PREA AUDIT REPORT ☐ **Interim** ☒ **Final**

COMMUNITY CONFINEMENT FACILITIES

Date of report: March 18, 2016

Auditor Information			
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Email: robobem@gmail.com / rpalmquist@cccscorp.com			
Telephone number: 509-464-9736			
Date of facility visit: March 7 - 9, 2016			
Facility Information			
Facility name: Spokane Residential Reentry Center			
Facility physical address: 3614 East Ferry Avenue, Spokane, WA 99202			
Facility mailing address: *(if different from above)* same			
Facility telephone number: 509-535-3572			
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: Kevin Camp			
Number of staff assigned to the facility in the last 12 months: 17			
Designed facility capacity: 40			
Current population of facility: 29			
Facility security levels/inmate custody levels: minimum			
Age range of the population: 21-61			
Name of PREA Compliance Manager: Kevin Camp		**Title:** Director	
Email address: kevin.camp@phs.com		**Telephone number:** 509-535-3572	
Agency Information			
Name of agency: Pioneer Human Services			
Governing authority or parent agency: *(if applicable)* n/a			
Physical address: 7440 West Marginal Ave S, Seattle, WA 98108			
Mailing address: *(if different from above)* same			
Telephone number: 206-768-1990			
Agency Chief Executive Officer			
Name: Karen Lee		**Title:** Chief Executive Officer	
Email address: Karen.lee@phs.com		**Telephone number:** 206-766-7022	
Agency-Wide PREA Coordinator			
Name: Rebecca Judy		**Title:** Director State Reentry/PREA Coordinator	
Email address: Rebecca.judy@phs.com		**Telephone number:** 206-716-3659	

AUDIT FINDINGS

NARRATIVE

The Prison Rape Elimination Act audit for the Spokane Residential Reentry Center (SRRC) operated by Pioneer Human Services (PHS) from the initial notification through this auditor's summary report began in February 2016 with a review of documentation provided by PHS staff. The documentation included facility information, and documents to support the 39 standards. The Pre-Audit questionnaire provided the necessary information to complete a substantial portion of the PREA Audit Compliance Tool. The onsite portion of the audit was conducted on March 7, 8, and 9th, 2016. On the morning of March 7th, the Auditor met with the Director of Reentry Programs who is also the agency PREA Coordinator and the Director of Spokane Residential Reentry Center who is also the PREA Compliance Manager. The Auditor explained the audit process, reviewed the Pre-audit Questionnaire and answered questions about various interpretations of the PREA standards. The auditor was provided access to and observed all areas of the facility.

The tour included the Intake, reception and screening areas, all housing units, the recreation area, cafeteria, and programming areas. The video monitoring system is available to the reception staff and they monitor cameras 24/7. There is information posted about PREA and the information is available to non-English speaking residents. The intake paperwork provided to new residents was reviewed and it contains specific information about PREA. Intake staff review this information with all new residents during their admission to the facility. Central files are not maintained in the Intake area, upon completion of orientation paperwork the information is forwarded to the Case Managers. All central files are maintained by the Case Mangers.

Intake staff when queried indicated that all questions pertaining to risk of sexual abuse or predatory behavior were completed by Case Management staff. The Case Managers utilize and extensive form that includes a review of mental, physical or developmental disability, age, physical build, previous incarceration, criminal history, prior convictions, perceived sexual orientation, prior sexual victimization and the residents perceived vulnerability. Both the Case Managers and the Intake staff indicated that all information concerning a resident was reviewed and utilized to determine housing and program assignments.

The housing units had signs informing residents of their right to be free of sexual abuse. There were signs informing residents how to report incidents of sexual abuse. The signs were posted in both English and Spanish. In addition there was information provided concerning local services provided by Lutheran Community Services Northwest Sexual Assault and Family Trauma Response Center.

Video Monitoring cameras were appropriate, the cameras have a line of sight into dorms.

The Resident Monitors indicated supervisory staff make rounds throughout the facility and that all staff of the opposite gender knock and announce their presence on the unit. The Auditor spoke with several residents who indicated they were aware of the information concerning PREA and that staff always announce their presence when entering the housing unit or the bathrooms. The residents further indicated that they had experienced no privacy issues and that staff were professional.

Throughout the tour Resident Monitors were visible and interacting with residents. Residents stated that staff are always available to answer questions and assist with issues.

DESCRIPTION OF FACILITY CHARACTERISTICS

Since being founded in 1963, Pioneer has expanded from a single halfway house in Seattle to an organization that offers an integrated array of treatment, housing, employment and training services in nearly 60 locations across Washington State. Unlike most nonprofits, Pioneer is a social enterprise organization that operates a diverse line of businesses to provide on the job training and work experience for the people it serves. Research shows that the keys to long-term success and stability for individuals with addiction and criminal histories are: treatment, housing and employment. For over 50 years, Pioneer Human Services has helped people reentering society from prison or jail as well as those who are overcoming chemical addition and mental illness.

The Spokane Residential Reentry Center (SRRC) serves males and females who are in the custody of the Federal Bureau of Prisons, or under the supervision of the US Probation or the Pre-trial Services. The 40-bed facility houses males only, but supervises both males and females while on home confinement. Residents are required to be fully employed or enrolled in an education program, participate in recovery/counseling, complete in-house work details and meet all screening requirements for placement.

SRRC offers a comprehensive array of services focused on helping individuals safely and successfully transition from prison into the community. Programs include: risk/needs assessment, Moral Recognition Therapy (MRT), GED classes, chemical dependency assessment, intensive outpatient treatment/aftercare and community transition skills. There are two dormitory style housing units with shower and toilet facilities available in each dorm.

SRRC provides case management and employment assistance including:
Obtaining necessary documentation (i.e. Identification, Driver's License, Social Security Cards)
Identifying and referring for mental health/substance abuse treatment
Referrals for various life skills, and skills development programs
Assistance with budgeting and restitution issues

SUMMARY OF AUDIT FINDINGS

The PREA Coordinator provided extensive documentation in conjunction with the Pre-Audit questionnaire. This documentation was reviewed before the audit and any discrepancies on the Auditor's part were cleared up well in advance of the on-site visit. The SRRC Staff provided full access to the facility, full access to documentation and the use of office facilities during the onsite visit. The majority of the staff members interviewed for this audit were professional and knowledgeable concerning their responsibilities as first responders. They understood the need to monitor potentially vulnerable inmates and they were diligent in their efforts to manage the diverse population of offenders.

The residents' were aware of the PREA standards, the majority knew how to report incidents of sexual abuse or harassment. They were aware of reporting procedures and most were aware of the availability to have a family member or close friend make a report. There are PREA posters in English and Spanish throughout the facility. The residents were aware of the Sexual Assault and Family Trauma Center however, none of the residents interviewed had utilized the services provided by the Community partner.

A total of 14 male residents were interviewed, the Spokane Residential Reentry Center does not house female residents. A total of 15 staff interviews were conducted. Interviews for random staff included both Resident Monitors and case managers and included all shifts. The specialized staff interviews included, administrative staff, investigative staff, risk assessment staff, intake staff and incident review team staff.

Number of standards exceeded: 0

Number of standards met: 39

Number of standards not met: 0

Number of standards not applicable: 0

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.

Pioneer Human Services has a zero tolerance policy and training program that meets the requirements for this standard. The policy provides the agency's approach to preventing, detecting and responding to sexual abuse and sexual harassment. It has definitions of prohibited behaviors and sanctions for those prohibited behaviors. The policy provides strategies and responses to reduce and prevent sexual abuse. The agency has an upper level agency wide PREA Coordinator. The facility has a PREA Compliance Manger. Both the PREA Coordinator and the Compliance Manager indicated they have sufficient time to manage and oversee the implementation of PREA standards.

Standard 115.212 Contracting with other entities for the confinement of residents

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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This standard is not applicable. Pioneer Human Services is a private Non Profit group, they do not contract with other agencies for services. Both the State of Washington and the U.S. Government contract with Pioneer Human Services for confinement beds.

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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Pioneer Human Services implements a staffing plan that provides adequate levels of staffing. In addition there is video monitoring available

to protect residents from sexual abuse. The staffing plan is reviewed on a yearly basis by both the Compliance manager and the Coordinator. The Spokane Residential Reentry Center (SRRC) houses residents who have been released from Federal Bureau of Prisons Facilities. Pioneer Human Services is contracted by the Federal Bureau of Prisons to provide Reentry services for these individuals. The staffing plan was developed in conjunction with the contractual requirements of the Federal Bureau of Prisons. The staffing plan is consistently complied with, there have been no deviations from the staffing plan in the past 12 months. The facility staffing plan is reviewed on a yearly basis, this review includes a vulnerability analysis that looks at the physical plant, video monitoring systems and the overall allocation of resources. Interviews with the Director and the PREA Coordinator indicate that during each yearly monitoring visit (conducted by the Bureau of Prisons) the Director and the PREA Coordinator review the staffing plan with Bureau of Prisons staff.

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.

SRRC does not conduct cross gender strip searches. There has been no circumstances in the past 12 months where a cross gender search has taken place. No residents are restricted from participation in any programs. All pat searches are conducted by same sex individuals. There have been no deviations from this policy. SRRC has taken extensive care to ensure all residents shower, perform bodily functions and change clothing outside the view of all staff. Staff announce their presence when entering a housing unit. The facility has a policy prohibiting staff from searching or physically examining a transgender or intersex resident for the sole purpose of determining the resident's genital status. All staff (100%) have participated in training on searches of transgender and intersex residents in a professional and respectful manner. All residents interviewed on this subject indicated they are pat searched by same sex staff. All staff interviewed on this subject indicated they are aware of the search policy and have not deviated from the policy.

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.

SRRC has procedures to provide disabled residents with the opportunity to participate in the center's efforts to prevent and respond to sexual abuse and harassment. In addition to written and visual education materials, SRRC and PHS has agreements with interpreters to assist in providing effective communication with residents who have disabilities. The Agency's Vice President of State and Federal Reentry Programs indicated during his interview that procedures are in place to ensure residents with disabilities and those who are limited in the English language have an equal opportunity to participate in the agency's effort to prevent sexual abuse and harassment. The SRRC does not rely on inmate interpreters in any manner.

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 prohibits hiring or promoting anyone who may have been previously involved in sexual abuse in a prison, jail, lockup, community confinement facility or juvenile facility. Agency policy requires consideration of sexual harassment issues during hiring. Criminal background checks are required. Additionally, staff who have worked at correctional facilities are required to provide an institutional work history. That information is used to contact prior employers to detect any information on substantiated allegations of sexual abuse or a resignation pending investigation for an allegation of sexual abuse. Interviews with Human Resource staff confirm these efforts. There have been seven new employees hired within the past 12 months, all criminal background checks were completed appropriately. Background checks are completed every five years for current employees and employees who fail to disclose information concerning misconduct can be terminated from employment. Interviews with Human Resource staff confirm that five year checks are completed and that appropriate sanctions are available for staff who fail to report 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.

SRRC has not made any substantial expansions or modifications to the existing facility since August 20, 2012. A vulnerability assessment was completed and the recommendations of that study has resulted in procedural and minor changes to the physical building. Several staff were involved in the vulnerability assessment including the PREA Coordinator. Finally the Vice President of State and Federal Reentry programs was involved in all decisions concerning the implementation of the recommendations from the Vulnerability assessment. In his interview the Vice President of State and Federal Reentry programs indicated the importance of utilizing technology to enhance the protection of residents from incidents of sexual abuse.

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.

The agency is responsible for conducting administrative sexual abuse investigations. Criminal investigations are conducted by a Law Enforcement agency. Those agencies are the Spokane County Sheriff's Office, the Federal Bureau of Prisons and the US Office of Inspector General. The outside agencies listed have appropriate protocols in place to conduct sexual assault investigations. There are no youth housed at this facility. In the event of an incident all victims are provided access to forensic medical examinations at a health care facility (Sacred Heart Hospital) at no cost. Examinations are not provided by Sexual Assault Nurse Examiners. At the present time there are no Sexual Assault Nurse Examiners in the Spokane area. The PHS PREA Coordinator and the Auditor confirmed this information. Several letters of correspondence between Pioneer Human Services and Sacred Heart Hospital were provided to the auditor to confirm the efforts of Pioneer Human Services to access the ability to utilize the services of a Sexual Assault Nurse Examiner. There have been no incidents at SRRC that required a forensic medical exam in the past 12 months. The auditor reviewed the Memorandum of Understanding between PHS and Lutheran Community Services Northwest (LCSNW). In addition the auditor interviewed the Director of the Sexual Assault and Family Trauma Center. Both the agency and the Center indicated a victim of a sexual assault would be provided an advocate and services for intervention and related assistance. The Director of the Center indicated an advocate would support the victim through the forensic examination and investigatory interviews. The PREA Coordinator established an appropriate Memorandum of Understanding that meets the requirements to provide services to victims of sexual abuse or harassment.

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.

SRRC and PHS ensure both administrative and criminal investigations are completed for all allegations of sexual abuse and sexual harassment. Although there has been no allegations in the past 12 months, appropriate procedures are in place to ensure investigation will be completed. PHS has procedures in place that require investigations by appropriate Law Enforcement Agencies and staff at PHS have been trained to conduct administrative investigations involving sexual abuse or harassment. In the event that an administrative investigation potentially involves criminal behavior the investigation is referred to a Law Enforcement agency. The agency documents all referrals. The PHS Web site provides information concerning PREA and the PREA Policy is posted on the Web site.

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.

SRRC trains' employees on zero tolerance and an employee's responsibilities to prevent, detect, report and respond to incidents of sexual abuse and harassment. Employees are informed of the residents' right to be free from sexual abuse and to be free from retaliation for reporting incidents of sexual abuse and harassment. Employees are trained on the dynamics of sexual abuse in confinement, the reactions of victims and how to detect sexual abuse. Employees receive training on standards of conduct, inappropriate relationships with residents and how to effectively communicate with all residents. In addition mandatory reporting laws are reviewed. The training is tailored to the residents at SRRC. All employees have been trained, they are trained annually, and the auditor confirmed the training records of the employees. All staff interviewed confirmed their participation in PREA training and their knowledge of the training curriculum.

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.

SRRC does not have volunteers entering the facility to conduct on site treatment or provide Religious programming for residents. All treatment or other programing is provided off site. Community services are coordinated by the resident and it is the resident's responsibility. Other individuals who enter SRRC for the purpose of repairs, IT, phone, physical plant, etc., are always supervised by staff and they do not have contact with residents. However, these individuals are provided with information concerning PREA and the Zero Tolerance policy.

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)

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Residents receive information on zero tolerance, how to report incidents of sexual abuse and harassment, their right to be free from sexual abuse and harassment and to be free from retaliation for reporting incidents. In addition, residents are informed about how SRRC will respond to such incidents. Intake Staff interviews verify that residents receive the appropriate information. In addition to this information residents are provided a handbook that also provides information concerning Zero Tolerance and how to report sexual abuse and harassment. The auditor confirmed all residents receive this information. Interviews with residents also confirm that SRRC Staff provide information on reporting incidents of sexual abuse. The agency documents the receipt of this information. Subsequent to the intake process SRRC Case Management staff provide additional information to residents concerning PREA in both video and written format. Interpretation services are provided for residents who may not be able to understand the presented material. Throughout the facility there is information posted about PREA, Zero Tolerance and how to report incidents of sexual abuse. This information is presented in both Spanish and English. This information is visible and readily available.

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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PHS conducts administrative investigations involving sexual abuse and sexual harassment. The investigator has received training in conducting investigations in confinement settings. This training was on line and coordinated by the National Institute of Corrections. The title of the training is "Investigating Sexual Abuse in a Confinement Setting". That training includes the proper use of Miranda and Garrity warnings, evidence collection, and the criteria and evidence required to substantiate a case for administrative action or criminal referral. The auditor reviewed the training certificate and interviewed the Investigator. The Investigator was aware of his responsibilities during an investigation, he indicated that upon notification of an allegation the investigation would begin immediately. Any allegation that potentially involved criminal behavior would require police involvement. The training he took from NIC covered all areas of the investigative process, interviewing techniques, evidence collection, evidence protection and victim advocacy.

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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Not Applicable. PHS does not provide in house medical and mental health staff. Residents are referred to community providers.

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)

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All residents are provided Risk Assessments upon intake. The policy provides that assessments are conducted within the first 72 hours. The Auditor notes that these assessments are done almost immediately after the initial intake. The assessment includes the mental, physical and developmental disability of the resident, the age of the resident, the physical build of the resident, previous incarcerations, criminal history, prior sex offenses, whether the resident is or is perceived to be gay, lesbian, bisexual, transgender, intersex or gender non-conforming, prior sexual victimization and the resident's perception of his or her vulnerability. Residents are reassessed within 30 days or if additional information is received. Residents are not disciplined for failing to answer any questions. All information gathered during intake is shared with only those staff that have a need to know. Sensitive information is not shared unnecessarily. Interviews with Case Management staff confirmed the use of the assessment tool. In addition resident interviews indicated the use of the assessment tool.

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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SRRC utilizes the intake information to make decisions on housing assignments. The needs of each resident are taken into consideration. Work and education programs are off site in the community, SRRC staff do not share intake information with community providers. Although no transgender or intersex offenders are currently in the population, Case Management staff indicated they would determine housing on a case by case basis and have appropriate facilities available to ensure the safety of all residents. The PREA Coordinator stated during her interview the Agency would consider a transgender or intersex resident's own views with respect to safety. During the audit there we no transgender or intersex residents at the SRRC.

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.

Residents have multiple ways to report allegations of sexual abuse and sexual harassment. There is an external PREA hotline that is not recorded. They can report verbally or in writing. Third party reports can be made to any staff or directly to PHS headquarters. Residents may file a grievance, residents also may contact the US Office of Inspector General. Staff can privately report to a supervisor, headquarters or they may use the hotline. These multiple methods of reporting are posted throughout the facility, they are available in the handbook and they are reviewed with the resident during intake and subsequent follow up with the Case Manager. Resident interviews confirm knowledge of the reporting procedures. Staff interviews confirm knowledge of reporting procedures.

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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PHS has an administrative procedure to address sexual abuse grievances. PHS does not impose a time limit, no informal grievance process is required. If an allegation is made against a staff member that staff member is not involved in the grievance process. There is an initial response within 48 hours and a final agency decision within 90 days. Third parties are allowed to submit and if necessary assist the resident in filing a grievance. There is an established procedure for emergency grievance and an initial response within 48 hours with a final decision within 5 days. If a grievance is filed in bad faith the resident may be disciplined. SRRC has not had a grievance filed within the past 12 months alleging sexual abuse.

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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PHS has established a Memorandum of Understanding with the Lutheran Community Services Northwest Sexual Assault and Family Trauma Center (SAFeT). These advocates provide support related to sexual assault. Residents have access to the mailing address, telephone numbers including a toll free number that provides confidential communication between residents and the center. The residents indicated their awareness of the SAFeT. However, none of the residents interviewed had utilized the services provided by Lutheran Community Services Northwest.

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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PHS has established a method to receive third party reports of sexual abuse. This information is available on the PHS website (www.phs.org). Information is available to the public on how to report resident sexual abuse or sexual harassment on behalf of the residents.

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)

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PHS requires all staff to report all allegations of sexual abuse or harassment. Staff are to report any violation of neglect that may have resulted in or contributed to an incident or retaliation. All staff interviewed are knowledgeable of the requirement to report, they have received training in this area.

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.

PHS Policy requires that immediate action is taken to protect residents from sexual abuse. Although there have been no incidents in the past 12 months at the SRRC, staff interviewed are aware of their reporting requirements and the steps that need to be taken to ensure the safety of the resident.

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.

Upon receiving an allegation that a resident was sexually abused while confined at another facility, PHS policy requires notification to the head of the facility and to appropriate Law Enforcement authorities within 72 hours. This notification is documented. There has not been any reports from a resident that they were sexually abused at another facility in the past 12 months. Interviews with both the Director and the Vice President indicate compliance with this procedure.

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.

SRRC Staff were interviewed concerning first responder responsibilities. Staff were aware of their responsibility in this area. Staff indicated a need to separate the victim from the abuser, preserve and protect the crime scene, advise the victim to not take any action that would compromise the evidence, and if possible ensure the alleged abuser did not take any action that would compromise any evidence. In addition staff were aware that they needed to contact local law enforcement and the Sexual assault center. The staff interviewed indicated they had received training that included the duties of a first responder. During the past 12 months SRRC has not had any incidents of sexual assault.

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.

SRRC has a written plan that includes, immediate notification to the Compliance Manager, law enforcement and sexual assault advocates. The Director stated during his interview that staff are trained to follow the PREA Response Plan that includes but is not limited to, separating the involved individuals, contacting law enforcement, maintaining evidence integrity, contacting the PREA Coordinator, Community Partners, and assisting in transport if necessary.

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.

PHS has no limit on its ability to remove alleged sexual abusers from contact with any residents pending the outcome of an investigation. There is no collective bargaining agreement that would prohibit immediate action to protect residents. The Agency Head and HR staff confirm there is no prohibition against removing alleged staff sexual abusers from contact with residents.

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.

PHS prohibits retaliation against both residents and staff who report sexual abuse or sexual harassment or cooperate with investigations. The SRRC Director (Compliance Manager) is the designated staff member to monitor retaliation. Multiple measures are available that include removal of alleged staff and alleged resident abusers, housing changes and advocate support. Monitoring can last for at least 90 days and includes periodic status checks. The SRRC Director was aware of his requirements for monitoring.

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.

PHS has procedural guidelines for criminal and administrative investigations. All allegations that appear to be criminal in nature are referred to a law enforcement agency. Upon the completion of a criminal investigation PHS will conduct a follow up investigation for Human Resource action if necessary. All allegations are investigated. The credibility of an alleged victim, suspect or witness is assessed on an individual basis, polygraph or other devices are not required to proceed with an investigation. PHS retains all investigations of alleged sexual abuse or sexual harassment for as long as the alleged abuser is incarcerated or employed by the agency, plus 5 years. Investigations will not be terminated because the source of the allegation is unavailable or recants.

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.

The Investigative Officer was interviewed concerning the evidential standard for administrative investigation. His response to the standard of evidence was as follows: "The evidence standard for administrative investigation is a "preponderance of the evidence". The Investigative Officer has received specialized training relevant to PREA. Specifically "Investigating Sexual Abuse in a Confinement Setting". The Investigative Officer was interviewed and explained to the auditor in detail the steps to be taken during a PREA related investigation.

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.

Residents are informed of the results of the investigation. That information includes whether or not the staff member is or is not allowed to work in the resident's unit; the staff member is or is not employed; the staff member has been indicted and/or the staff member has been convicted. In addition if the alleged abuser is a resident, the resident victim would be informed if the alleged abuser was indicted and or convicted. All notifications are documented.

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.

PHS Staff are subject to disciplinary sanctions up to and including termination for violating agency sexual abuse or sexual harassment policies. During the past 12 months there has not been any allegations of staff sexual abuse or sexual harassment at SRRC. Interviews with Human Resource staff confirm that if necessary, appropriate sanctions are available for violations of PHS Policy relating to PREA.

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.

PHS Policy requires that contractors or volunteers who engage in sexual abuse or sexual harassment are reported to law enforcement and to relevant licensing bodies. In these cases contractors or volunteers who have been found to have violated PHS PREA Policies are not allowed contact with residents. There have been no incidents of contractors or volunteers violating PHS PREA policies within the past 12 months at the SRRC.

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 following an administrative finding that the resident engaged in resident on resident sexual abuse or following a criminal finding of resident on resident sexual abuse. The sanctions are commensurate with the circumstances of the abuse committed. Appropriate rights and responsibilities are afforded to the resident during the disciplinary hearing process. The residents are provided the opportunity to work with a community provider in an effort to correct underlying reasons or motivations for the abuse. Residents can be disciplined for sexual contact with staff if the staff member did not consent to such contact. SRRC prohibits all sexual activity between residents and disciplines residents for such activity.

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.

SRRC procedures indicates residents would be taken or referred to Sacred Heart Hospital for medical care and forensic evidence collection and examination. Mental Health care is offered by LCSNW SAFeT and their advocate would be at the hospital with the resident victim. Treatment for these services is at no cost to the resident. The Director of SAFeT stated there is a coordinated response to sexual assault crimes in Spokane County. The three main partners, medical services, mental health services and law enforcement work together to provide services to the victim. LCSNW coordinates the Regional PREA Coordinating Meeting. This group of individuals represents the Spokane area correctional facilities both juvenile and adult, community treatment centers, Providence medical staff, SAFeT staff and Law Enforcement staff. This group meets on a quarterly basis; the partnership between these agencies and SAFeT has improved the level of organization and care provided to incarcerated individuals.

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.

SRRC and PHS provide ongoing medical and mental health care for sexual abuse victims and abusers. Appropriate follow-up services, treatment plans and continuing care upon release from custody are available. All treatment is provided by community providers, if necessary pregnancy tests and follow-up care would be provided. Appropriate STD tests as medically indicated would be provided. There would be no cost to the resident for this care. The PHS PREA policy and appropriate MOU's are in place to meet the needs of the victim. SRRC does offer to provide a mental health evaluation for abusers and offer treatment when deemed appropriate by a mental health practitioner.

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.

At the conclusion of the investigative process, PHS and SRRC staff would review the incident regardless of the outcome of the investigation. The review would be scheduled within 30 days of the conclusion of the investigation. The review team consists of the Vice President of Reentry Programs, the PREA Coordinator, PREA Compliance Manager and relevant staff involved in the investigation. The review team would determine if a change in procedure was necessary, if it was motivated by any class affiliation, sexual orientation, or other

group dynamic. A review of the monitoring technology would be conducted to assess its effectiveness. The physical barriers of the facility and the staffing pattern would also be evaluated. There would be a final report of the incident with appropriate recommendations. As noted throughout this report there has been no incident of sexual abuse at the SRRC in the past 12 months.

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.

Uniform data is collected which accurately tracks allegations of sexual abuse. The data is aggregated annually. The PREA Coordinator is responsible for collecting the data necessary to answer all questions from the U.S. Department of Justice Bureau of Justice Statistics Survey of Sexual Violence. The annual review is posted on line and was reviewed by the Auditor.

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.

PHS reviews the data and identifies problem areas, takes corrective action and prepares a final report. The report provides an assessment of the agency's progress in addressing sexual abuse. The Agency Head reviews the report and it is available on line at www.phs.org.

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.

Required data is collected, maintained and is available on line. PHS maintains this data for 10 years after the date of the initial collection. The data collected includes, incident reports, investigation reports, electronic evidence, law enforcement referrals, criminal investigation reports, administrative investigation reports, PREA review committee reports, and retaliation monitoring reports.

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.

Robert J. Palmquist  March 18, 2016

Auditor Signature Date