PREA AUDIT REPORT ☐ Interim ☒ Final
COMMUNITY CONFINEMENT FACILITIES

Date of report: 9/9/16

Auditor Information			
Auditor name: Bridgette M. Collins			
Address: 8933 Caminito Rd, Indianapolis, In 46234			
Email: confinementsafety@gmail.com			
Telephone number: 3176790879			
Date of facility visit: August 11,2016			
Facility Information			
Facility name: Bartholomew County Community Corrections			
Facility physical address: 540 1st Street, Columbus, In 47201			
Facility mailing address: *(if different from above)* same			
Facility telephone number: 812 565 5906			
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: Bradford Barnes			
Number of staff assigned to the facility in the last 12 months: 30			
Designed facility capacity: 82			
Current population of facility: 43			
Facility security levels/inmate custody levels: Minimum			
Age range of the population: 18+			
Name of PREA Compliance Manager: Rob Gaskill	**Title:** Director of Residential Services		
Email address: rgaskill@bartholomew.in.gov	**Telephone number:** 812 565 5906		
Agency Information			
Name of agency: Bartholomew County Community Corrections			
Governing authority or parent agency: *(if applicable)* Bartholomew County Court Services			
Physical address: 540 1st Street, Columbus, In 47201			
Mailing address: *(if different from above)* Click here to enter text.			
Telephone number: 812 565 5906			
Agency Chief Executive Officer			
Name: Bradford Barnes	**Title:** Director of Court Services		
Email address: bbarnes@bartholomew.in.gov	**Telephone number:** 812 565 5906		
Agency-Wide PREA Coordinator			
Name: Rob Gaskill	**Title:** Director of Residential Services		
Email address: rgaskill@bartholomew.in.gov	**Telephone number:** 812 565 5906		

AUDIT FINDINGS

NARRATIVE

The Statement of Purpose for Bartholomew County Court Services is " We are committed to making the community safer by reducing the risk of repetitive criminal behavior."

At least 2 weeks prior to the on-site audit, flyers are hung throughout the facility in common areas as well as public access areas with contact information for the Auditor in the event staff, residents or community members want to send anonymous materials through the mail. As of the date of this report, no contact was made with the Auditor from staff, residents or community members regarding the PREA audit.

The Bartholomew County Community Corrections Center is an 82 bed (48 male and 34 female) residential work release facility, located in Columbus, Indiana. It is has been in practice since September of 2009. Currently four separate programs are operated through the work release facility. There are 24 male beds and 10 female beds for local county work release, 24 male beds for the Indiana Department of Correction and 24 female beds for Women Recovering with a Purpose (WRAP) treatment Program.

The WRAP program began in March 2011. It is a female substance abuse program with 6 months residential followed by 6 months intensive supervision with continuing care.

Work Release was originally housed in the Bartholomew County Jail until 2003 when it was suspended due to jail overcrowding. In 2009, work release was again offered as as sentencing option through the residential center.

On August 11, 2016, an on-site audit was conducted on Bartholomew County Community Corrections Residential Facility. The total population on the day of the audit was 40 (6 male IDOC work release, 24 male local work release, 7 female residential and 3 female local work release). There are currently 30 staff employed including both custody and treatment positions for the operation of the facility 24 hours per day/7 days per week.

Interviews were conducted on 8 residents (5 male and 3 female). The selection of residents was based on availability and attempting to randomize based on sentencing authority, ages, race, level of charges, and length of time in the facility. Some of them had previous incarceration at a different correctional facility prior to their arrival to Bartholomew County Community Corrections. Because the interviews are not mandatory, the Auditor sought permission to speak with each individual before moving forward with information gathering. All agreed to speak to the Auditor with no reservations. There was both a male and female resident who openly identified as being a part of the Lesbian, Bi-sexual, Gay, Trangender, and Intersex (LBGTI) Community.

The residents all stated that PREA education took place within the first 30 minutes to 24 hours after arrival. They felt that staff had provided multiple ways to report sexual abuse and sexual harassment but if they forgot, flyers were available to them as reminders. There was no concern that if they made an allegation, that it wouldn't be taken seriously and investigated. They each felt that the PREA Coordinator would absolutely do the policy requirements without question. The residents rights to be free from sexual abuse, harassment and retaliation after reporting was clearly communicated. Each of them stated without hesitation that they felt safe within the institution.

The two residents who identified as being a part of the LBGTI Community felt that they were not singled out or treated differently due to this difference. They are housed in general population and feel that they are afforded the same opportunities as those who don't identify differently.

Facility specific staff were also interviewed including the Facility Head, who is also the PREA Coordinator, Residential Supervisor (1), Residential Officers (3), WRAP Coordinator (1), Community Corrections Supervisor (1), Community Transition Program (CTP) Coordinator (1), and Contract staff (1). The results of the interviews confirmed that the staff feel they are employed in a safe working environment and that the agencies zero-tolerance policy would be followed in the event of a PREA sexual assault.

All staff were able to provide feedback on the frequency and curriculum of the PREA training that they receive annually and in staff meetings. They were able to communicate multiple ways that reports of allegations could be made for both staff and residents as well as what the consequences were up to and including prosecution. There was a clear and concise understanding of the chain of command and how information was to be relayed on a need to know basis. Staff confirmed that they felt safe in their working environment and believe that the PREA Coordinator would do as expected following an event.

On August 12, 2016, employee, contractor and volunteer files were reviewed. All files were well organized and presented in a uniform fashion. PREA documentation was easily accessible and specific to the employee with dated signatures.

DESCRIPTION OF FACILITY CHARACTERISTICS

Bartholomew County Community Corrections is located as a separate wing of the Bartholomew County Jail with its own exit/entrance. Because both agencies are housed together, there is a sharing of resources in the maintenance of the physical plant. There are 4 housing pods equally distributed by gender. Each pod has its on shower/toilet facilities. There is laundry facilities that are shared amongst the residents with use being scheduled per pod. There are designated, gender specific smoking areas. The control area of the facility is manned 24 hours/day with rotating schedules for staff. There is a front reception area that monitors movement in and out of the facility. There are 9 administrative offices.

If residents have a valid driver's license and proof of insurance they are allowed to drive. Public transportation and bikes is also an acceptable mode of transit.

Jail trays are available for meals as well as vending.

SUMMARY OF AUDIT FINDINGS

Bartholomew County Community Corrections was well prepared for the audit. All pre-audit information was received by the Auditor in a timely manner. The PREA Coordinator was in constant contact and provided well organized documentation that was easily reviewed for compliance.

The facility and its grounds were clean and well maintained. Based on interviews with staff and residents, there is a level of respect present for upper level management and an overall feeling of safety.

There were a few minor details that required updates but were completed within the 30 day post-audit period. Most suggestions made were in place prior to the Auditor leaving the facility for the day.

Bartholomew County Community Corrections has met the standards for the PREA audit. There is no need to start the 180 day corrective action period.

Number of standards exceeded: 0

Number of standards met: 34

Number of standards not met: 0

Number of standards not applicable: 5

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.

Bartholomew County Community Corrections has a PREA policy that specifically states that there is zero tolerance towards all forms of sexual abuse and sexual harassment. It outlines the agency's approach to preventing, detecting and responding to such conduct. Included in the policy are definitions of prohibited sexual abuse and sexual harassment behaviors and sanctions for those found to be in violation. There is also a description of agency strategies and responses to reduce and prevent sexual abuse and sexual harassment of residents.

The Director of Residential Services serves as the PREA Coordinator for Bartholomew County Community Corrections Center. Interviews with the PREA Coordinator suggests that there is sufficient time and authority to develop, implement and oversee the agency effors to comply with PREA standards within the work release.

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)

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Bartholomew County Community Corrections does not contract with other facilities for the confinement of residents. Therefore this standard is non-applicable.

Standard 115.213 Supervision and monitoring

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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It is the expectation that a staffing plan be developed and reviewed at least annually to ensure adequate levels of staffing and video monitoring, where applicable, to protect residents against sexual abuse. This is the responsibility of the Director of Residential Services. If at any point, there is a deviation from the staffing plan, it is expected that facility documentation and justification be provided in writing.

A copy of the current staffing plan along with the annual review were provided. Community Correction Advisory Board Meeting Minutes were also provided wherein discussion about the application for additional grant monies were on the agenda to maintain adequate staffing levels.

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)

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The PREA policy states that no cross-gender strip searches or cross-gender visual body cavity searches of residents shall take place except in exigent circumstances or when performed by medical practitioners. Cross-gender pat-down searches of female residents are not allowed and staff will use a wand if no female staff is available.

Residents are able to shower, perform bodily functions, and change clothing without being seen in a state of undress by staff, including viewing on video cameras. The Facility handbook states that residents are not to leave the restroom area in a state of undress or be subjected to disciplinary action. Signs are posted at the restroom entrances/exits as a reminder of the expectation.

Any time an opposite sex staff enters a resident housing unit, they announce themselves. It is recorded in writing in the control log the first time of the shift, but is expected to be done each time the area is re-entered.

The policy states that never shall a search be conducted on a transgender or intersex resident for the sole purpose of determining the residents genital status.

Interviews with both staff and residents support that this policy is being adhered to. Residents stated that they had never been denied access to regularly available programming or other outside opportunities due to the absence of a female staff.

Documentation provided support that all current staff have received training on conducting cross-gender pat down searches and searches of transgender and intersex residents in a professional and respectful manner, consistent with security needs.

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.

Residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agencies efforts to prevent, detect, and respond to sexual abuse and sexual harassment. This includes access to resources to address those who may be visually or hearing impaired, have intellectual disabilities, limited reading skills, or be in need or an interpreter. The expectation is that the agency shall not rely on resident interpreters, resident readers or other types of resident assistance except in limited circumstances wherein a delay could compromise the residents safety, the performance of first-response duties or the investigation of the residents allegations.

The protocols in place include working with the sentencing court to recommend placement on another Community Corrections Component, such as electronic monitoring or day reporting instead of work release if reasonable accomodations cannot be made.

Facility materials have been translated into Spanish and are readily accessible if needed. A copy of the materials were provided for review.

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.

Agency policy requires that all new employees, volunteers or contractors must have a criminal background record check conducted prior to having contact with residents and then be rechecked at least every 5 years. The prohibition of hiring or promoting anyone who has engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility, or other institution is written in the policy. Civil, criminal or admistrative adjudications are also prohibited by policy for hiring and promoting of staff. Material omissions regarding misconduct, or the provision of materially false information shall be ground for termination.

Staff are aware of the expectations and know that the policy is being followed. The PREA Coordinator was able to provide Human Resource files with dated documentation of criminal background checks being conducted at hire and every 5 years thereafter or in the event of a promotion for all current employees and volunteers. There were no contractors are the time of the audit.

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)

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There have been no upgrades to facilities or technology since August 20, 2012. However, in the event of a needed expansion or upgrade, the ability to protect participants from sexual misconduct or sexual abuse will be considered.

This standard is non-applicable.

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.

Bartholomew County Community Corrections is not responsible for conducting administrative or criminal sexual abuse investigations. Bartholomew County Sheriff or Columbus Police Department would conduct investigations of allegations of sexual abuse. There are detectives trained in sexual assault crimes employed to conduct the investigations.

Any resident who has experienced sexual abuse shall be given access to a Sexual Assault Nurse Examiner (SANE) or a Sexual Assault Forsenic Examiner (SAFE). Columbus Regional Health would provide forsensic examinations following a PREA event.

A victim advocate from a rape crisis center either in person or by other means shall be made available to the victim as well. Bartholomew County Community Corrections would contact Turning Point Crisis Hotline for these services. While they mostly address domestic violence, they have the ability to make referrals to partnering agencies to address sexual assault concerns. There are case managers on duty to aid in the process.

Contact information for outside agencies can be found on flyers hung throughout the facility as well as the PREA policy. This information is also included in the residents handbook.

Standard 115.222 Policies to ensure referrals of allegations for investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The PREA policy requires that allegations of sexual abuse or sexual harassment be referred for investigation to an agency with the legal authority to conduct criminal investigations, unless the allegation doesn't involve potentially criminal behavior. Bartholomew County Sheriff or Columbus Police Department have such authorities to do so.

This information would be made accessible to the public through the agencies website. Per the PREA Coordinator, all allegations of sexual abuse or sexual harassment will be referred to lew enforcement for a thorough investigation.

This information is disseminated at hire and throughout employment to all employees. Staff interviews support that they have been made aware and trust that any allegations reported will be investigated and prosecuted to the fullest extent of the law.

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.

The PREA Policy provides training upon hire and at each monthly Residential All-Staff meeting. The training consists of understanding that the facility has zero tolerance for sexual harassment and sexual abuse. Responsiblities as first responders, as well as the right to be free from abuse and harassment for staff and residents are discussed. They dynamics of abuse, common reactions of victims, detection and response to signes and how to avoid inappropriate relationships are a part of the curriculum. Also effective and professional communication with those of the Lesbian, Gay, Bi-sexual, Transgender, Intersex or Gender Non-conforming community (LBGTI) is included in the training. The curriculum also includes how to comply with relevant laws regarding mandatory reporting to outside authorities.

Training is tailored to the gender of the resident within the facility. All staff are current with training as evidenced by dated and signed documentation provided in the Human Resources files. Also interviews with correctional staff confirmed that training is regular and reoccurring.

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.

All volunteers and contractors who have contact with residents have been trained on their responsibilities under the agency's policies and procedures. Files on current volunteers and contractors provided signed and dated proof of training and expectations regarding PREA.

An interview with a Centerstone contract employee confirmed that training was provided and is a fundamental requirement for her responsibilities when working with the population. She was able to explain her role in the event of being the first responder to a PREA event, the chain of command and what should happen following the aftermath.

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.

Multiple residents were interviewed, all of whom admitted to receiving information regarding the zero-tolerance policy, reporting, their rights including freedom from retaliation and the agency's expected response within 24 hrs of arrival. All residents sign a document stating that they have been made aware of the PREA policy and its expectations. This is a part of the intake process that is completed upon arrival to the facility for both genders. There are flyers hung throughout the facility with information on different ways to report abuse if victimized. Information can also be found in participaints manuals and other written formats.

Bartholomew County Court Services is able to provide PREA education to those with limited English proficiency, deaf, visually impaired, otherwise disabled or limited in their reading skills.

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)

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All investigations are conducted by either the Columbus Police Department, Bartholomew County Sheriff's Department or the Indiana State Police. Bartholomew County Court Services will not conduct internal investigations for PREA related incidents. Law Enforcement training is provided by the specific agency in which they are employed.

Therefore this standard is non-applicable.

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)

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Bartholomew County Court Services doesn't employ medical or mental health care staff. Services of this nature are fulfilled by outside agencies in the community.

This standard is non-applicable.

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.

Within 72 hours of arrival, all residents are assessed using an objective PREA risk instrument. The screen is to seek the probability of risk for sexual abuse victimization or sexual abusiveness towards other residents. Policy requires that a reassessment be completed on all residents within 30 days following arrival based on any additional, relevant information received since intake. Policy also states that a resident is not to be disciplined for refusing to answer questions based on disability, being a part of the LBGTI community, previous victimization or the residents own perception of vulnerability.

This has been the practice of the facility per the PREA Coordinator as well as staff and resident interviews. It was suggested that protocol be put in place not only to complete the 30 day reassessment but have the resident sign and date that their safety was re-confirmed.

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)

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The information provided by the PREA risk screen is used when making decisions about housing, work, program assignment and education. The goal is to keep residents at high risk of being sexually victimized away from those at high risk of being sexually abusive. Individualized determinations are made on how to ensure the safety of each resident. Housing and programming assignments for transgender or intersex residents are made on a case-by-case basis.

Interviews with staff provided feedback on the ability to place residents on electronic monitoring if the work release is not the best environment for a resident. There are specific housing and bed assignments used for those at risk however it is not discriminatory or used as a way to isolate those of likened risk.

Standard 115.251 Resident reporting

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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It is the understanding that every effort will be made to prevent sexual assault and misconduct from occurring; every allegation witll be investigated; every perpetrator punished; and every victim offered services, per the PREA policy. Residents can report victimization privately, anonymously or publicly. Reports can be made verbally, in writing, through grievance procedures, via telephone or direct contact with Law Enforcement. Reporting can also be done by third party through any of these means. Staff are expected to respond to all reports of abuse immediately without delay.

Residents are also protected from retaliation following a PREA event. The PREA Coordinator expressed that retaliation monitoring would occur for the duration of the residents sentence or staffs employment, depending on whom was being monitored.

Residents were able to express ways to report abuse if they were the victim or witnessed someone else being victimized. Staff were able to express how reports could be made and what their response to allegations should be. They were also able to express that action was to be taken immediately upon notification.

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)

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Residents may utilize the grievance process to report allegations of sexual abuse and sexual harassment, however it is not the only means to make a report. There are no time limits as to when the submission of the grievance must occur. Residents are not required to submit the grievance to a staff member who may be the subject of the complaint. Residents may file emergency grievances alleging that they are subject to a substantial risk of imminent sexual abuse. These filings require an initial response within 48 hours.

Within 90 days of the grievance being filed, the agency shall provide a decision on the merit regarding the alleged sexual abuse. An extension of up to 70 additional days may be claimed if the normal time period for a resonse is insufficient to make an approcpiate decision. However, notification in writing of the extension must be provided to the resident along with an anticipated conclusion date.

Agency policy allows for third parties, including fellow residents, staff members, family members, attorneys and outside advocates to assist a resident in filing a request for administrative remedies relating to allegations of sexual abuse and to file such requests on behalf of the resident. If a resident declines to have third-party assistance in filing a grievance, the agency shall provide documentation of such. Policy limits its ability to discipline a resident for filing a grievance alleging sexual abuse to occasions where the agency demonstrates that the resident filed the grievance in bad faith.

There have been no grievances filed regarding sexual abuse in the past year, emergent or otherwise.

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)

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Reasonable communication between a resident and victim advocate services are provided in as confidential a manner as possible per policy. The Director of Residential Services provides referrals to victims through Turning Point Crisis Center. Services are provided at no cost to the victim. If a resident should decide to use the services of a different agency, it will be honored.

Residents are made aware of mandatory reporting rules governing privacy, confidentiality, and/or privilege that apply to disclosure of sexual abuse made to outside victim advocates. If a resident choses to have a victim advocacy agency involved, they are required to sign a release of information so that any information pertinent to a criminal investigation could be communicated.

There is no Memorandum of Understanding in place between Bartholomew County Court Services and Turning Point Crisis Center althought it was attempted. The reason is because Turning Point provides services to anyone in the community at no cost and a referral is not needed as there is no contract in place.

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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Third-Party reports of sexual abuse or sexual harassment can be received verbally, in writing, anonymously, via telephone or direct report to Law Enforcement. Information on ways to report can be found in common areas throughout the facility as well as the agency website.

Interviews of staff and residents supported that third-party reporting was an option and how it could be communicated to launch an investigation.

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.

Agency policy prohibits staff from revealing any information related to a sexual abuse report to anyone other than to the extent necessary to

make treatment, investigation, and other security and management decisions. All staff are required to report immediately any knowledge, suspicion, or information they receive regarding an incident of sexual abuse or sexual harassment that occurred withint the facility, whether or not it is part of the agency. Incidents of retaliation and staff negligence or violation of responsibilities are also expected to be reported immediately.

Interviews of line staff confirmed that they understood the expectations, knew who to contact and trusted that any reports would be acted upon without question.

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.

Policy states that upon notification of the substantial risk of imminent sexual abuse for a resident, immediate action to protect shall be implemented without unreasonable delay.

There have been no reports of substantial risk of imminent sexual abuse for residents within the last year.

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.

Agency policy states that upon receiving an allegation of previous sexual abuse on a resident while confined at another facility, the head of the facility must notify the head of the other agency as soon as possible but no later than 72 hours after receiving the allegation. Documentation of the notification must be kept on file. Likewise, if the facility head is notified by another facility head of allegations that were said to have occurred within the facility prior to the transferal of a resident, an investigation is to commence immediately.

There have been no reports of allegations from this facility or previous facilities within the last year. The Director of Residential Services was able to convey the required action regarding reporting to other confinement facilities.

Standard 115.264 Staff first responder duties

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the

relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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

The first responder policy for allegations of sexual abuse provides step by step instructions on what is to be done upon being made aware of a sexual abuse allegation. Staff have been trained to separate alleged victim and abuser, preserve and protect the crime scene, collect any physical evidence, refrain from allowing the victim and/or perpetrator from taking any actions that could destroy evidence and immediately notify the PREA Coordinator and Law Enforcement.

Security, contract and case management staff were able to convey their duties as a first responder during interviews. There have been no reports of allegations of sexual abuse within the last year.

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.

Protocols have been established on the step by step expectations following a report of sexual abuse. Once all facility level first responder duties have been completed, the victim will be transported either by staff or ambulance depending on the nature and extent of physical injury to Columbus Regional Health. This will initiate a Sexual Assault Nurse Exam (SANE) for the purpose of Forensic Evidence Collection. Victim Advocate services will be provided at no cost through Turning Point Crisis Center. Bartholomew County Prosecutors Office would be contacted to intitiate an investigation to the alleged sexual assault/abuse. Investigations would be conducted by law enforcement. The Director of Residential Services is expected to provide any information from the point of notification of alleged abuse until prosecution in any capacity necessary.

If the perpetrator is staff, contractor or volunteer, they will be placed on administrative leave or banned from entrance to the facility pending the results of the investigation. If the allegation is substantiated and involves staff, contractor or volunteer, the resident shall be made aware of the outcome of the investigation including employment and volunteer status.

If the perpetrator is another resident, a court petition to revoke placement will be completed. The victim shall be notified of an criminal charges being filed against the peer.

If the allegation is determined to be unsubstantiated or unfounded, notification will be made to the victim by the Director of Residential Services. If appropriate, removal from the program may occur due to making false allegations.

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.

There have been no new or renewed collective bargaining agreements or other agreements since August 20, 2012.

Therefore this standard is non-applicable.

Standard 115.267 Agency protection against retaliation

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The Director of Community Corrections is responsible for monitoring retaliation following the report of sexual abuse or sexual harassment for both staff and residents. This process is completed for the remainder of their incarceration period for a resident.

Housing changes, removal of abusers (staff or resident), emotional support services and transfers are some of the protection measures in place to avoid retaliation. Periodic status checks are also utilized.

There have been no PREA allegations or retaliation concerns in the past year.

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.

There is a policy in place that provides specific instructions on how to handle both criminal and administrative investigations. Any substantiated allegations of conduct that appear criminal are referred for prosecution. All written reports pertaining to criminal and administrative investigations of alleged sexual abuse or harassment are retained for as long as the alleged abuser is incarcerated or employed by the agency plus five years.

There have been no administrative or criminal investigations within the last year.

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.

PREA Policy states that the agency shall impose no standard higher than the 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.

It is required by policy that any resident who makes an allegation of sexual abuse while in the facility will be informed either verbally or in writing as to the outcome of either substantiated, unsubstantiated or unfounded following an investigation. If the investigation is conducted by an outside agency, Bartholomew County Court Services will request relevant information for the purpose of informing the resident.

The agency will inform the resident of any substantiated or unsubstantiated allegations of abuse by a staff member unless it is unfounded. They will provide information as to the employees post, employment status, indictment and conviction.

If the resident is abused by a fellow resident, they are to be informed once an indictment or conviction has been made.

The PREA Coordinator communicated his responsibilities of reporting to residents following an investigation of abuse by either staff or resident. Policy states that it shall be documented. There have been no sexual abuse or sexual harassment allegations within the last year involving staff or residents.

The agency's obligation to report under this standard shall terminate if the resident is released from custody.

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.

Disciplinary sanctions up to an including termination are the expectation for staff who violate agency policy concerning sexual abuse or sexual harassment. All termination for violations of PREA or resignations by staff who would have been terminated if not for their resignations, are reported to law enforcement agencies (unless the activity was clearly not criminal) and any relevant licensing.

There have been no staff in violation of or terminated due to PREA policy within the last year. There have been no staff disciplined, short of termination, for violation of agency sexual abuse or sexual harassment policy. No staff have been reported to law enforcement or licensing boards following their termination for violating agency PREA policy within the last year.

The PREA Coordinator expressed his commitment to follow the disciplinary sanctions for any staff in violation of PREA policy.

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.

Agency policy requires that any contractor or volunteer who engages in sexual abuse be reported to law enforcement (unless the activity was clearly not criminal) and to relevant licensing bodies. Contractors or volunteers who engage in sexual abuse will be prohibited from contact with residents.

In the event that the sexual abuse or harassment was not criminal in nature, the facility takes appropriate remedial measures to consider further prohibition from residents by contractors and volunteers.

There have been no violations of PREA policy by contractors or volunteers in the last year, criminal or otherwise.

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.

Residents are subject to disciplinary sanctions only pursuant to a formal disciplinary process following an administarative finding that a resident engaged in resident-on-resident sexual abuse. A criminal finding of guilt for resident-on-resident sexual abuse is cause for

subjectivity to disciplinary sanctions.

There has been neither administrative or criminal findings of guilt concerning resident-on-resident sexual abuse in the last year.

Therapy, counseling or other interventions designed to address and correct the underlying reasons or motivations for abuse will be offered to residents. If these services are offered, the facility shall consider whether to require the offending resident to participate in such interventions as a condition of access to programming or other benefits.

Residents who participate in sexual conduct with staff without consent are disciplined. There is no consensual sexual relationships between staff and or residents. All sexual activity is prohibited, and disciplinary action is taken only if it is determined that the activity is coerced.

Bartholomew County Court Services prohibits disciplinary action for a report of sexual abuse made in good faith based upon a reasonable belief that the alleged conduct occurred, even if an investigation does not establish evidence sufficient to substantiate the allegation.

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.

Policy states that resident victims of sexual abuse receive timely, unimpeded access to emergency medical treatment and crisis intervention services. The nature and scope of such services are determined by medical and mental health practitioners according to their professional judgement. These services are provided by outside agencies who are governed by other organizational jurisdictions. They are expected to follow the guidelines as required for licensing.

Resident victims of sexual abuse while incarcerated are offered timely information about and timely access to emergency contraception and sexually transmitted infections prophylaxis in accordance with professionally accepted standards of case, where medically appropriate. Treatment services are provided to every victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident.

Turning Point and Columbus Regional Health were both contacted regarding their standards of care and expectations regarding this standard. Both agreed that services are provided free of charge to the victim.

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.

Medical and Mental Health evaluations as well as other forms of treatment are offered where appropriate to all residents who have been victimized sexually while in any prison, jail, lockup or juvenile facility. They are offered sexually transmitted infection testing as deemed medically appropriate.

Female victims of sexual abuse involving vaginal penetration while incarcerated are offered pregnancy tests. If a pregnancy results from the abuse while incarcerated, the victim receives timely and comprehensive information about and access to all lawful pregnancy-related medical services.

Within 60 days of learning of abuse history for all known resident-on-resident abusers, the facility attempts to conduct a mental health evaluation and offeres treatment where deemed appropriate by mental health practitioners.

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.

Policy requires that a sexual abuse incident review is conducted at the conclusion of every criminal or administrative sexual abuse investigation, unless the allegations has been determined to be unfounded. These reviews are to take place within 30 days of the conclusion of the administrative or criminal investigation. The review team includes upper-level management officials with input from line supervisors, investigators and medical or mental health practitioners. Recommendations for improvement are either implemented or documented as to the reason for not doing so.

There have been no criminal or administrative investigations of alleged sexual abuse within the facility within the last year. There have been no criminal or administrative investigations that were followed by a sexual abuse incident review within 30 days following the incident within the last year.

Interviews with the PREA Coordinator and specialized staff as well as line supervisors confirmed their expectations to participate in a sexual abuse incident review team upon conclusion of the investigation. Line staff reported feeling that their input would be taken into consideration in the event of a sexual abuse investigation despite not being supervisory staff.

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.

There is a standardized instrument used to collect accurate, uniform data for every allegation of sexual abuse for all facilities under its direct control including a set of definitions. At a minimum, the instrument includes data necessary to answer all questions from the most recent

version of the Survey of Sexual Violence (SSV) conducted by the Department of Justice. This information is aggregated at least annually and is posted on the website. All available incident-based documents, including reports, investigation files and sexual abuse incident reviews are maintained, reviewed and collected for data.

There is no contract in place for the confinement of its residents, therefore this portion of the standard is non-applicable.

Provision of such data can be provided to the Department of Justice (DOJ) from the previous calendar year no later than the following June 30th. This information has not been requested by DOJ.

Standard 115.288 Data review for corrective action

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The review and aggregation of data collected is used to access and improve the effectiveness of its sexual abuse prevention, detection, response policy and training. It helps to identify problem areas, taking corrective action on an ongoing basis and prepare an annual report of its findings for each facility and the agency as a whole.

This report provides an assessment of the agency's progress in addressing sexual abuse. The annual report includes a comparison of the current years data and corrective actions with those from prior years. The report can be found on the agency website after approval from the agency head. If any information is redacted, it is limited to specific material where publication would present a clear and specific threat to the safety and security of the facility. The agency would indicate the nature of the material redacted.

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.

Bartholomew County ensures that incident-based and aggregate data are securely retained for at least 10 years after the date of initial collection, unless federal, state or local law requires otherwise. This information is readily available to the public annually through its website. Prior to posting, all personal identifiers are removed.

AUDITOR CERTIFICATION

I certify that:

☒ The contents of this report are accurate to the best of my knowledge.

☒ No conflict of interest exists with respect to my ability to conduct an audit of the agency under review, and

☒ I have not included in the final report any personally identifiable information (PII) about any inmate or staff member, except where the names of administrative personnel are specifically requested in the report template.

Bridgette M. Collins 9/9/16

Auditor Signature Date