**PREA AUDIT REPORT ☐ INTERIM ■ FINAL**

**COMMUNITY CONFINEMENT FACILITIES**


| | | | |
|---|---|---|---|
| **Auditor Information** | | | |
| **Auditor name:** Candy Snyder | | | |
| **Address:** PO Box 405, Custer SD 57730 | | | |
| **Email:** snyder@gwtc.net | | | |
| **Telephone number:** (605) 517-1747 | | | |
| **Date of facility visit:** December 15 to December 17, 2014 | | | |
| **Facility Information** | | | |
| **Facility name:** Lake Region Residential Reentry Center | | | |
| **Facility physical address:** 225 West Walnut Street, Devils Lake, ND 58301 | | | |
| **Facility mailing address:** *(if different from above)* | | | |
| **Facility telephone number:** (701) 662-0735 | | | |
| **The facility is:** | ☐ Federal | ☐ State | ■ County |
| | ☐ Military | ☐ Municipal | ☐ Private for profit |
| | ☐ Private not for profit | | |
| **Facility type:** | ☐ Community treatment center<br>■ Halfway house<br>☐ Alcohol or drug rehabilitation center | ☐ Community-based confinement facility<br>☐ Mental health facility | ☐ Other |
| **Name of facility's Chief Executive Officer:** Rob Johnson | | | |
| **Number of staff assigned to the facility in the last 12 months:** 7 | | | |
| **Designed facility capacity:** 28 | | | |
| **Current population of facility:** 23 | | | |
| **Facility security levels/inmate custody levels:** Minimum Security/Minimum Custody Level | | | |
| **Age range of the population:** 18 and above | | | |
| **Name of PREA Compliance Manager:** Rob Johnson | | **Title:** | Operations Mg. |
| **Email address:** rgj@lrlec.org | | **Telephone number:** | (701) 662-0735 |
| **Agency Information** | | | |
| **Name of agency:** Lake Region Law Enforcement Center | | | |
| **Governing authority or parent agency:** *(if applicable)* | | | |
| **Physical address:** 222 West Walnut Street, Devils Lake ND 58301 | | | |
| **Mailing address:** *(if different from above)* | | | |
| **Telephone number:** (701) 662-0700 | | | |
| **Agency Chief Executive Officer** | | | |
| **Name:** Tom Rime | | **Title:** | Director |
| **Email address:** tpr@lrlec.org | | **Telephone number:** | (701) 662-0700 |
| **Agency-Wide PREA Coordinator** | | | |
| **Name:** Cole Schwab | | **Title:** | PREA Coordinator |
| **Email address:** cms@lrlec.org | | **Telephone number:** | (701) 662-0700 |

## AUDIT FINDINGS

### NARRATIVE

The Lake Region Residential Reentry Center (RRC) is a 28-bed facility that houses up to 20 men and 8 women. The center provides assistance to offenders transitioning back to the community. The RRC provides a safe, structured, supervised environment, as well as employment counseling, job placement and other programs and services. The PREA Audit took place on December 15th through December 17th, 2014. The audit was performed by the auditor, Candy Snyder, and an auditing assistant, Mark Snyder. At the time of the audit the population was 23 residents – 17 males and 6 females. The facility maintains an active contractual agreement with the federal Bureau of Prisons and is also inspected by them on a continuous basis. The RRC is one of the several programs that operate jointly under the shared resources of the Lake Region Law Enforcement Center (LRLEC).

Prior to arrival at the Lake Region RRC the auditor reviewed pertinent policies, procedures, and related documentation used to demonstrate compliance with PREA standards. The on-site portion of the audit began with an entrance briefing with the purpose of organizing the audit schedule. The meeting was attended by the following staff: Steve Nelson, Interim Operations Administrator; Rob Johnson, RRC Operations Manager; Kurt Weaver, PREA Coordinator; and Captain Duane Armstrong, Jail Administrator for the Lake Region Correctional Center. The Operations Manager provided the auditor with a list of staff and a list of residents. The group toured the facility. During the tour the auditor informally questioned staff to gain better understanding of the facilities standard operating procedures. The auditor then began the interview portion of the audit. The audit team interviewed four staff directly from the RRC and several staff from the Lake Region Law Enforcement Center. The staff composition included the Operations Manager, the Case Manager, two direct care staff, one volunteer, the Agency Head, the PREA Coordinator, the facility investigator, a law enforcement investigator and the nurse. Five residents were selected randomly from a roster with specific characteristics in mind to include both housing areas and varying lengths of stay. There were no residents who identified as lesbian, gay or bisexual; no residents that identified as transgender or intersex; there were no residents who needed translation services or other disability related services; and there were no residents who had been involved in a facility investigation. There were no residents who requested to speak with the auditor. Finally, the auditor completed a review of all pertinent policies, records, and documents. The Lake Region Law Enforcement Center's PREA policy mirrors the written language of the Prison Rape Elimination Act standards. At the time of the on-site portion of the audit the policy was still in draft form and many of the standards were not considered compliant until the policy was approved by the Board of Directors with an effective date of February 18, 2015. At the conclusion of the on-site portion of the audit an exit interview was held with Steve Nelson, Interim Operations Administrator, Rob Johnson, RRC Operations Manager, Kurt Weaver, PREA Coordinator, James Sayler, Program Administrator from North Dakota Department of Corrections and Rehabilitation and Captain Duane Armstrong of the Lake Region Law Enforcement Center Jail.

## DESCRIPTION OF FACILITY CHARACTERISTICS

The RRC has two housing units – one for females and one for males. The units are divided by a common area in the middle that consists of an entry point manned by a direct care staff member, a staff office for the Operations Manager and Case Manager, a lounge, dining room and kitchen.

The RRC allows residents to transition slowly in their return and release back to the community giving them the opportunity to reunite with family and relatives, develop living arrangements, secure or train for employment, participate in community-based treatment, community service activities at the Boys Ranch and develop resources for the many needs that come from returning home after a long period of absence.

## SUMMARY OF AUDIT FINDINGS

Although the policy was in draft form at the time of the on-site portion of the audit, it was apparent the staff had already implemented practices consistent with the PREA standards for the protection of residents. All interviews and observations by the auditor indicated that most practices follow the procedures outlined in their PREA policy. Residents felt very comfortable reporting information to staff. Staff were well trained in how to handle all incidents swiftly, appropriately and with confidentiality.

All residents reported that they feel safe at RRC. All residents reported at least two methods of reporting. The RRC had posters placed throughout the facility. The residents stated they had a handbook provided upon intake to refer to throughout their stay. Residents are allowed to use their cell phones during certain times and residents were familiar with how to contact either the advocacy center or family members for assistance. However, they stated they would also feel comfortable reporting to staff.

All staff were familiar with how to perform their responsibilities in prevention, detecting and responding to incidents of sexual abuse and sexual harassment. Staff were able to relay to the auditor signs to watch for in residents who may have experienced sexual abuse or harassment. The Operations Manager is assigned to monitoring for retaliation and was able to relay to the auditor the duties necessary to detect and monitor for retaliation. The nurse was knowledgeable in her role, had received specialized training and more importantly, was very concerned about the well-being of each resident.

The interviews of residents reflected all were aware of PREA, had received written material and acknowledged their familiarity with how they could report allegations of sexual abuse and sexual harassment. Staff (including specialized staff, and one volunteer) interviewed indicated they were knowledgeable about PREA and of their responsibilities related to reporting requirements as well as their awareness of the proper procedures to follow if they were the first responders to any PREA related allegation.

The auditor reviewed documentation to include background checks, applications, signed staff training records, and resident records acknowledge receipt of PREA training. The RRC had no reported sexual assaults and sexual harassment incidents and therefore no PREA investigations. However, the facility is operated jointly under the same practices as the LRLEC and those investigative reports were reviewed. The investigative reports indicated a good investigative process.

Through the pre-audit and on-site audit processes, the audtior determined that several standards were not met. A corrective action plan for compliance was developed and agreed upon. Over the next three months the facility worked in conjuction with the auditor on their corrective action plan.The Operations Manager, Rob Johnson, was instrumental in implementing the corrective actions that resulted in bringing the Lake Region Residentail Reentry Center into full compliance with PREA standards. Details of corrective actions are written under each applicable standard within this report.

Number of standards exceeded: 1

Number of standards met: 37

Number of standards not met: 0

Number of standards not applicable: 1

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

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

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

At the time of the audit the PREA policy was in draft form. The policy states the facility's zero-tolerance for sexual abuse and sexual harassment. The policy outlines the facility's efforts in preventing, detecting and responding to sexual abuse and harassment. The policy includes all necessary and related defined terms. In addition, it was evident through the interviews and the tour that RRC has a culture of zero tolerance. In order to become compliant the auditor required the RRC to provide the auditor with the signed PREA policy with an effective date.The signed policy was provided to the auditor with an effective date of February 18, 2015.

The original LRLEC PREA Coordinator was committed to implementing PREA standards into the facilities. Unfortunately, the PREA Coordinator resigned on January 2, 2015, shortly after the on-site portion of the audit. The RRC Operations Manager temporarily assumed the additional duties as the acting PREA Coordinator. On February 2, 2015 a new PREA Coordinator assumed duty at the LRLEC. This Coordinator has turned in his resignation effective March 25, 2015. A new PREA Coordinator has been selected and is transitioning into the LRLEC. The auditor continued to monitor throughout the corrective action period to ensure that the acting PREA Coordinator and then the newly assigned PREA Coordinator had sufficient time to oversee the agency's efforts. Although the parent organization of the LRLEC has been in a state of flux, the auditor directly observed the professionalism, strong PREA knowledge, and the firm committment of the RRC Operations Manager. With assistance from the RRC Operations Manaager, the auditor is confident that the RRC will continue to maintain all items in place while the newly assigned PREA Coordinator gets up to speed.

**Standard 115.212 Contracting with other entities for the confinement of residents**

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

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

This standard is not applicable, as the RRC does not contract with other facilities for the confinement of its residents.

**Standard 115.213 Supervision and monitoring**

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

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

There was no Annual Staffing Plan at the time of the audit. However, in March 2015 the facility completed a staffing plan. Currently the RRC has an Operations Manager and a Case Manager that are on duty during the normal business hours. There are four direct care staff employed by the RRC. There is always one direct care staff on duty 24 hours each day. In addition there is a part time staff that conducts random site visits to the places employing residents throughout the Devils Lake community.

The facility implemented unannounced rounds even though they were not required by the standards for Community Confinement Centers, exceeding the standard. Documentation of the rounds were provided to the auditor.

**Standard 115.215 Limits to cross-gender viewing and searches**

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

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

RRC prohibits male staff from conducting cross gender searches of female residents. If a female staff is not available to conduct a pat search of a female resident then a search is not conducted. All interviews with both residents and staff confirmed this practice. The facility has not had transgender or intersex residents but their policy prohibits examination for the sole purpose of determining gender. Staff through training were knowledgeable in the prohibition of an examination for this propose. Staff are adequately trained in searches of lesbian, gay and bi-sexual residents as was indicated through interviews and training records. Such training is required by their policy. Residents shower in private shower stalls with shower curtains to provide privacy and to prevent observation by staff of the opposite gender or casual observers. Based on staff and resident interviews, staff of the opposing gender were not announcing their presence when entering sleeping quarters where the probability exists that the resident may be changing clothes. During the exit interview with senior level staff at the facility, the issue of staff hourly rounds and security checks was discussed. Staff expressed concern over security needs and alerting residents who may not be following facility rules. The auditor recommended that staff of the same gender as the residents could continue to conduct security checks without alerting the resident prior to the room check. If staff of the opposite gender will have to enter a room without an announcement for emergency purposes only, a log will be kept documenting these exigent circumstances. Staff will not announce themselves during rounds conducted during sleeping hours so as not to disturb resident's sleep. Residents will be made aware that during sleeping hours rounds will be conducted without an announcement and there is no expectation of privacy. This is still in compliance with the standard as viewing during this check would be incidental to a routine cell check and during resident sleeping hours a resident should not be disrobing. The facility implemented knock and announce December 19, 2014. On February 5, 2015 the auditor conducted video conferencing interviews with two male and two female residents. The residents confirmed that the knock and announce policy has been implemented. There were a few procedural incidents that were swiftly remedied by the operations manager.

**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.**

To date they have not experienced any residents who do not speak English or have learning disabilities prohibiting them from understanding written materials or verbal training on PREA requirements. However, they still need to be prepared for when this may occur. There is a Spanish poster posted in the facility. The policy prohibits using resident interpreters. Although there were no documented residents with disabilities, staff were aware of the expectations of providing necessary services. At the time of the audit there was no language translating service available for those residents that may arrive who do not speak or understand English proficiently. However, a copy of the facility's contract with the LanguageLink signed on February 4, 2015 was provided to the auditor. This service can be used in the event they have a resident that does not speak, read or understand English. Their PREA policy does address properly communicating with residents with disabilities and residents who are limited English proficient.

**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.**

The auditor reviewed personnel records and all staff hired over the reporting period had the required background checks. They were not aware that the background check needed to be run again when an employee is promoted within the facility. They will be running all background checks again so that it is easier to manage the every five-year requirement from a logistical standpoint. They stated they were asking recent interviewees the three questions required by the standard regarding any previous misconduct. However, the auditor suggested that they add these questions in written form to their application process so that there is consistent written documentation. Also, the prospective applicant can sign acknowledging that they have a continuing duty to report. The facility conducts checks with all previous institutional employers regarding substantiated allegations of sexual abuse. The employees' records that were checked by the auditor had no previous institutional employment history listed, but staff were completing inquiries to other previous employers. The policy states that material omissions in applications regarding such misconduct, or the provision of materially false information, shall be grounds for termination.

The facility provided the auditor an updated form on January 29th that is completed by prospective employees. This form asks the applicant three questions regarding disclosure of previous sexual misconduct and a statement acknowledging that if employed by the RRC they have a continuing duty to disclose sexual misconduct.

**Standard 115.218 Upgrades to facilities and technologies**

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

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

The facility considers protection of residents when contemplating upgrades to the facility or in the application of technology such as cameras. They have already identified that a camera is needed in the blind spot of the custodial closet off the kitchen. They currently allot certain times of the day for either the men or women to occupy the common spaces of the kitchen and dayroom. If they ever have the funds to expand, they would like to construct separate dayrooms for male and female housing units. The auditor recommended that they document their plans within their annual report and in an annual facility assessment. This was completed on March 16, 2015.

**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.**

Victims of sexual abuse have access to forensic medical exams through Mercy Hospital. The facility has spoken with staff at Mercy Hospital in an attempt to set up provisions for only using SANE nurses for forensic exams at the hospital. However, there is only one recently trained SANE nurse at the Mercy Hospital and the hospital staff stated that she may not always be available. However, the hospital staff has communicated that they anticipate training more SANE nurses in the near future. The facility has an MOU with Safe Alternatives for Abused Families (SAAF) in Devils Lake for advocacy services. Devils Lake Police Department is contacted to investigate criminal allegations – both sexual abuse and sexual misconduct allegations. When they respond, evidence protocol including offering a victim advocate is followed.

**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 facility has a policy to refer all allegations for investigation. Although the RRC had no allegations put forward for investigation, the LRCF which operates under the same agency and policy did have a few investigations. Those investigations were completed by qualified investigators and required documentation and reporting occurred. Criminal investigations are conducted by the Devils Lake Police Department investigator that has received specialized training. These steps are properly documented in the PREA policy.

**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.**

PREA training with staff was apparent during the interviews as staff were very knowledgeable in the required competencies such as the correct first responder response – separate, provide care, protect evidence, call for assistance, notify shift supervisor and provide a written report. Staff were also very well versed in how to recognize signs of sexual abuse and how to communicate effectively with LGBTI residents. Staff had signed attendance rosters for multiple four-hour block trainings, but the forms did not specifically acknowledge what they learned. The auditor requested they provide signed forms that acknowledged their understanding of the components as specified in the standard. Within a few weeks following the on-site portion of the audit the facility provided signed training forms for all RRC staff that specifically acknowledge understanding of the required components as stated in the standard.

**Standard 115.232 Volunteer and contractor training**

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

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

The facility has a plan to provide PREA training to their religious volunteers. The auditor viewed and verified documentation of training that has been provided to other contractors. The auditor spoke with a religious volunteer who was able to state that facility's zero-tolerance policy and the appropriate actions to take if a resident indicated sexual abuse. The volunteer had previous training and experience outside of the facility that has well prepared him to respond to residents that may have been sexually abused. However, the auditor requested the facility provide and document formal PREA training to its two religious volunteers and any future volunteers who may serve the RRC. The facility provided that training and a signed acknowledgment form of the training for the two religious volunteers dated March 4, 2015.

**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.**

The residents receive a handbook on the day of arrival that outlines important PREA information. They keep these handbooks with them to refer to throughout their stay. There are posters posted throughout the facility. The interviews confirmed that residents were well aware of how to report and were familiar with multiple ways to report. Residents interviewed reported they feel safe at the RRC. The residents acknowledged receiving orientation and the facility has them sign a review of receipt of the information in the handbook.

**Standard 115.234 Specialized training: Investigations**

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

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

LRLEC staff members who conduct investigations receive training and the curriculum meets the specialized training requirements. There is documentation of when and who received the training. The PREA Coordinator at the time of the on-site audit was a trained facility investigator and able to conduct administrative investigations. However, the investigator resigned on January 2, 2015. The RRC staff supervisor completed the NIC PREA investigator training on December 31. Also, the RRC Operations Manager, the newly hired PREA Coordinator and another staff member from the LRLEC completed the PREA Resource Center investigator course on February 19, 2015.

All criminal allegations are turned over to the Devils Lake Police Department for investigation. The auditor interviewed the criminal investigator and found her experience and skills were superb in addressing criminal sexual abuse investigations for the LRLEC.

**Standard 115.235 Specialized training: Medical and mental health care**

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

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

The nurse for the LRLEC has completed the specialized training through NIC and was very knowledgeable during the interview. The RRC does not provide in-house mental health services. Residents are referred to either community providers or the Lake Region Human Services Center for mental health care.

**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.**

The facility initiated their screening process shortly before the on-site portion of the audit. Therefore many of the residents had not been screened. The RRC had a good plan for completing screenings for all residents and for following up with a second screening within the first 30 days of arrival. They met the standard as of January 26th when they provided the auditor with a roster of residents and copies of the screenings for all residents on the roster.

**Standard 115.242 Use of screening information**

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

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

The screening information is appropriately protected and only shared with those that need to make informed housing and work assignment decisions. RRC staff use the screening information to determine placement within their housing unit – ensuring that known aggressors are not placed with potential victims. RRC staff state there have been no transgender or intersex residents placed at the facility. However, if there were to be in the future, housing assignment would be done on a case-by-case basis considering the residents own views of safety. During the interviews staff were knowledgeable of this PREA standard. All residents at the facility shower separately.

**Standard 115.251 Resident reporting**

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

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

The RRC has established procedures allowing for multiple ways for residents to report privately to facility staff about sexual abuse or sexual harassment, retaliation by other residents or staff for reporting sexual abuse and sexual harassment, and staff neglect or violation of responsibilities that may have contributed to such incidents. Residents can report allegations to someone outside of the facility by contacting Safe Alternatives for Abused Families in Devils Lake. In addition, residents stated that they have access to their personal cell phones at designated times each day which allow them to make calls privately to family members, the local victim advocacy agency, any national victim advocacy 1-800 number, an attorney, a case worker or parole agent. All residents interviewed stated that they would feel very comfortable reporting any issues directly to staff.

**Standard 115.252 Exhaustion of administrative remedies**

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

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

The RRC uses an informal process to address resident grievances regarding sexual abuse. There are no set time frames for reporting sexual abuse and a resident may report at any time, to any person via multiple ways. Residents are encouraged to report directly to staff members, but if they do not feel comfortable in doing this, they may report to SAAF, the local abuse advocacy center in Devils Lake. A resident does not have to exhaust one method of reporting before being allowed to employ another method in order to obtain action.

**Standard 115.253 Resident access to outside confidential support services**

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

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

Residents have access to outside confidential support services. The facility has an agreement with the Safe Alternatives for Abused Families in Devils Lake for advocacy services. The residents interviewed all stated that they also may contact attorneys and/or family members. Referrals can also be made to the Lake Region Human Services Center.

**Standard 115.254 Third-party reporting**

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

**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.**

At the time of the audit the facility did not have any publically distributed information on how to report sexual abuse and sexual harassment on behalf of a resident. The auditor recommended that they post notices on how to report for the benefit of facility visitors whom may report on behalf of the residents. In addition, the auditor recommended third party reporting instructions be posted on the facility's website. On January 29th the Operations Manager provided the auditor with copies of the posters for their visit area. In addition, the auditor verified that contact information for third party reporting has been posted on their website.

**Standard 115.261 Staff and agency reporting duties**

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

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

The facility requires all staff to immediately report any knowledge, suspicion or information received related to sexual abuse/harassment incidents, retaliation and staff negligence that may have contributed to such incidents. Staff are required to make such reports to the staff supervisor and a report is submitted to the investigator. Random staff interviews confirmed their responsibility to report and to maintain that information in confidence. The facility Operations Manager and the PREA Coordinator supported their adherence to reporting standards and responsibilities. The PREA policy requires that outside investigators be informed when there is suspected criminal activity.

**Standard 115.262 Agency protection duties**

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

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

The facility requires all staff to take immediate action to protect the resident from imminent sexual abuse. The RRC has no reported incidents where a resident was subject to risk of imminent sexual abuse. Interviews confirmed compliance with expected practices. Administrators and line staff understood and agreed that "immediate" means when the response is needed – that could mean within minutes if the abuse was recent or it could mean before the end of the shift for incidents in which an abuse was reported that occurred in the distant past.

**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.**

Interviews with the Operations Manager confirm actions that will be taken upon receiving an allegation of sexual abuse while a resident was at another facility. Such action will be initiated no later than 72 hours and actions will be documented. There have been no instances of these allegations received from other 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.**

All facility staff comply with this standard. Interviews with staff verified their process to provide assistance, separate alleged victim/abuser, preservation and protection of evidence by securing the scene including the request of the victim not to take any actions that could destroy any physical evidence. All staff have been trained accordingly.

**Standard 115.265 Coordinated response**

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

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

The RRC has coordinated actions to be taken when an incident occurs that are very well outlined within their PREA policy. This plan coordinates actions among staff, first responders, medical/mental health staff, investigators and facility administrators. Staff interviews and interviews with the Operations Manager and PREA Coordinator indicate that staff are aware of their responsibilities to coordinate responses within the facility.

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

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

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

The administrators will remove alleged staff sexual abusers from contact with residents pending the outcome of the investigation. The facility does not employ represented (union) employees. The facility is not restricted in any way from protecting residents from contact with abusers.

**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 Operations Manager is charged with monitoring for retaliation. Should any person who cooperates with a sexual misconduct investigation express fear of retaliation; appropriate protective measures will be taken. Retaliation monitoring will be discontinued should the allegation be unfounded. Measures include housing changes, removing contact of alleged staff/resident abusers and emotional support services for those who fear retaliation. Interviews with the Operations Manager confirmed his duties and responsibilities. These steps are properly documented in the PREA policy.

**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 were no reported incidents at the RRC to be investigated. The facility shares resources with the Lake Region Law Enforcement Center and although the RRC had no incidents, the auditor reviewed the documented investigations at the jail and determined all standards are being properly followed for both administrative and criminal investigations. Through interviews with the investigator and the Operations Manager it was determined that investigations are not terminated should the source of the allegation recant. Should criminal prosecution be considered, the investigator coordinates with the prosecutor. Polygraph tests are not used in the course of their investigations. Administrative investigations will include efforts to determine whether staff actions/failures contributed to the abuse documented through written reports, which will include physical/testimonial evidence, credibility assessments and investigative facts and findings. All written reports will be retained for as long as the alleged abuser is incarcerated or employed by the facility plus five years. Investigations will not be terminated due to the departure of an alleged abuser or victim. These steps are properly documented in the PREA policy.

**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.**

Through the interviews with the investigator and the Operations Manager there was confirmation that the facility uses no standard higher than the preponderance of evidence in making final determinations of sexual abuse/harassment. This evidentiary standard is also stated in the PREA policy.

**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.**

Although the RRC has had no reportable incidents, the LRLEC did not have a method for documenting that residents are informed of the outcome of an investigation. The standard requires that "All such notifications or attempted notifications shall be documented." The PREA policy states that they will report the outcome in writing, but does not specifically state how to accomplish this. The auditor provided a sample for the facility to use in reporting back to residents. In order to meet this standard the auditor requested the RRC provide the form that they will use in reporting the outcome of an investigation back to residents. The auditor received the facilities report to resident form on February 11, 2015.

**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.**

No RRC staff have violated agency sexual abuse or harassment policies. Interviews conducted with the Operations Manager and Investigator verified that there have been no substantiated allegations at the facility during this audit period. Interviews also confirmed that the facility's policies would be followed should disciplinary measures be required including a report to the Devils Lake Police Department should termination and/or resignation of staff occur.

**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.**

Contractors and volunteers are subject to disciplinary actions including termination for violation of facility sexual abuse/harassment policies. According to the Operations Manager and the PREA Coordinator, should any violation of this type be substantiated, the facility has complete authority to administer remedial measures including prohibiting further contact with residents. They also verified that if disciplinary measures are required it could also include a report to the Devils Lake Police Department. Through the interview with a volunteers it was confirmed that they are informed that they could be prohibited from the facility for violation of the facility's sexual abuse/ harassment policies.

**Standard 115.278 Disciplinary sanctions for residents**

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

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

The facility prohibits disciplinary action for a report of sexual abuse made in good faith based upon a reasonable belief that the alleged conduct occurred. The RRC would work with the Lake Region Human Services Center or the referring agency (BOP, NDDOCR) to provide counseling, or other interventions designed to address and correct the underlying reasons or motivations for abuse. If findings of resident on resident sexual abuse, administrative sanctions will be administered following the formal disciplinary processes and applied commensurate with the level of infractions.

**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.**

Emergency medical response was not needed during the review period. The PREA policy documents PREA requirements for access to emergency medical and mental health services. Emergency services would be provided by Mercy Hospital. The RRC would coordinate with the Lake Region Human Services Center or the referring agency (BOP, NDDOCR) to provide mental health services. Emergency medical and mental health services are provided without charge to residents.

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

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

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

The PREA policy requires treatment and interventions occur, and review of facility practices strongly indicates that those treatments and interventions, and the timeliness of responses are consistent to the level of community care. The facility had not adopted the practice of offering a mental heath evaluation to abusers within 60 days of learning of an abuse history and offering treatment when deemed appropriate by the mental health practitioner. The nurse did state upon learning of an abuse history she will now refer the resident to see a mental health provider at the Human Services Center. The resident does not have to comply with the referral. However, the nurse must document that the referral was made and that the resident declined.

**Standard 115.286 Sexual abuse incident reviews**

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

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

The RRC has not had any reported sexual abuse incidents to review. However, they share the same administrative procedures and staff as the LRCF and at the time of the on-site audit the LRCF was not conducting sexual abuse incident review following each sexual abuse investigation regardless of final determination of findings, unless unfounded. Residents may be assigned to another living unit to increase supervision capabilities. The auditor has provided samples of how to conduct such reviews and to document them. In addition, the LRLEC found a previous review that was conducted on April 3, 2014 and provided to the auditor on February 11, 2015. The auditor requested a documented incident review noting the attendance of the RRC Operations Manager. The review of all incidents was completed on March 17, 2015 and the RRC Operations Manager was present at this review.

**Standard 115.287 Data collection**

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

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

The facility collects uniform data for all allegations of sexual abuse based on incident reports and investigation files. The auditor recommended that the facility conduct an annual review and post their aggregate data on their website in order to be compliant with this standard. The facility annual review was completed on March 16, 2015. In addition, the auditor verified that the aggregate data was posted the 2014 aggregate data on their website http://www.lrlec.org.

**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 RRC did not have any incidents to review. However, the LRLEC operates over both the RRC and the LRCF. The incidents that occurred in the LRCF were reviewed on March 16, 2015 and they provided an annual review to the auditor. The RRC Operations Manager was present for the LRCF incident reviews. Their review team included the newly selected Administrator, the Captain of the Jail, the PREA Coordinator and the RRC Operations Manager.

**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.**

Data collected is retained via limited access to retain for at least ten (10) years. The facility posted the annual report on the facility's website http://www.lrlec.org. The PREA policy addresses data storage, publication and destruction requirements.

**AUDITOR CERTIFICATION**

I certify that:

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

Candace L. Snyder — March 25, 2015

Auditor Signature — Date