risk of victimization. In the last 12 months, the facility has not had a resident that was subject to substantial risk or imminent sexual abuse.</p>	

115.263	REPORTING TO OTHER CONFINEMENT FACILITIES
<input type="checkbox"/> Exceeds Standard (substantially exceeds requirement of standard) <b>XX Meets Standard</b> (substantial compliance; complies in all material ways with the standard for the relevant review period) <input type="checkbox"/> Does Not Meet Standard (requires corrective action) <input type="checkbox"/> Does Not Apply	
<b>Auditor comments, including corrective actions needed if does not meet standard</b>	
<p>The agency did not have a policy outlining the action the facility would take should they receive information that one of their residents had been sexual abused while incarcerated at another facility. In addition, the agency/facility did not have a policy outlining actions should they receive a report from another facility that a past resident was sexual abuse while housed on the Aquinas Campus.</p> <p><b>Corrective Action Period:</b></p> <p>During the CAP the agency revised PREA policy 70-074 to show, “(1) Upon the agency receiving an allegation that an offender was sexually abused while confined at another facility, the Director of Community Reentry Services Shall notify the head of the facility where the alleged abuse occurred. (2) Such notification shall be provided as soon as possible, nut no later than 72 hours after receiving the allegation. (3) The agency documents such notification. (4) Upon the agency receiving an allegation that a former offender was sexually abused while at the Aquinas facility, the Director of CRS shall immediately initiate an investigation.”</p> <p>The agency received no such reports during the CAP.</p>	

115.264	STAFF FIRST RESPONDER DUTIES
<input type="checkbox"/> Exceeds Standard (substantially exceeds requirement of standard) <b>XX</b> Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period) <input type="checkbox"/> Does Not Meet Standard (requires corrective action) <input type="checkbox"/> Does Not Apply	
<b>Auditor comments, including corrective actions needed if does not meet standard</b>	
<p>Staff's knowledge of the duties of a first responder varied. All staff that <i>may</i> have contact with residents should know their first responder duties.</p> <p><b>Corrective Action Period:</b></p> <p>The agency provided documentation demonstrating all staff, including staff assigned to DMH SA program, has received training regarding their duties as a first responder.</p> <p>The training covered the following:</p> <p>When a Community Reentry Services or Behavioral Health Technician first responder learns that an offender has been sexually abused, they shall take immediate action to protect the offender, which shall include:</p> <ul style="list-style-type: none"> <li>• Separating the offender from the alleged perpetrator;</li> <li>• Preserving and protecting any crime scene until appropriate steps can be taken to collect evidence;</li> <li>• If abuse occurred within a time period that still allows for the collection of physical evidence, requesting that the alleged victim, and ensuring the alleged perpetrator, not take any actions that could destroy physical evidence including washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating;</li> <li>• Instructing that SEMOBH will contact Parkland Hospital to provide medical assistance for the victim and Horizon of Hope will provide mental health assistance for the victim.</li> </ul>	

115.265	COORDINATED RESPONSE
<input type="checkbox"/> Exceeds Standard (substantially exceeds requirement of standard) <b>XX</b> Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period) <input type="checkbox"/> Does Not Meet Standard (requires corrective action) <input type="checkbox"/> Does Not Apply	
<b>Auditor comments, including corrective actions needed if does not meet standard</b>	
<p>The agency did not have a written coordinated response as required by this standard. This standard requires that the facility have a written coordinated response that shows action taken by the first responder, investigator, agency leadership, medical and mental health services. The coordinated</p>	

response should be utilized when responding to allegations of sexual abuse. In addition, the facility's response to allegations of sexual abuse should be documented and maintained.

**Corrective Action Period:**

The agency revised policy 70-074 to include a facility specific coordinated response plan. The plan outlines the responsibilities for the Behavioral Health Technician, House Supervisor and Director of the Community Reentry Services program and includes obtaining medical and mental health services as appropriate. In addition, the agency provided documentation demonstrating staff had received training regarding their role following an allegation of sexual abuse.

During the CAP, the agency received one allegation of staff sexual misconduct. The agency provided the auditor with the documentation demonstrating the coordinated response plan was utilized.

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)
- XX** Does Not Apply

**Auditor comments, including corrective actions needed if does not meet standard**

This standard does not apply. The agency does not have a collective bargaining agreement.

115.267

**AGENCY PROTECTION AGAINST RETALIATION**

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

**Auditor comments, including corrective actions needed if does not meet standard**

The agency had not implemented retaliation monitoring at the time of the onsite audit. This standard requires that victims be monitored for retaliation following an allegation of sexual abuse or sexual harassment, for at least 90 days, which includes periodic status checks. In addition, staff that report suspected sexual abuse must also be monitored for retaliation. The facility should review this standard for additional detail.

**Corrective Action Period:**

During the CAP, the agency revised policy 70-074 to support this standard, which shows the agency protects all offenders and staff who report sexual abuse or sexual harassment or cooperate with

sexual abuse or sexual harassment investigations from retaliation by other offenders or staff. Multiple protective measures such as housing changes or transfers for offender victims or abusers, removal of alleged staff or offender abusers from contact with victims, and emotional support services for offenders or staff who, fear retaliation for reporting sexual abuse or sexual harassment or for cooperating with investigations have been employed by the agency.

For a minimum of 90 days following a report of sexual abuse, the a CRS staff will monitor the conduct and treatment of offenders or staff who reported sexual abuse; as well as, the offenders who were reported to have suffered sexual abuse for signs of retaliation by offenders or staff. If retaliation is noted, staff will act promptly to remedy any such retaliation. Monitoring can extend beyond 90 days should the initial monitoring indicate an on-going need at which time monitoring shall include:

- Periodic in-person conversations with offenders and/or staff;
- Review of disciplinary incidents involving offenders;
- Review of housing or program changes;
- Review of negative performance reviews or reassignments of staff.

Monitoring will be documented in the client's electronic health record as well as the staff member's personnel file.

The agency's obligation to monitor terminates should the agency determine that the allegation is unfounded.

When a staff member reports the harassment, the agency will monitor for retaliation for at least 90 days following the report. The monitoring will be documented in the staff member's personnel file.

**115.271**

**CRIMINAL AND 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)

Does Not Apply

**Auditor comments, including corrective actions needed if does not meet standard**

The agency/facility did not have a policy or protocol addressing criminal or administrative PREA investigations as outlined in this standard. This standard details how investigations should be conducted and mandates that all investigations be documented in a written report that includes a description of the physical and testimonial evidence, the reasoning behind credibility assessment and the investigative facts and findings. In addition, this standard requires the written report be retained for as long as the alleged abuser housed or employed by the agency plus five years.

**Corrective Action Period:**

The agency revised policy 70-074 to support this standard. The policy shows that when the agency conducts its own investigations into allegations of sexual abuse and sexual harassment, it will do so promptly, thoroughly, and objectively, including third party and anonymous reports.

When sexual abuse is alleged, a PREA Specialized Investigator trained staff member will conduct an administrative investigation. Allegations of sexual abuse that appears to be criminal will be referred to and investigated by the St. Francois Co. Sheriff's Department.

All evidence will be gathered and preserved by investigators including any physical evidence as well as any electronic monitoring data. Investigators will also conduct an interview with the alleged victim(s), suspected perpetrator(s), witnesses and review prior complaints and reports of sexual abuse involving the suspected perpetrator. DNA evidence will be collected by the St. Francois County Sheriff's Department.

Administrative investigations will include an effort to determine if staff actions or failure to act contributed to the abuse, are documented in written reports that include description of physical and testimonial evidence, reasoning behind credibility assessments, and investigative facts and findings. The agency shall impose no standard higher than a preponderance of evidence to determine whether allegations of sexual abuse or sexual harassment are substantiated in administrative investigations.

The departure of an alleged perpetrator or victim from the employment or control of the facility or agency shall not provide a basis for terminating an investigation.

When other agencies investigate sexual abuse, the agency will cooperate with outside investigators and shall endeavor to remain informed regarding the progress of the investigation.

The agency will retain all written reports required by this section for as long as the alleged perpetrator is incarcerated or employed by the agency, plus five years.

During the CAP, the agency conducted one staff sexual misconduct investigation that was unfounded.

**115.272**

**EVIDENTIARY STANDARDS 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)

Does Not Apply

**Auditor comments, including corrective actions needed if does not meet standard**

At the time of the audit, the facility did not have anyone who was trained to conduct sexual abuse investigation therefore no one has been trained on the standard of proof needed to substantiated an administrative investigation. As per this standard, agencies must impose no standard higher than preponderance of evidence in determining if the investigation is substantiated.

**Corrective Action Period:**

The agency revised policy 70-074 to support this standard. Selected agency staff has received Specialized PREA Investigator Training. The auditor was provided documentation to demonstrate the staff completed the training.

**115.273**

**REPORTING TO RESIDENTS**

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

**Auditor comments, including corrective actions needed if does not meet standard**

The agency/facility had not implemented this standard at the time of the audit. The standard requires that residents that make an allegation of sexual abuse that occurred at the facility be informed of the findings following the conclusion of the investigation. The standard contains additional details regarding reporting to residents. It is recommended the facility refer to the standard for additional details.

**Corrective Action Period:**

The agency revised policy 70-074 to support this standard. The policy shows it is the responsibility of the Director of Community Reentry Services to inform the offender of the findings of the investigation and all follow up notifications as required by this standard until the resident is no longer housed at SEMOBH. As noted previously, the agency has investigated one allegation during the CAP. The agency provided a memo from the former CRS Director showing the resident was informed verbally of the findings of the investigation.

RECOMMENDATION: Agency should ensure all notifications are documented as required by agency policy.

**115.276**

**DISCIPLINARY SANCTIONS FOR STAFF**

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

**Auditor comments, including corrective actions needed if does not meet standard**

Staff interviews, policy and record review showed staff is subject to disciplinary sanctions up to and including termination for violating the agency's policies on abuse. In the past 12 months, the facility has not had any staff disciplined or terminated due to violating the agency's policies on abuse.

During the CAP, the agency added components of this standard were added to agency's PREA policy.

**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)
- Does Not Apply

**Auditor comments, including corrective actions needed if does not meet standard**

The facility has had no allegations of sexual abuse or harassment by a contractor or vender. Staff interviewed reported that should that occur, the vendor/contractor would be removed from the premises. The facility has an AA facilitator and service contractors that enter the facility and have unescorted access to residents.

It was recommended that the facility develop policy addressing corrective action for contractors and vendors as outlined in the 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)
- Does Not Apply

**Auditor comments, including corrective actions needed if does not meet standard**

CRS residents are on inmate status or supervision. Staff reported that a perpetrator would be removed from the facility immediately and they would not be involved in the disciplinary process. It was recommended the facility add language to a policy addressing actions taken with a perpetrator.

**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)
- Does Not Apply

**Auditor comments, including corrective actions needed if does not meet standard**

The facility does not employ medical or mental health staff. Should medical services be indicated, the resident would be transported to the area hospital. The Federal Bureau of Prisons' contracted mental health provider would provide mental health services. All emergency services are provided at no cost to the victim as outlined in the facility's contract with the Federal Bureau of Prisons.

It was recommended that policy outline how the facility will ensure victim have access to emergency medical and mental health care as well as addressing access to contraception and prophylaxis.

115.283

**ONGOING MEDICAL AND MENTAL HEALTH CARE FOR SEXUAL ABUSE VICTIMS AND ABUSERS**

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

**Auditor comments, including corrective actions needed if does not meet standard**

This standard requires facilities to offered medical and mental health evaluation and treatment to all residents who report previous sexual victimization that occurred in any prison, jail, lockup or juvenile facility. This includes reports made during the PREA Risk Assessment when residents are asked about previous sexual abuse.

Staff is trained by the Director of Community Reentry Services to document any disclosures of sexual abuse or victimization in the offender's electronic health record and to offer mental health services through approved providers. If services are requested, the CRS case manager will make the referral and document in the offender's electronic health record.

If an offender reports a history of sexual abuse or perpetration that occurred in a prison, jail, lockup or juvenile facility the CRS staff notify the Director of Community Reentry Services and the offenders respective US Parole Officer to alert them to the offender's situation. The US Parole Officer will then forward to the local mental health provider a request for mental health services who, will then schedule an appointment and notify the case manager. The case manager will document the notification to the US Parole Officer as well as the notification of mental health services in the offender's electronic file.

Additional training on documentation and the referral process occurred for staff during PREA training offered during the CAP.

115.286

**SEXUAL ABUSE INCIDENT REVIEWS**

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

**Auditor comments, including corrective actions needed if does not meet standard**

The agency did not have a policy that supported this standard. The agency had not implemented this standard at the time of the audit. The facility did not have a practice of conducting incident reviews of substantiated and unsubstantiated investigations of sexual abuse that addresses the components required by this standard. The standard requires that a review be conducted within 30 days of the completion of the investigation by a team that includes upper level management with input from line supervisor and the investigator. It was recommended that the facility review the standard for additional details regarding the components that must be reviewed and documented.

***Corrective Action Period:***

Following the onsite audit, agency PREA policy 70-074 was revised to include language to support the elements of this standard. The policy shows incident reviews will be conducted within 30 days from the completion of the investigation by a review team that includes the following: CEO, other Executive Staff, Director of Community Corrections CRS Director, Director of Operations, Director Farmington Area and Staff involved in the investigation. The agency investigated one allegation of staff sexual misconduct during the CAP however; the investigation was unfounded and did not require a Sexual Abuse Incident Review.

**115.287**

**DATA COLLECTION**

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

**Auditor comments, including corrective actions needed if does not meet standard**

The agency had not implemented this standard at the time of the audit. The facility did not have a plan in place to collect data as outlined in this standard.

***Corrective Action Period:***

The agency revised PREA policy 70-074 to include language to support this standard. The policy shows the Performance Improvement Department aggregates the incident-based sexual abuse data annually. The data collection will include at minimum the data necessary to answer all the questions from the most recent survey of sexual violence. The Director of Community Corrections sent a memo stating the PREA committee has reviewed and may utilize the SSV-IA: Survey of Sexual Violence: Incident Form to collect the necessary data.

**115.288**

**DATA REVIEW FOR CORRECTIVE ACTION**

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

Does Not Meet Standard (requires corrective action)

Does Not Apply

**Auditor comments, including corrective actions needed if does not meet standard**

The agency had not implemented this standard at the time of the audit and did not have a plan in place to review the data collected for corrective measures. The facility had not prepared an annual report as required by this standard or posted an annual report on the agency's website.

***Corrective Action Period:***

The agency prepared the annual PREA report for FY 2016 and posted the report on the agency's website. The report can be found at <http://semobh.org/Reports/CRSAnnualReportFY16.pdf>

115.289

**DATA STORAGE, PUBLICATION, AND DESTRUCTION**

Exceeds Standard (substantially exceeds requirement of standard)

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

Does Not Meet Standard (requires corrective action)

Does Not Apply

**Auditor comments, including corrective actions needed if does not meet standard**

As noted above, the agency had not posted an annual report to its website and did not have a retention schedule that complied with this standard. This standard requires that sexual abuse data collected be retained for at least 10 years after the date of the initial collection.

***Corrective Action Period:***

The agency's annual PEA report for FY2016 is posted on the agency's website and can be accessed at <http://semobh.org/Reports/CRSAnnualReportFY16.pdf>. In addition, the agency updated policy 70-074 to include the retention schedule of at least 10 years after date of the initial collection of the aggregated sexual abuse data as required by this standard.

**AUDITOR CERTIFICATION:**

The auditor certifies that the contents of the report are accurate to the best of his/her knowledge and no conflict of interest exists with respect to his or her ability to conduct an audit of agency under review.

Veria Sturm

August 18, 2016

**Certified PREA Audit**

**Date**