PREA AUDIT REPORT ☐ INTERIM ■ FINAL

COMMUNITY CONFINEMENT FACILITIES

NATIONAL PREA RESOURCE CENTER

BJA Bureau of Justice Assistance U.S. Department of Justice

Auditor Information			
Auditor name: Stephen J. Huffman			
Address: 11820 Parklawn Drive, Suite 240, Rockville, MD 20852			
Email: stephen.huffman@nakamotogroup.com			
Telephone number: 614-940-4696			
Date of facility visit: June 19, 2015			
Facility Information			
Facility name: Marshalltown Residential Facility			
Facility physical address: 1401 South 17th Ave. Marshalltown, Iowa 50158			
Facility mailing address: *(if different from above)*			
Facility telephone number: 641-753-5571			
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: Amanda Milligan			
Number of staff assigned to the facility in the last 12 months: 16			
Designed facility capacity: 57 (46 males and 11 females)			
Current population of facility: 51 (43 males and 8 females)			
Facility security levels/inmate custody levels: Minimum Levels 1,2,3,4,Orientation and Job Seeking			
Age range of the population: 19-54			
Name of PREA Compliance Manager: Jon Groteluschen		**Title:**	PPO Supervisor
Email address: jon.groteluschen@iowa.gov		**Telephone number:**	515-574-4027
Agency Information			
Name of agency: Second Judicial District Department of Correctional Services			
Governing authority or parent agency: *(if applicable)* Second Judicial District Department of Correctional Services			
Physical address: 510 5th Street, Ames, Iowa 50010			
Mailing address: *(if different from above)*			
Telephone number: 515-232-1511			
Agency Chief Executive Officer			
Name: Amanda Milligan		**Title:**	District Director
Email address: amanda.milligan@iowa.gov		**Telephone number:**	515-574-4021
Agency-Wide PREA Coordinator			
Name: Jon Groteluschen		**Title:**	PPO Supervisor
Email address: jon.groteluschen@iowa.gov		**Telephone number:**	515-574-4027

AUDIT FINDINGS

NARRATIVE

The on-site Prison Rape Elimination Act (PREA) compliance audit of the Marshalltown Residential Facility, Marshalltown, Iowa was conducted June 19, 2015 by the Nakamoto Group, Inc. certified PREA auditor Stephen J. Huffman. When the auditor arrived at the facility, an "in-briefing" meeting was held with Acting District Director/Assistant Director, PPO Supervisor/PREA Compliance Coordinator and Residential Manager. The introductions and audit process was discussed during the briefing.

The standards used for this audit became effective August 20, 2012. This auditor discussed information contained in the Pre-Audit Questionnaire with the PREA Compliance Coordinator prior to the on-site audit visit. As part of the audit, a review of all agency and local facility policies and a tour of the the facility was completed. A total of nine residents (7 male - 2 female) of the fifty-one total population were interviewed by the auditor. The total population consisted of forty-three male residents and eight female residents. All residents stated the facility assists them to meet their needs. The female and male residents are separated at all times. There were five allegations of sexual abuse/harassment filed by residents during the rating period. Three of the allegations were determined to be unfounded and one was determined to be unsubstantiated and one case determined to be substantiated. There were three allegations against staff with two cases determined to be unfounded and one case unsubstantiated. No staff were prosecuted for sexual abuse of a resident. The other two incidents involved resident on resident allegations with one case determined to be substantiated. A male resident touched a female resident on the buttocks. A recommended procedural change of having only one resident working in the kitchen unsupervised instead of two was adopted immediately.

The average length of stay at the minimum security facility is 3.9 months. The age range of the population is 19-54 years of age. A total of 9 of the 16 employed staff were interviewed including residential officers from all three eight hour shifts and housing units. Four administrative staff were interviewed including the Acting District Director/Assistant Director, PPO Supervisor/PREA Compliance Coordinator, Residential Manager and Human Resource Manager. A total of five specialized staff (investigators, incident review team member, retaliation monitor, intake and unit staff) were interviewed. No volunteers or contractors were available for interview.

The auditor interviewed a representative from the local advocacy center, Assault Care Center Extending Shelter and Support (ACCESS). The representative believes the facility has an excellent PREA culture and they periodically meet with facility staff to discuss PREA issues and how the culture can be improved to enhance the safety of the residents and staff. The Marshalltown Residential Facility has an agreement with the local hospital Marshalltown Medical and Surgical Center for medical and mental health services.

The auditor concluded, through interviews and review of policy and documentation, that all staff and residents were very knowledgeable concerning their responsibilities involving the PREA. During the interviews, the residents stated that staff were respectful and that they felt safe at the facility. All residents stated they would ask staff for assistance if they were being sexually harassed or abused, indicating they have confidence in the facility staff. Staff were able to describe in detail their specific duties and responsibilities, including being a "first responder" if an incident occurred or allegation of sexual abuse/harassment was made.

DESCRIPTION OF FACILITY CHARACTERISTICS

The Department of Correctional Services within the Second Judicial District is one of eight judicial district correctional programs currently existing within the State of Iowa. These are the end result of statewide development of correctional programs with the objectives of providing total services at the community-based level to correctional clients, the court system, and ultimately, the public. The Second Judicial District operates its programs as mandated by Chapter 905 of the Code of Iowa. Additionally, a Board of Directors with established By-Laws governs the District. The Board of Directors is comprised of a county supervisor from each county in the district, a judicial appointee, and one citizen advisory representative. The Department of Correctional Services, as it exists in this judicial district, provides the usual historic services and, in addition, some innovative and functional services.

The Marshalltown Residential Facility (originally known as the State Work Release Center) has been in Marshalltown since 1978. The facility has had three different locations, with the original one now housing the Marshalltown Historical Society Museum, located at 202 East Church Street. In 1982 the residential facility moved to 106 East Church Street and on February 14, 1996 moved to it's current location at 1401 South 17th Avenue.

The facility provides community based correctional services to twenty-two counties in north central Iowa. The mission of Iowa Community Based Corrections is to enhance community safety and facilitate positive change in adult offenders. The facility promotes law abiding behavior through supervision, accountability, treatment, education and community programming, in an innovative and cost effective manner.

The District provides the following services to the offenders: Pretrial Release Services, Community Service, Probation, Parole, Intensive Supervision Programs, Thinking for a Change, Strategies for Self-Improvement and Change, Sex Offender Programs, Achieving Change Through Value-Based Behavior, Comprehensive Aftercare Program, Power and Control Tactics of Men Who Batter, Electronic Monitoring, Moving On, Special Services Treatment Unit and Residential Correctional Programming.

The Mission Statement of the Marshalltown Residential Facility is Public Safety through Risk Reduction.

The Iowa Department of Corrections Mission Statement is: Advance successful offender reentry to protect the public, employees and offenders from victimization.

SUMMARY OF AUDIT FINDINGS

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

Number of standards exceeded: 2

Number of standards met: 36

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.

Policy 101 1AB page 1 addresses this standard. The facility PREA Plan meets zero tolerance as required by the standard. The facility PREA Compliance Coordinator is the Parole and Probation Supervisor who reports directly to the Director. The facility has zero tolerance posting in all areas of the facility and residents receive several PREA zero tolerance documents. Staff receive initial training and annual training, as well as updates throughout the year.

Standard 115.212 Contracting with other entities for the confinement of residents

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

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

Not Applicable-The facility does not contract with other entities for the confinement of residents.

Standard 115.213 Supervision and monitoring

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

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

Policy 101 A-C page 1 addresses this standard. The facility administration including the PREA Compliance Coordinator reviews the staffing plans on an annual basis. Interviews with the Acting Director, PREA Compliance Coordinator and Residential Manager, indicated compliance with the PREA and other safety and security issues are always a primary focus when they consider and review their staffing plan. The auditor reviewed the facility staffing plan and it was determined to be acceptable. The facility has been provided with all necessary resources to support the programs and procedures to ensure compliance with PREA standards. The audit included an examination of all video monitoring systems, inmate access to telephones, review of documentation and staff interviews and rosters. Documentation of unannounced rounds by administrative staff that cover all shifts were reviewed. Interviews with staff confirmed unannounced rounds to all areas of the facility on a weekly basis and conducted with no warning to staff. Thirteen video cameras are placed throughout the facility with monitoring capabilities. The camera monitoring system is monitored in the main control center. There were four additional cameras recently installed. The cameras have recording capabilities and are maintained for 30 days. A recommended procedural change of having only one resident working in the kitchen unsupervised instead of two was adopted immediately.

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.

Policy 101 3A-F pages 1 and 2 and the staff training curriculum address this standard. Cross-gender strip and body cavity searches are prohibited, except in emergency situations, are completed by staff of the same gender as the resident, and are documented. Staff indicated they received cross-gender pat search training during initial and annual training sessions. Residents, resident officers and administrative staff stated residents are allowed to shower, dress and use the toilet privately without being viewed by the opposite gender. Residents and staff reported that staff of the opposite gender announce their presence before entering the housing areas. This was observed by the auditor. Staff were aware of the policy prohibiting the search of transgender or intersex residents to just determine their genital status.

Standard 115.216 Residents with disabilities and residents who are limited English proficient

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

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

Policy 101 4A-C pages 1 and 2 addresses the requirements of this standard. The facility takes appropriate steps to ensure residents with disabilities and inmates with limited English proficiency have an opportunity to participate in and benefit from the facilities efforts to prevent, detect and respond to sexual abuse and harassment. PREA handouts, zero tolerance posting and resident handbooks are in English and Spanish. The auditor reviewed all mentioned documents. Staff interviewed were aware that under no circumstances are resident interpreters or assistants to be used when dealing with PREA issues. Staff and local interpreters are used when an interpreter is needed. There were no residents with disabilities or with limited English speaking proficiency available for interview and there were no instances that an interpreter was utilized.

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.

Policy 101 5A-H pages 2 and 3 and the Employment Application address this standard. The Human Resource Manager was interviewed, and stated that all components of this standard have been met. All employees, contractors, and volunteers have had their background checks completed through the National Crime Information Center. Staff promotions require a background check before the promotion is approved. A tracking system is in place to ensure that updated background checks are conducted every five years. Policy states false information submitted by applicants is grounds for termination. The auditor reviewed employment documentation supporting compliance to this standard.

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 recently installed 4 additional cameras for a total of 13 cameras during the audit period. The cameras have recording capabilities for 30 days and are monitored in the control center.

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.

Policy 102 1A-G page 1 addresses this standard. Facility staff were interviewed concerning this standard and all were knowledgeable of procedures to secure and obtain usable physical evidence when sexual abuse is alleged. Staff were aware who was responsible for conducting investigations. Residents are transported to local Marshalltown Medical and Surgical Center for SAFE/SANE exams. The facility has an agreement with the hospital. There were five sexual abuse/harassment allegations during the audit period and there was no SAFE/SANE forensic exams conducted during the audit period. The facility has an agreement with the local Assault Care Center Extending Shelter and Support (ACCESS) for advocacy services.

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.

Policy 102 2A-D page 1 addresses this standard. Administrative and criminal investigations are completed on all allegations of sexual abuse/harassment. Various administrative staff conduct administrative investigations and were interviewed and found to be very knowledgeable concerning their responsibilities. There are five facility trained investigators who received training through the Moss Group. The Marshalltown City Police Department and Iowa Department of Corrections Division of Investigative Services conduct the criminal investigations for the facility. There were five allegations of sexual abuse or harassment during the audit period.

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.

Policy 103 A1-4 page 1 and the Annual Training Plan address all employee training required by this standard. The Iowa Department of Corrections provides extensive web-based E-Learning of PREA standards training which all staff successfully complete. Contractors and volunteers are provided training relative to their duties and responsibilities. Annual refresher training including PREA topics is provided to all staff. Staff receive continuous updating throughout the year. Staff acknowledge in writing their understanding of the PREA. Staff training files and facility training curriculum were reviewed and contained documentation supporting compliance to this standard. All staff interviewed indicated they had received and understood PREA training.

Standard 115.232 Volunteer and contractor training

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

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

Policy 103 B1-3 page 1 and the Annual Training Plan address the requirements of this standard. There are three contractors and volunteers who have received PREA training that covered zero-tolerance, reporting and responding requirements. All training is documented and the auditor examined training files that confirmed standard compliance. There were no volunteers available for interview, but PREA training documentation was reviewed indicating training was received.

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.

Policy 103 C1-5 page 2 addresses the requirements of this standard. The auditor believes the facility does a good job in educating the inmates on the PREA. Residents receive information during the intake process that includes a PREA Training information packet, a handout and the resident handbook is printed in English and Spanish. Facility staff meet periodically with residents concerning PREA standards giving the residents an opportunity to ask questions and present any concerns. There are zero tolerance posters throughout the facility and in each housing unit and a "hot line" telephone number to call the National Sexual Abuse and Assault Care Center Extending Shelter and Support (ACCESS) advocacy program to report abuse or harassment and the address for the Iowa Ombudsman Office. The residents watch a PREA video during the intake process and have a grievance system to report sexual abuse. Interviews with staff and residents, as well as documentation review, support the facility exceeding compliance of the standard.

Standard 115.234 Specialized training: Investigations

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

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

Policy 103 D1-2 page 2 addresses this standard. The Marshalltown City Police Department or Iowa Department of Corrections Division of Investigative Services perform criminal investigations. Five facility investigators received PREA specialized investigative training through the Moss Group Training Program and perform administrative investigations. Training records were reviewed confirming the completion of the required training.

Standard 115.235 Specialized training: Medical and mental health care

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

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

Policy P-22 pages 1-3 addresses this standard. The facility doesn't employ medical or mental health staff. The facility has memorandum of understanding with the local Marshalltown Medical and Surgical Center and the Assault Care Center Extending Shelter and Support (ACCESS) victim advocacy program for medical and mental health services.

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.

Policy 104 A1-4 page 1 and the State of Iowa Sexual Violence Propensity intake screening instrument-(SVP) address the requirements of this standard. All residents are assessed at intake immediately upon arrival at the facility for their risk of being sexually abused or harassed by other residents or being sexually abusive towards other residents. An intake staff member screens all new arrivals within their first 72 hours. They are almost always seen the first day of intake. The staff review all relevant information from other facilities and continues to reassess when additional information is received within 30 days of arrival. Residents identified as high risk for sexual victimization or at risk of sexually abusing other residents are referred to the hospital medical and mental health staff for additional assessment. Staff and resident interviews, a review of documentation, and observation of intake process confirmed this information. There were 7 inmates screened for risk of sexual victimization or risk of sexually abusing other inmates whose length of stay was more than 72 hours. There were 171 inmates screened that were reassessed after 30 days of arrival for possible sexual abuse or victimization based upon additional information received during the audit period.

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.

Policy 104 B1-6 page 1 addresses compliance to this standard. Policy requires the use of a PREA Objective Screening Instrument (reviewed by auditor) to determine proper housing, bed assignment, work assignment, education and other program assignments with the goal of keeping residents at high risk of being sexually abused / harassed separate from those residents who are at a high risk of being sexually abusive. Housing and program assignments are made on a case by case basis for all residents with continued follow-up and monitoring when needed. There are weekly staff meetings addressing PREA concerns and issues. Staff and resident interviews and a review of screening documents confirm compliance of the standard.

Standard 115.251 Resident reporting

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

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

Policy 106 A1-4 page1, PREA Intake Packet, zero tolerance posters, grievance policy and the resident handbook in English and Spanish address compliance to this standard. A review of documentation and staff/resident interviews indicated that there are multiple ways (including verbally, in writing, anonymously, privately, "hot line" telephone calls, National Sexual Abuse, Iowa Department of Corrections and Assault Care Center Extending Shelter and Support advocacy center contact, and Marshalltown City Police Department) for residents to report sexual abuse/harassment. Staff document all allegations reported internally or externally. There are posters and other reporting documents, on display throughout the facility, observed by auditor, that also explain reporting methods. The facility does have an agreement with Assault Care Center Extending Shelter and Support local advocacy center to provide all services relevant to this standard. Documentation review and interviews with residents and staff confirmed that the facility exceeds compliance with this standard.

Standard 115.252 Exhaustion of administrative remedies

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

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

Policy 105 B1-15 pages 1 and 2 and the grievance policy address this standard. Residents may file a grievance; however, all allegations of abuse/harassment when received by staff, would immediately result in an administrative or criminal investigation. The policy allows for an emergency grievance to be completed by the residents. There were no grievances filed involving PREA related issues during the audit period.

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.

Policy 105 C1-2 pages 2-3 and the resident handbook address this standard. The facility does have an agreement with the local advocacy center; Assault Care Center Extending Shelter and Support (ACCESS), to provide all services relevant to this standard. The facility has contact information for the advocacy center and other outside agencies to address resident issues. The auditor made contact with a representative from ACCESS and the representative confirmed the facility had a good PREA culture and stated they have an excellent relationship with the facility.

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.

Policy 105 D1 page 3, the facility website, the resident handbook, posters and posted addresses of the local advocacy center address the requirements of this standard. The resident handbook, various information handouts, the PREA packet and facility posters assist third party reporters on how to report allegations. The posted telephone number of the local advocacy service center (ACCESS) allows residents to contact the agency at any time. Staff and resident interviews confirm compliance to this standard.

Standard 115.261 Staff and agency reporting duties

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

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

Policy 106 A1-4 page 1 addresses this standard. All staff interviewed were well aware of their duty to immediately report all allegations of sexual abuse and harassment and retaliation relevant to PREA standards including third party. This standard of compliance was verified through resident officers and administrative staff interviews and a review of policies.

Standard 115.262 Agency protection duties

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

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

Policy 106 B page 1 addresses this standard. All staff interviewed stated their duties and responsibilities if they were aware of a resident being sexually abused or harassed and they would act immediately to protect the resident. The staff interviewed stated they would separate residents, secure the scene, protect possible evidence, not allow residents to destroy possible evidence and contact their supervisor and medical staff. During the rating period there were no residents determined to be subject to substantial risk of imminent sexual abuse.

Standard 115.263 Reporting to other confinement facilities

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

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

Policy 106 C1-2 page 1 addresses this standard. Policy requires the reporting of any PREA related allegation by an resident that occurred at another facility. There was one allegation received during the rating period stating that sexual abuse occurred at another facility and was immediately investigated. Policy requires the Director where the resident is currently being housed notify the Director where the resident was previously housed within 72 hours after being notified. The policy requires an investigation be immediately initiated. This standard was verified by reviewing policy and interviewing the Acting Director/Assistant Director, PPO Supervisor/PREA Compliance Coordinator and Residential Manager.

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.

Policy 106 D1 a-d page 1 addresses this standard. All staff interviewed were very knowledgeable concerning their first responder duties and responsibilities upon learning of a sexual abuse or harassment allegation by a resident. The staff stated they would separate the residents, secure the scene, would not allow residents to destroy any evidence and contact their supervisor. The residents would be sent to the local hospital if needed. There were five allegations filed by residents that they were sexually abused/harassed during the audit period. Three of the allegations were determined to be unfounded and one was determined to be unsubstantiated and one case determined to be substantiated. There were three allegations against staff with two cases determined to be unfounded and one case unsubstantiated. No staff were prosecuted for sexual abuse of a resident. The other two incidents involved resident on resident allegations with one case determined to be substantiated. A male resident touched a female resident on the buttocks. A recommended procedural change of having only one resident working in the kitchen unsupervised instead of two was adopted immediately.

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.

Policy 106 E-1 page 1 and the coordinated plan address this standard. The documentation was reviewed by the auditor. The policy and plan describes first responders, investigators, facility administration, advocacy center and medical facilities coordination to resolve sexual abuse / harassment incidents.

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

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

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

The Collective Bargaining Agreement between the State of Iowa and (AFSCME) American Federation of State, County and Municipal Employees, Council 61 AFL-CIO complies with this standard. Employees are subject to discipline, including removal, if they engage in any sexual abuse/harassment with a resident. The agreement was examined by the auditor.

Standard 115.267 Agency protection against retaliation

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

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

Policy 106 F1-5 page 2 addresses this standard. The policy prohibits any type of retaliation to any staff person or resident who has reported sexual abuse or harassment or cooperated in any PREA allegation investigation. The Assistant Director is designated the retaliation monitor. He was interviewed and he stated he would conduct checks with the resident weekly or as needed up to 90 days or as long as needed to make sure the resident is safe from retaliation or the resident is transferred. There have been no cases of retaliation during the rating period.

Standard 115.271 Criminal and administrative agency investigations

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

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

Policy 107 A1-10 page 1 addresses this standard. The Assistant Director, Residential Manager, PPO Supervisor/PREA Compliance Coordinator and other administrative staff conduct administrative investigations within the facility. Criminal investigations are referred to the Marshalltown City Police Department or Iowa Department of Corrections Division of Investigation Services who confer with the county prosecutor to determine if prosecution will be pursued. There were no criminal prosecutions during this audit period. Per the Acting Director, the facility cooperates fully with any outside agency who initiates an investigation.

Standard 115.272 Evidentiary standard for administrative investigations

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

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

Policy 107 B page 1 addresses this standard. The evidence standard is a preponderance of the evidence in determining whether allegations of sexual abuse or sexual harassment are substantiated. Compliance to the standard was determined through interviews with facility investigators and documentation review.

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.

Policy 107 C1-5 pages 1 and 2 address this standard requiring the resident be informed of the outcome of the investigation. There were five administrative investigations during the audit period requiring resident notification as required by this standard. Only three residents were notified in writing. Other residents had left the facility and could not be reached for notification.

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.

Policy 108 A1-4 page 1 and the employee handbook address this standard. The facility has not issued any disciplinary sanctions to residents as a result of sexual conduct with other residents or staff. There have not been any reported cases of residents engaging in sex with staff during the audit period. The Collective Bargaining Agreement between the State of Iowa and (AFSCME) American Federation of State, County and Municipal Employees, Council 61 AFL-CIO allows for disciplinary sanctions against staff including termination for sexual abuse/harassment of an resident.

Standard 115.277 Corrective action for contractors and volunteers

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

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

Policy 108 B1-2 page 1 addresses this standard. During the audit period there were no contractors or volunteers accused of sexual abuse/harassment of an resident. The Acting Director/Assistant Director interview indicated contractors or volunteers would be terminated immediately if they engaged in sexual abuse or harassment of an resident.

Standard 115.278 Disciplinary sanctions for residents

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

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

Policy 108 C1-7 pages 1 and 2 addresses this standard. There were two cases of resident on resident sexual abuse/harassment investigated at the Marshalltown Residential Facility during the audit period. There have been no cases of staff and residents engaging in sex during the audit period. There were no cases of residents having sex with other residents. Policy does not allow consensual sex of any nature. Residents that sexually abuse or harass staff will be disciplined if not consensual. The facility does not discipline residents who make allegations in good faith, even if the investigation does not establish evidence sufficient to substantiate the allegation. Interviews with facility investigators confirm compliance to this standard.

Standard 115.282 Access to emergency medical and mental health services

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

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

Policy 109 A1-3 page 1 addresses this standard. The facility has an agreement with the local Marshalltown Medical and Surgical Center for emergency medical and mental health treatment. The treatment is offered at no financial cost to the residents. There are no facility medical and mental health staff.

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

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

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

Policy 109 B1-8 page 1 addresses this standard. The facility has an agreement with local Marshalltown Medical and Surgical Center for ongoing medical and mental health services without financial cost to the resident. This standard compliance was determined by documentation review and administrative staff interviews.

Standard 115.286 Sexual abuse incident reviews

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

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

Policy 110 A1-5 page 1 addresses this standard. Administrative and criminal investigations are completed on all allegations of sexual abuse/harassment. The Acting Director/Assistant Director, Residential Manager, PPO Supervisor/PREA Compliance Coordinator and other supervisory staff perform administrative investigations for sexual abuse/harassment. Three investigators were interviewed and found to be very knowledgeable concerning their responsibilities. There are five trained facility investigators. The Marshalltown City Police Department and Iowa Department of Corrections Division of Investigative Services conduct the criminal investigations for the facility. There were five allegations of sexual abuse or harassment during audit period. All investigations ordinarily will be completed within 30 days. The review team consists of the Assistant Director, Residential Manager and PPO Supervisor/PREA Compliance Coordinator and all were very knowledgeable concerning their duties for investigating and reviewing incidents. The auditor reviewed the monthly administration meeting minutes, sexual abuse incident form and incident review form.

Standard 115.287 Data collection

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

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

Policy 110 B1-5 page 1 addresses this standard. The facility collects accurate uniform data for every allegation of sexual abuse/harassment by using a standardized Iowa Department of Corrections PREA Investigation Data Base Report. The incident-based data collected includes the data necessary to answer all questions from the most recent version of the Survey of Sexual Violence conducted by the Department of Justice. The agency aggregates all data annually and reviews it annually. The auditor reviewed the annual report.

Standard 115.288 Data review for corrective action

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

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

Policy 110 C1-4 pages 1 and 2 addresses this standard. The Iowa Department of Corrections and the Marshalltown Residential Facility Director and administration staff review and assess all sexual abuse/harassment data at least annually to improve the effectiveness of its sexual abuse prevention, detection and response policies, and to identify any issues or problematic areas and take corrective action if needed. The facility PREA Compliance Coordinator forwards data to the Iowa Department of Corrections. An annual report is prepared and placed on the facility and department website. The Annual Report was reviewed by the auditor.

Standard 115.289 Data storage, publication, and destruction

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

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

Policy 110 D1-4 page 2 addresses this standard. The facility PREA Compliance Coordinator reviews data compiled and issues a report to the Iowa Department of Corrections. The data is securely retained and published on the facility and department website. The reports cover all data noted in this standard, and is retained in a secured file.

AUDITOR CERTIFICATION

I certify that:

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

Stephen J. Huffman — July 2, 2015

Auditor Signature — Date