# PREA AUDIT: AUDITOR'S SUMMARY REPORT
# COMMUNITY CONFINEMENT FACILITIES-FINAL REPORT


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| **Name of facility:** | **Fannie M. Lewis Community Corrections & Treatment Center** | | | |
| **Physical address:** | 1829 East 55th Street, Cleveland, Ohio 44103 | | | |
| **Date report submitted:** | April 24, 2015 | | | |
| **Auditor Information** | | | | |
| **Address:** | 60 East Monroe Street, Chicago, IL 60603 | | | |
| **Email:** | bhuskey@huskey-associates.com | | | |
| **Telephone number:** | 312-658-0150 | | | |
| **Date of facility visit:** | October 2-3, 2014 | | | |
| **Facility Information** | | | | |
| **Facility mailing address:** *(if different from above)* | | | | |
| **Telephone number:** | 216-881-7882 | | | |
| **The facility is:** | ☐ Military | ☐ County | ☐ Federal | |
| | ☐ Private for profit | ☐ Municipal | ☐ State | |
| | X Private not for profit | | | |
| **Facility Type:** | ☐ Community treatment center<br>☐ Halfway house<br>☐ Alcohol or drug rehabilitation center | Community based confinement facility<br>☐ Mental health facility | X Other: Community Correctional Facility | |
| **Name of Facility Head: Raven L. Kauffman** | | | **Title:** | **Program (Facility) Administrator** |
| **Email address: RavenKauffman@orianahouse.org** | | | **Telephone number:** | **216-881-7882** |
| **Name of PREA Compliance Manager (if applicable): NA (the facility does not have a PREA Compliance Manager as Mary Jones is the Agency PREA Coordinator** | | | **Title:** | **Vice President of Administration & Legal Counsel** |
| **Email address: maryjones@orianahouse.org** | | | **Telephone number:** | **330-535-8116** |
| **Agency Information** | | | | |
| **Name of agency:** | **Oriana House, Inc.** | | | |
| **Governing authority or parent agency:** *(if applicable)* | Board of Directors | | | |
| **Physical address:** | 885 E. Buchtel Avenue, Akron, Ohio 44305 | | | |
| **Mailing address:** *(if different from above)* | P.O. Box 1501 Akron, Ohio 44309 | | | |

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|---|---|---|---|
| **Telephone number:** | 330-535-8116 | | |
| **Agency Chief Executive Officer** | | | |
| **Name:** | **James Lawrence** | **Title:** | **President/CEO** |
| **Email address: jameslawrence@orianahouse.org** | | **Telephone number:** | **330-535-8116** |
| **Agency-Wide PREA Coordinator** | | | |
| **Name:** | **Mary H. Jones, Esq.** | **Title:** | **Vice President of Administration & Legal Counsel** |
| **Email address: maryjones@orianahouse.org** | | **Telephone number:** | **330-535-8116** |

# AUDIT FINDINGS

**NARRATIVE:**

**Pre-Audit Activities:** The PREA Audit of the Fannie M. Lewis Community Corrections & Treatment Center (FMLCCTC) was initiated in August 2014 with an interview with the Oriana House Executive Vice President, the Agency's PREA Coordinator/Vice President of Administration and Legal Counsel and the Agency's Compliance/Accreditation Manager to discuss goals, objectives and time line. The Auditor created a PRE-Audit Timeline outlining 15 pre-audit tasks to be completed together by the Agency and the Auditor during August 22-October 1, 2014. The Notice of the October 2-3 Audit was posted six weeks prior to the audit notifying residents and staff of the methods for them to communicate confidentially with the Auditor prior to and at any time during the audit process.

During this pre-audit phase, the Agency completed and submitted to the Auditor its Agency/Facility Questionnaire. The Auditor reviewed the PREA Agency Questionnaire and examined numerous documents on each of the PREA Standards including: policies and procedures, resident and staff incident reports, resident and staff investigations, staffing plans, e-mails, training curriculum, staff training records and certifications, contracts and Memoranda of Agreements with outside agencies and vendors, risk screening instrument, and video monitoring system plan. The Auditor and the Agency had several review meetings before the Audit to respond to the Auditor's questions, to discuss issues needing clarification and to discuss follow-up data requested by the Auditor. The Agency was very responsive to these requests, and additional clarifications, data and explanations were provided to the Auditor within 24-48 hours of the Auditor's request. The Auditor completed its initial review of the documentation and prepared a working confidential draft of the Auditor Compliance Tool.

The Auditor met two days before the on-site audit to interview the Agency's Executive Vice President, the PREA Coordinator/Vice President of Administration and Legal Counsel, the Compliance/Accreditation Manager, the Facility Program Manager, Program Administrator and key staff, and to obtain an overview of the facility.

**Audit Activities:** The Fannie M. Lewis Community Corrections & Treatment Center (FMLCCTC) PREA Audit was conducted on October 2-3, 2014. The audit began with an interview with the Program Manager and the Program (Facility) Administrator. At this meeting, the Auditor indicated that the short-term goal was to document compliance with each of the PREA Standards. The Auditor further indicated that the long-term goal was to assist the FMLCCTC staff and residents to improve its operational approach to resident care, particularly toward individuals who have been sexually abused, sexually harassed or at risk of sexual abuse and/or sexual harassment.

A stratified random sample of 10 residents was selected from the daily population sheet, ensuring that each resident met the following criteria:

1. Housed in each of the living units (each resident represented a different living unit)
2. Who have reported a sexual abuse complaint
3. Who have reported a sexual harassment complaint
4. Who represent each of the groups LGBTI
5. Resident who has disabilities
6. Resident who is limited English proficient

Out of the total 177 residents housed in the facility on October 2, 2014, there were 148 males and 29 females housed representing 84% males and 16% females. Random numbers were generated between 1 and the number of active residents. A random sample of 5.4% of the males and 6.8% of the females was drawn from the entire population using an excel software program to ensure that there was no bias in selecting residents. From this sample, each of the six criteria was examined to ensure that each resident interviewed resided in a different dorm and met at least one additional criterion. This methodology resulted in a list of 8 males and 2 females to be interviewed for a total of 10 residents. The two females presented themselves as LBTI. One resident in the original list was working when the interviews were conducted so another resident was interviewed who met the criteria.

The Auditor interviewed a total of 25 staff working at the facility. The following individuals were interviewed during this two–day Audit:

Administrative Staff Interviewed

1. Executive Vice President of the Agency
2. PREA Coordinator for the Agency/Vice President of Administration/Legal Counsel
3. Program Manager
4. Program (Facility) Administrator
5. Vice President of Correctional Programs-Cuyahoga County
6. Compliance/Accreditation Manager
7. Human Resources Manager
8. Program Coordinator
9. Clinical Coordinator
10. Caseworker

Specialized Staff Interviewed

1. Sexual Abuse Nurse Examiner (SANE) at Fairview Hospital, Cleveland, OH
2. SANE at Cleveland Clinic, Cleveland, OH
3. Contract Staff (Food Services Manager)
4. Internal Investigators (2)
5. Staff who perform screening for risk of victimization and abusiveness
6. Chair, of the Sexual Abuse Incident Review Team
7. First responders (security and non-security staff)
8. Intake staff (security staff)

Random Staff Interviewed

A total of 10 randomly selected line staff and first responders were interviewed using the following methodology.

There is a total of 23 security staff working at FMLCCTC including 19 Resident Supervisors (RS), 1 Lead Resident Supervisor (LRS) and 3 Shift Supervisors (SS), representing 40% of the total facility staff of 57. Each of these security staff was broken down by shift to ensure that the Auditor interviewed security staff and first responders on each shift and in each dorm. Random staff on the shifts was also selected

by the excel software to minimize any bias among the selection of security staff. The following staff was interviewed:

- First Shift: 9 (20%) total staff (1 LRS, 2 SS, 6 RS): Auditor interviewed 4 from first shift
- Second Shift: 6 (14%) total staff (6 RS): Auditor interviewed 3 from second shift
- Third Shift: 8 (18%) total staff (1 SS, 7 RS): Auditor interviewed 3 from third shift
- Total Security Staff Interviewed: 10 staff who represented security and first responders

Interviews with staff and residents were conducted in a private conference room. Each was instructed to explain to others if they were asked that they were randomly selected by the computer for an interview to reduce any potential of harassment. Staff and residents were informed that the information they provided to the Auditor during the interview would be confidential. However, the Auditor indicated that if they shared information that would indicate that they are being sexually abused or sexually harassed, or if they feel they are at risk of being sexually abused or sexually harassed, the Auditor had a duty to report this to the Facility Administrator.

In addition to the interviews to gather qualitative data from staff and residents, the Auditor examined additional documents, files, and conducted a facility tour of intake/reception/screening, main post, housing unit posts, bedrooms, dayrooms, toilets and showers, smoking pits, visiting room and the cafeteria. The Auditor examined blind spots, placements of video monitoring, configuration of showers and toilets and staff and resident interactions.

**DESCRIPTION OF FACILITY CHARACTERISTICS:**

The Fannie M. Lewis Community Corrections & Treatment Center is a 218-bed, co-ed community correctional center opened in 2001 with 183 beds designated for males and 35 beds designated for females. The current population is 217 residents. FMLCCTC serves seven populations including adult males and females, ages 19-68 years of age referred by the U.S. Bureau of Prisons, Court of Common Pleas Department of Probation and Parole, and the Municipal Court Department of Probation. FMLCCTC is used as a transitional center for federal and state inmates released from federal and state prisons, a work release for the courts and probation departments and as a jail diversion program. Residents are assessed as minimum custody. A total of 843 residents were admitted to the facility in the past 12 months. The average length of stay for residents at the FMLCCTC is 128 days.

The mission of FMLCCTC is "to provide quality and humane chemical dependency treatment and community corrections services to clients while contributing to safer communities". The therapeutic goal of the FMLCCTC is to reduce the resident's dependence on alcohol and illegal substances, reduce their thinking errors, teach residents prosocial values, attitudes and behaviors, and support them in their job search and placement. Residents progress through a four-phase program, and residents are housed in housing units based on their level within the program.

Because this facility is a community transitional center, residents participate in services off-site including, medical, mental health, adult education, GED testing, computer classes, and family counseling.

The facility consists of one, two-story building subdivided into 21 dorms into four separate areas (A, B, C, and D) for a total of 52,916 gross square feet. The facility was renovated in 2001, which included HVAC, electric, plumbing, exterior and interior walls. Subsequent renovations were made in the bathrooms to provide privacy to inmates using the bathrooms and to comply with PREA standards. Previously, there would be a view from the living room into the open bathroom stall. Privacy doors were installed to provide privacy and to prevent others viewing into the bathroom stall. This modification is commendable as it communicates respect for the privacy of the residents.

A total of 57 staff is employed at FMLCCTC. It is managed by the Program Administrator and the Program Manager with a combined 30 years of experience in corrections.

FMLCCTC received its national reaccreditation from the American Correctional Association (ACA) in August 2013. The ACA Auditors found 100% compliance with mandatory standards and 99.5% compliance with non-mandatory standards. FMLCCTC is to be commended for reaching this high level of compliance. This level of excellence with national ACA Standards is consistent with the other facilities operated by Oriana House.

**SUMMARY OF AUDIT FINDINGS:**

At the conclusion of the PREA Audit, the Auditor conducted a post-audit briefing complimenting staff on the work that the Agency's administration and the FMLCCTC staff, in particular, has done to comply with the PREA standards at this first PREA Audit. It is evident from the PREA Audit, that policies and protocols have been developed to prevent, detect and respond to allegations of sexual abuse and sexual harassment.

The Agency and FMLCCTC are commended for exceeding 10 of the PREA standards and in successfully meeting 26 PREA standards.

Number of standards exceeded: 10
Number of standards met: 26
Not Applicable: 3
Total: 39 standards

The following provides the rating for each of the 39 standards and includes the Auditor's rationale for each rating.

| **Standard number here** | 115.211 Zero tolerance of sexual abuse and sexual harassment; PREA coordinator. |
|---|---|

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

Policy 1080, Chapter 1000, page 1, mandates that sexual abuse and sexual harassment will not be tolerated; it outlines the steps in preventing, detecting and responding to sexual abuse and sexual harassment; it defines prohibited behaviors; it includes sanctions for those participating in prohibited behaviors; and it describes the facility's strategies and responses to prevent and reduce sexual abuse and sexual harassment. The Agency has designated the Vice President of Administration/Legal Counsel to serve as the PREA Coordinator. Ms. Jones is an experienced attorney with 18 years' experience working with Oriana House. She is supported by an experienced Manager of Compliance and Accreditation with 20 years' experience with Oriana House. Further, these two individuals are supported by support staff from the agency's Training Department and from staff subcommittees addressing various PREA activities.

Based on this organizational structure, the qualifications of the staff designated to coordinate PREA activities, the number of individuals assigned to address PREA activities, and on staff interviews, the Auditor determined that the PREA Coordinator has sufficient time and authority to develop, implement, and oversee agency efforts to comply with PREA standards.

| **Standard number here** | 115.212 Contracting with other entities for the confinement of residents. |
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☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

X Not Applicable

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

The agency does not contract with other entities to confine residents under the responsibility of FMLCCTC.

| **Standard number here** | 115.213 Supervision and monitoring. |
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X 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 comments, including corrective actions needed if does not meet standard**

FMLCCTC has developed, and the Auditor documented, that the facility Staffing Plan is reviewed annually and that it considers the physical layout of the facility, the type of residents being served, and the prevalence of substantiated and unsubstantiated incidents of sexual abuse as required by the PREA Standard. The Auditor confirmed through interviews that the staffing plan also considers the number of posts, number and type of incidents by post, workflow on the shift, the video monitoring plan, the activity schedule, the facility traffic patterns, the offender's risk level internally and their risk to reoffend and the minimum staffing level. Female staff is assigned to the female living unit to ensure that the needs of female residents are fully understood and addressed.

There are 30 video cameras located at strategic locations throughout the facility. The security cameras are placed to allow maximum observation by staff. Facility supervisors randomly check camera play back and live footage. The Program Manager, Program Administrator, Program Coordinator and Lead Resident Supervisor have access to camera footage at their desktop computer.

Staff is required to conduct client counts a minimum of once an hour to provide staff presence. Staff is encouraged to interact verbally with the residents. Staff also completes client whereabouts three times every eight hours and six times for individuals on observation. If a staff member has to leave the post, a rover is called in to supervise. Daily reviews of coverage are conducted per shift. Staff will be called in from Judge Nancy R. McDonnell CBCF if FMLCCTC needs additional staff to meet the mandatory coverage requirements.

The Staffing Plan is based on a total of 218 residents but houses 195 residents on an average daily basis. The Auditor requested and was given the number of staff who actually is on duty at any given time. The facility provided the Auditor staff rosters indicating that FMLCCTC has an overall vacancy rate of 22% (as of September 2014). Based on the Auditor's national experience, vacancy rates among community corrections facilities can be as high as 45% illustrating how low this facility's vacancy rate is compared to facilities operated by other agencies. This speaks to the positive culture and professionalism that is evident at FMLCCTC.

Given the type and number of residents being served, the configuration of the posts and the dorms, the number of staff assigned within the dorms and the floater that walks through all areas of the facility on each shift to provide backup to staff, the placement of video monitoring, the privacy within the toilets and showers, and the supervisory leadership of the Leadership Team (consists of the Lead Resident Supervisor, Program Coordinator, Program Administrator, Program Manager), the Auditor concludes that FMLCCTC has adequate number and deployment of staff. Since the facility Staffing Plan considers more factors than what is required in the PREA standard, the Auditor determined that FMLCCTC exceeded the minimum standard.

| **Standard number here** | 115.215 Limits to cross-gender viewing and searches. |
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Exceeds Standard (substantially exceeds requirement of standard)

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

Policy 1080, Chapter 1000, page 3, and Policy 8089 item 2, prohibits cross-gender viewing and pat downs by staff of the opposite sex. These policies indicate that pat downs will only be

conducted by members of the same sex in a professional and respectful manner. Visual pat downs via a metal wand are performed by the opposite sex but no hands-on contact occurs. A resident must wait until a same sex staff is available when a physical pat down is warranted. The Auditor confirmed through the review of Policy 1080 and Policy 8089, through interviews with staff and residents and through observations of security checks when residents entered the facility, that residents are not patted down by staff of the opposite sex nor are they viewed by staff of the opposite sex in the shower/toilet room or in the dorms.

Additionally, Policy 1080, page 3, requires that staff announce their presence when entering the living unit of the opposite sex and when clients shower, perform bodily functions and change clothing. One of the Resident Supervisors indicated that he announces himself while entering the hallway of the female housing unit. Another staff member indicated that he delays 3-4 seconds at the door of a female resident's room after knocking. The Auditor observed staff announcing their presence when entering the dorm, the bedroom, the toilets and showers of the opposite sex. The Auditor also verified that Policy 8089 prohibits the opposite sex from patting down residents, searching or physically examining a resident to determine the resident's gender. The Auditor confirmed this policy through interviews with staff and residents.

Policy 8022 requires logging entries into the Client Management Information System when cross-gender viewing and searches occur. There were no logging entries verifying that cross-gender viewing does not occur.

| **Standard number here** | 115.216 Residents with disabilities and residents who are limited English proficient. |
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☐ Exceeds Standard (substantially exceeds requirement of standard)

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

Policy 1080, Chapter 1000, page 6, item 1 and 2, mandates equal opportunity for residents with disabilities and residents who are limited English proficient to participate in and benefit from all aspects of the facility's efforts to prevent, detect, and respond to sexual abuse and sexual harassment. The Auditor reviewed and verified written contracts and invoices with the International Service Center (ISC) who are professional interpreters to assist residents who are limited English proficient or deaf. The Auditor reviewed and verified in the Client Handbook that the resident is given assistance from the ISC interpreters if needed. The Auditor reviewed and verified that the training curriculum and presentation slides discuss the PREA compliant practices with residents with disabilities.

Policy 1080, chapter 1000, page 6, item 2 and Policy 8004, chapter 8000, page 4, item 13, prohibits the use of resident interpreters, resident readers, or other types of resident assistants except in limited circumstances. The Auditor confirmed through interviews with staff and residents that resident interpreters are not permitted. In the past 12 months, there was no instances in which resident interpreters, resident readers, or other types of resident assistants was used on a limited basis.

| **Standard number here** | 115.217 Hiring and promotion decisions. |
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X☐ 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 comments, including corrective actions needed if does not meet standard**

Policy 1080, Chapter 1000, page 6 and Policy 3003, Chapter 3000, page 3, item 14, prohibits the hiring or promoting of anyone and prohibits enlisting the services of any contractor who may have contact with residents who has engaged in sexual abuse in the past, or has been convicted of engaging in or attempting to engage in sexual activity in the community or who has been civilly or administratively adjudicated. Policy 3006 requires a criminal background record check on new employees and contractors who have contact with residents. A total of 30 new individuals were hired since October 2013 and 2 contracts for services were entered into where criminal background record checks were conducted. The Human Resources Department conducts a criminal background check on line and with the Ohio Bureau of Criminal Investigations on all new hires. Administrative adjudications are also reviewed on all newly hired employees who may have contact with residents. The Human Resources Department considers prior incidents of sexual harassment when determining whether to hire or to enlist the services of any contractor.

Contractors are required to conduct their own criminal background check as part of their contract with the Agency, and they are required to send a copy of the investigation to the Human Resources Department. The Auditor reviewed and verified that background checks are conducted on contract employees and that the Human Resources Department and the PREA Coordinator receive copies of these criminal background checks.

Policy 1080 requires that the Agency make best efforts to contact all prior employers for information on sexual abuse or on any resignation during a pending investigation. Policy 3003, chapter 3000, page 3, item 14, indicates that candidates who have engaged in sexual harassment may not be considered for hire or for promotion. The individuals are required to disclose allegations of sexual abuse and sexual harassment on their written employment application, in the initial phone interview conducted by the Resident Supervisor and in the in-person employment interview. The Resident Supervisor reviews all disciplinary incidents within the employees' employment history looking for complaints of sexual harassment. The Interview Selection Procedure gives instructions to the interviewers to ask questions about whether the staff member has engaged in sexual abuse or sexual harassment in their past employment history.

The Agency has established a protocol (Policy 3009) that requires current staff to notify one's immediate supervisor immediately when they are arrested for any offense. Further, the employee has a continuing duty to disclose any sexual harassment or sexual abuse in their Performance Evaluation-Self Appraisal Form.

The Auditor verified that these policies are complied with from the following documentation: a) interviewed and confirmed with the Human Resource Manager and the PREA Coordinator b) reviewed and verified in the written application form that the new employee must sign that he/she has not engaged in sexual abuse and have not been convicted of engaging in sexual activity in the community by force or threat of force and have not been civilly or

administratively adjudicated c) reviewed and verified in the instructions to the resident supervisor and in the new hire interview questions that the individual is asked if they have engaged in sexual abuse in any institutional setting or in the community or was civilly or administratively adjudicated and d) reviewed a sample of personnel files, employee and contractor criminal background checks of individuals hired within the past year. The protocol outlined in Policy 3009 exceeds the minimum PREA Standard of a criminal background check of current employees every 5 years since the policy requires on-going and immediate notification to one's supervisor when an employee is arrested, and they are required to disclose sexual harassment or sexual abuse in their Performance Evaluation-Self Appraisal Form.

| **Standard number here** | 115. 218 Upgrades to facilities and technology. |
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☐ Exceeds Standard (substantially exceeds requirement of standard)

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

FMLCCTC has not acquired or expanded the physical plant since August 20, 2012. The video camera plan was modified in the last year which requires staff to monitor closely the locations of incidents within the facility. The Auditor reviewed and observed the video cameras and intercoms during the facility tour and at subsequent tours of the facility.

| **Standard number here** | 115. 221 Evidence protocol and forensic medical examinations. |
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Exceeds Standard (substantially exceeds requirement of standard)

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

The Auditor verified that FMLCCTC uses a uniform evidence protocol for the Cleveland Police Department (CPD) investigators to use when they conduct their criminal investigations and for the agency's investigators to use when they conduct their administrative investigations. A written Memorandum of Understanding (MOU) has been developed with the CPD that requires that they comply with PREA. This MOU is currently under review.

The FMLCCTC offers all victims of sexual abuse access to forensic medical exams at outside hospitals at no cost to the resident. A list of outside hospitals was provided to the Auditor that conducts forensic evaluations by qualified SAFEs and SANEs. The Auditor interviewed professionals at the Fairview Hospital and at the Cleveland Clinic to verify that these services are available to residents at no cost. Within the past 12 months, no forensic medical exams were conducted.

Policy 1080 indicates that emergency medical treatment and crisis intervention services are offered to the victim at no cost to them. A written MOA with the Cleveland Rape Crisis Center is entered into with FMLCCTC to provide no-cost victim advocacy and emotional and crisis counseling services 24/7 when needed to the residents at FMLCCTC.

| **Standard number here** | 115. 222 Policies to ensure referrals of allegations for investigations. |
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X☐ 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 comments, including corrective actions needed if does not meet standard**

Policy 1080, chapter 1000, page 12, states that instances of sexual abuse that are criminal, the Client Sexual Abuse Response Team will refer to law enforcement promptly, thoroughly and objectively. This policy is posted on the agency website: www.orianahouse.org. FMLCCTC conducts an administrative investigation in anticipation of litigation to determine if employee's actions or failures to act facilitated the abuse. As of August 19, 2014, the Auditor reviewed reports on seven allegations of sexual abuse and sexual harassment and seven administrative investigations. Six of the investigations were completed and one was pending. None of these investigations was referred by the Client Sexual Abuse Response Team to the Cleveland Police Department because they were not criminal. Even if law enforcement does not get involved, the Oriana House investigators conduct their own investigation. Since the facility routinely conducts an administrative investigation after all criminal investigations are conducted, the Auditor concludes that the agency exceeds the minimum.

| **Standard number here** | 115. 231 Employee training. |
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☐ Exceeds Standard (substantially exceeds requirement of standard)

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

The Staff Training Policy 1080, Chapter 1000, page 7, outlines all 10 areas in the PREA Standard to be included the agency's staff training program. The Auditor verified these topics in the facility's training curriculum, verified that these topics were covered in the presentation slides, asked staff about each of these 10 areas and staff verified that these areas were covered. A total of 55 staff has been trained who have contact with residents, representing 96.5% of the total staff. In between the training, the facility provides staff biannual updates to PREA policies and protocols at mandatory staff meetings.

| **Standard number here** | 115. 232 Volunteer and contractor training. |
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☐ Exceeds Standard (substantially exceeds requirement of standard)

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

Policy 1080, chapter 1000, page 7, mandates specialized training on PREA given by the agency to all volunteers and contractors who have contact with residents.

The Auditor verified from the list provided that a total of 19 persons were trained by the agency who were either contractors or volunteers who have contact with residents in the past 12 months. The Auditor reviewed and verified that the training curriculum addresses PREA standards and zero tolerance for contractors and volunteers. The Auditor also verified that the instructions to Facilitators by the Compliance/Accreditation Manager indicated that they shall provide mandatory training to contractors and volunteers on PREA standards. Policy 1080 further states that the level and type of training provided shall be based on the services these individuals provide and on the level of contact they have with clients. The Auditor verified at its interview with the food services contractor that their staff received and understood the mandatory training.

| **Standard number here** | 115. 233 Resident education. |
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☐ Exceeds Standard (substantially exceeds requirement of standard)

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

Policy 1080, Chapter 1000, page 7, specifies that during the intake process, residents shall receive information explaining the agency's zero-tolerance policy regarding sexual abuse and sexual harassment, their rights to be free from sexual abuse and sexual harassment and from retaliation, and how to report such incidents. A total of 133 residents were given this information at intake in the past 12 months, which represents 100% of the individuals admitted to FMLCCTC. The Auditor conducted a spot check of resident's intake records and verified that newly admitted residents were given information by the staff on the agency's policy on zero-tolerance. The Auditor interviewed residents who indicated that they were informed of the agency's policy to protect them against sexual abuse and sexual harassment and how to report if they were harmed or felt at risk of being harmed within several hours of admission. The Auditor also verified that the Client Handbook adequately informs residents of the agency's zero-tolerance policy and of the agency's duty to protect them against sexual abuse and sexual harassment. The Auditor verified through interviews with the resident supervisors conducting intake functions and with residents that the Guide for Client Sexual Abuse and Sexual Harassment found in the Client Handbook is described at intake and the resident signs that they understand their right to be free from sexual abuse and sexual harassment.

Policy 1080, Chapter 1000, page 8, states that residents who have been transferred to FMLCCTC from another facility are given refresher training. There were no residents who were transferred from a different community confinement facility.

To ensure that residents who are limited English proficient or deaf understand this process, PREA posters are displayed in both Spanish and English. The Auditor verified that PREA posters were displayed at the facility. For individuals who are low level readers, intake staff indicated that they will explain the policy to the individual in a manner that they can understand. The Auditor reviewed and verified written contracts and invoices with the International Service Center (ISC) who are professional interpreters to assist residents who are limited English proficient or deaf.

| **Standard number here** | 115. 234 Specialized training: Investigations. |
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☐ Exceeds Standard (substantially exceeds requirement of standard)

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

Policy 1080, Chapter 1000, page 7, item 3 states that the investigators are trained in conducting sexual abuse investigations. The Auditor interviewed both investigators and they confirmed that they received the specialized training addressing the topics required by the PREA Standard. The Auditor also reviewed the training curriculum and confirmed that it addressed techniques for interviewing sexual abuse victims, proper use of Miranda and Garrity warnings, evidence collection and the evidence required to substantiate a case. The Auditor also reviewed the training certificates of the two investigators confirming that the investigators received the training.

| **Standard number here** | 115. 235 Specialized training: Medical and mental health care. |
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☐ Exceeds Standard (substantially exceeds requirement of standard)

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

Policy 1080, Chapter 1000, page 8, states that medical and mental health employees shall receive specialized training on PREA. There is no medical or mental health staff employed at FMLCCTC. Residents obtain medical care from hospital emergency rooms in case of emergencies, their private medical professionals or from local area clinics. There is a Licensed Social Worker who coordinates and supervises the mental health program at FMLCCTC and collaborates with community based treatment providers. This individual verified that he received specialized training on PREA. The Auditor reviewed the training curriculum and verified that it addressed how to detect and assess signs of sexual abuse and sexual harassment, how to preserve physical evidence, how to respond to victims and how and to whom to report.

| **Standard number here** | 115. 241 Screening for risk of victimization and abusiveness. |
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X☐ 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 comments, including corrective actions needed if does not meet standard**

Policy 1080, Chapter 1000, Page 3-4, states that all residents are screened within 72 hours of intake and upon transfer to another facility for their risk of being sexually abused. Interviews with residents and staff indicated that the screening occurs within several hours of admission to the facility. The Auditor reviewed the intake records of a sample of residents and confirmed that screening does take place at admission to the facility.

FMLCCTC uses an objective screening instrument (Oriana House, Inc., Residential Programs Intake and Background Information Screening Form) that considers all nine criteria identified in the PREA Standard, including prior acts of sexual abuse, prior convictions for violent offenses, history of prior institutional violence or sexual abuse. The Auditor verified that each of the variables are rated with a score, and residents are documented in their client record that they are either Highly Susceptible, Susceptible or Not Susceptible and either Highly Abusive, Abusive or Not Abusive.

Policy 1080, Chapter 1000, page 4, states that the assigned caseworker will re-screen clients within 15 days but no later than 29 days after arrival. Further, policy states that a reassessment will be conducted when it is warranted due to a referral, an incident or when new relevant information becomes available after the initial intake (page 5/item g). The Auditor interviewed intake staff, Program Coordinator, two caseworkers and resident supervisors (who were assigned to work in intake). The Auditor verified that a reassessment occurs generally no earlier than 15 days but no later than 29 days. The Auditor reviewed the one client record of a resident who was reassessed, and verified that the caseworker conducted the reassessment within the set time period.

Policy 1080, Chapter 1000, page 4/item 6, prohibits residents from being disciplined for refusing to answer questions or for not disclosing complete information. The Auditor interviewed residents and staff about this policy, and the Auditor verified that FMLCCTC does not discipline residents for refusing to answer these questions or for not disclosing complete information.

Policy 1080, Chapter 1000, page 4/item 6, state that sensitive information will not be exploited to the client's detriment by employees or other residents, and only disclosed on a need to know basis. The Auditor reviewed and confirmed from memoranda and from interviews with the PREA Coordinator, Program Administrator, Program Manager, Program Coordinator, Shift Supervisors, Resident Supervisors and with residents that only those individuals who had a need to know were aware of the sensitive information about the residents and the circumstances of an allegation. Protocol limits the information being shared to the Program Administrator, Program Manager, Program Coordinator, Caseworker, Resident Supervisor on the housing unit where the alleged incident occurred, and the Shift Supervisor.

| **Standard number here** | 115. 242 Use of screening information. |
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☐ Exceeds Standard (substantially exceeds requirement of standard)

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

FMLCCTC uses the information obtained from the risk screening to determine dorm and bed assignments based on their assessment of susceptibility (Dorm 103, 138, 208 and 222 for highly susceptible; or abusiveness (Dorm 104, 139, 209 and 223 for highly abusive). PREA beds are designated closest to the Phase Post in each of these dorms. The Auditor was given a

memo from the Program Administrator verifying this protocol, and the Auditor verified this practice during the facility tour and through staff and resident interviews.

The risk screening information is also used to inform the frequency of monitoring per shift (6 times per shift if the individual is assessed as highly susceptible or highly abusive). An individual will be placed on observation status until such time the Lead Resident Supervisor, Program Coordinator or Program Administrator determines the resident is no longer at risk.

The information is also used by the caseworker to determine programming, community service work and work assignments (kitchen, custodian chores in the facility) to minimize the risk of the resident being sexually victimized. Policy 1080, Chapter 1000, page 4/item 1, states that the admissions department will consider programming arrangements for transgender or intersex clients on a case-by-case basis to ensure the resident's health and safety, and whether the placement would represent management or security concerns. Further, the Oriana House Residential Programs, Intake and Background Information Form asks the resident if they have any concerns about being placed in a dorm with someone who is lesbian, gay, bisexual, transgender or intersex and if they feel vulnerable to sexual victimization. The Auditor verified through the interviews with the residents, including those who present to be lesbian and gay, that they were asked this question at intake.

Showering at FMLCCTC is only in individual showers to protect all individuals from sexual assault.

Policy 1080, Chapter 5, item 8, states that the Leadership Team will make an effort to separate those residents at high risk of being sexually victimized from those at high risk of being sexually abusive, within the limitations and resources available. The policy does not specifically prohibit the use of dedicated facilities, units or wings solely on the basis of their status; however, interviews indicated that, in practice, residents are not placed in dedicated facilities, units or wings solely on the basis of their gender.

| **Standard number here** | 115. 251 Resident reporting. |
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X☐ 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 comments, including corrective actions needed if does not meet standard**

Policy 1080, Page 8/item 1 (a-e), identifies multiple ways to allow residents to report sexual abuse and sexual harassment and retaliation by other clients or employees (by calling law enforcement, verbally telling a staff member, filling out the Client Sexual Abuse/Harassment Reporting Form, calling the Oriana House Client Sexual Abuse Hotline; emailing SexualAbuseReporting@orianahouse.org and calling toll-free the Division of Parole and Community Service, Ohio Department of Rehabilitation and Correction's (ODRC) PREA Hotline). The Client Handbook also states that the resident can call the Cleveland Rape Crisis Center if they need emergency medical services or crisis services and support. The Auditor observed the PREA posters displayed within the facility, reviewed and verified the reporting protocol in the Client Handbook, verified the Memorandum of Agreement with ODRC and verified the protocol with staff and residents in its interviews.

Policy 1080, Chapter 1000, Page 9/item 2, states that employees will accept reports verbally, in writing, anonymously, and from third parties. These reports will be forwarded to the Client

Sexual Abuse Response Team. The Auditor verified from interviews, from the posters, from the Client Sexual Abuse Reporting Form and from a March 28, 2014 memo that this policy is carried out in practice.

The Auditor verified through staff interviews the multiple ways staff can report privately sexual abuse and sexual harassment of residents, including verbally reporting it to their immediate supervisor, filing out the Sexual Abuse/Harassment Reporting Form, calling the Oriana House Client Sexual Abuse Hotline, and e-mailing the Sexual AbuseReporting@orianahouse.org. Since the agency has developed more than three ways for residents and staff to privately report, the Auditor determined that Oriana House exceeds this minimum standard.

| **Standard number here** | 115. 252 Exhaustion of administrative remedies. |
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☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

X Not Applicable

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

The agency has no administrative procedure to address resident grievances regarding sexual abuse; therefore FMLCCTC is exempt from this standard. Policy 8025 and 1080 states that all client grievances that involve allegations of sexual abuse or sexual harassment will be processed under the Client Sexual Abuse and Harassment Prevention Policy (Policy 1080). Clients are directed to their individual client handbooks for information and the Sexual Abuse/Harassment Reporting Form. If a client completes a Client Grievance Form when reporting an allegation of sexual abuse/sexual harassment, staff will treat the grievance as if it were filed properly and in accordance with the Client Sexual Abuse/Harassment Prevention Policy 1080. Staff will then follow all of the policy and procedures as stated in the Client Sexual Abuse/harassment Prevention Policy.

| **Standard number here** | 115.253 Resident access to outside confidential support services. |
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☐ Exceeds Standard (substantially exceeds requirement of standard)

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

Policy 1080, Chapter 1000, page 9, provides residents access to the Cleveland Rape Crisis Center as the outside victim advocate for confidential emotional support services. The policy indicates that reasonable communication is provided (agency must inform clients, prior to giving them access, of the extent to which such communications will be monitored and the extent to which reports of abuse will be forwarded to authorities in accordance with mandatory reporting laws). The Auditor verified through the Client Handbook and the Memorandum of Agreement between Oriana House and the Cleveland Rape Crisis Center that residents will be able to access the Rape Crisis Center at no cost to them for victim advocacy and emotional support services if needed.

| **Standard number here** | 115. 254 Third-party reporting. |
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X☐ 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 comments, including corrective actions needed if does not meet standard**

Policy 1080, Chapter 1000, page 9, states that a report from a family member, friend or any other third party is permitted on behalf of a resident. FMLCCTC provides several methods for third parties to report including filling out a Client Sexual Abuse Report Form, calling the Oriana House Client Sexual Abuse Hotline, and e-mailing the SexualAbuseReporting@orianahouse.org. Oriana House has developed a specific poster outlining the ways that family and friends can report on behalf of the resident. The Auditor verified that a poster is available outlining these methods. Since these methods go beyond the PREA standard, the Auditor determined that FMLCCTC exceeds the minimum.

| **Standard number here** | 115.261 Staff and agency reporting duties. |
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X☐ 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 comments, including corrective actions needed if does not meet standard**

Policy 1080, Chapter 1000, page 9-10/item 1, requires all staff to report immediately any knowledge, suspicion, or information they receive regarding an incident of sexual abuse or sexual harassment. Interviews with staff verified that they understood that they have a duty to report immediately without delay. Same policy prohibits staff from revealing any information related to sexual abuse report to anyone other than to make treatment, investigation and other security and management decisions. At FMLCCTC, the procedure is to report this information to the Lead Resident Supervisor, Shift Supervisor, Program Administrator, the Program Manager, and/or the Program Coordinator. Policy 1080 requires all employees and treatment providers to report all allegations to the Program Administrator. The Auditor verified that security staff understood they were to report allegations of sexual abuse and sexual harassment to the investigators. The Licensed Social Worker verified that he and his caseworkers have a duty to report sexual abuse or sexual harassment to the Clinical Director and to the Leadership Team.

FMLCCTC has developed a PREA Acknowledgement for visitors, contractors, vendors, volunteers, service providers, attorneys, clergy, etc. to read and sign when they enter the facility agreeing that they fully understand and will fully cooperate with Oriana House's zero-tolerance policy. This practice is unique and thus exceeds the PREA Standard.

| **Standard number here** | 115.262 Agency protection duties. |
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☐ Exceeds Standard (substantially exceeds requirement of standard)

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

Policy 1080, Chapter 1000, page 10, requires the agency to take immediate steps to protect the resident; the first staff to respond to the report shall separate the alleged victim and the abuser, preserve and protect any crime scene to allow law enforcement to collect evidence and to request the alleged victim and the alleged abuser to not take any actions that would destroy physical evidence.

From interviews with staff, the Auditor determined that the victim and the alleged abuser are separated immediately, the area in which the alleged incident took place is locked down in which no one is allowed to enter the area to destroy evidence, and the alleged victim and alleged abuser are instructed to not take any actions that would destroy physical evidence. If the alleged abuser remains in the facility, staff indicated that they will continue to separate the victim from the abuser and will place the victim on observation status for as long as they are at risk.

The assigned caseworker will also ensure that the victim has access to the Cleveland Rape Crisis Center if needed. The caseworker will provide crisis intervention counseling and support, information about community resources and referrals. The caseworker will also follow-up to ensure that legal advocacy and face-to-face crisis is provided. FMLCCTC has had no resident who reported to be at substantial risk of imminent sexual abuse in the past 12 months.

| **Standard number here** | 115.263 Reporting to other confinement facilities. |
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☐ Exceeds Standard (substantially exceeds requirement of standard)

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

Policy 1080, Chapter 1000, page 10, states that the Program Manager/Administrator shall notify in writing to the head of the facility where the alleged abuse occurred within 72 hours of receiving the allegation and that they have a duty to investigate the allegation in accordance with PREA standards. The policy requires a copy to be sent to the Vice President of Administration and Legal Counsel. In the past 12 months, there was one allegation of sexual abuse FMLCCTC received from other facilities.

| **Standard number here** | 115.264 Staff first responder duties. |
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☐ Exceeds Standard (substantially exceeds requirement of standard)

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

Policy 1080, pages 10-11, requires separation of the alleged victim from the alleged abuser, requires staff first responder to lock down the crime scene to preserve and protect physical evidence, requires the victim and the abuser to not destroy any physical evidence by not washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating, requires immediate reporting to the Program/Facility Administrator, Program Manager, PREA Coordinator, and to the investigator.

The Auditor requested guidance from the National PREA Resource Center regarding the time period for preserving evidence. According to the following clarification, the agency must take appropriate steps to collect and preserve evidence even if the time period has passed. This clarification is found in the Final Rule, June 20, 2012, page 37166.

"*The Department agrees that paragraph (a) (1), which requires the first responder to separate the alleged victim and the alleged abuser, and paragraph (a) (2), which requires that any crime scene be protected until appropriate steps can be taken to collect any evidence, should not be contingent upon the amount of time that has passed between the alleged incident of sexual abuse and the allegation. However, the Department remains of the view that it is appropriate to request that the alleged victim, and ensure that the alleged abuser, not take certain actions— such as brushing teeth, urinating, or drinking— only when the abuse occurred within a time period that still allows for the collection of physical evidence. Accordingly, the Department has removed the phrase "within a time period that still allows for the collection of physical evidence" from paragraph (a) and has added comparable language to paragraphs (a) (3) and (a) (4)".*

The Auditor verified that FMLCCTC requires the crime scene to be protected and that the appropriate steps be taken to preserve evidence. As stated in the Final Rule, June 20, 2012, page 37166, "physical evidence may persist for a long time and staff should assume that evidence may still be available in all cases". FMLCCTC does not limit the time to protect and preserve physical evidence consistent with the Final Rule. If there is a crime scene, FMLCCTC will preserve and protect it by clearing all clients and unnecessary staff from the area until law enforcement can assume responsibility of the crime scene.

The first responder protocol recommended by PREA requires immediate notification to medical and mental health practitioners of an alleged sexual abuse. Sexual abuse allegation leads to fear of safety and increased trauma that should be dealt with in the course of the medical and mental health treatment with their treatment provider. FMLCCTC immediately notifies Management staff, consisting of the Lead Resident Supervisor, Program Coordinator, Program Administrator or the Program Manager, by telephone, following the internal chain of command and shall notify by telephone the Clinical Director and if not available, the Clinical Administrator.

| **Standard number here** | 115.265 Coordinated response. |
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☐ Exceeds Standard (substantially exceeds requirement of standard)

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

FMLCCTC has its own Coordinated Response protocol that complies with the PREA Standard 115.264. It requires contacting the Cleveland Police Department to investigate criminal matters, it requires that in-house medical staff be notified, it requires a forensic medical exam, it requires that staff offer to contact the Cleveland Rape Crisis Center to request a victim advocate to accompany and support the victim through the forensic medical exam process and investigatory review, it requires that the FMLCCTC Leadership Team, Vice President of Administration and/Legal Counsel and Clinical Director be notified, it requires that an Incident Report be filed and the geographical Client Sexual Abuse Reporting group be notified. If the victim returns to the facility, the caseworker will be responsible for coordinating their evaluations, treatment and community follow up. The Auditor determined that the facility's Coordinated Response Policy meets this standard.

| **Standard number here** | 115.266 Preservation of ability to protect residents from contact with abusers. |
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☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

X Not applicable

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

The agency has no collective bargaining agreement.

| **Standard number here** | 115.267 Agency protection against retaliation. |
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☐ Exceeds Standard (substantially exceeds requirement of standard)

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

Policy 1080, Chapter 1000, page 11, protects all clients and employees who report abuse and harassment or who cooperate with investigations from retaliation. FMLCCTC's Program Manager has designated the Program Administrator to be responsible for monitoring the status of the resident on a weekly basis for 90 days after the incident has been reported or until the resident is released from the program to see if there are any changes that may suggest possible retaliation by residents or staff. Policy 1080 requires that the report shall describe the resident's physical appearance and emotional state and any changes or concerns.

FMLCCTC employs multiple ways to monitor individuals who fear retaliation, including bed and dorm changes; transfer to another facility while an investigation is pending, changes in employee assignments; offer crisis counseling by one of the Caseworkers or by a mental health agency in the community or refer to the Cleveland Rape Crisis Center. Staff can also be referred to the Employee Assistance Program, transferred to another facility or terminated.

The Auditor verified through its interviews with the Program Administrator that this protocol is followed.

| **Standard number here** | 115.271 Criminal and administrative agency investigations. |
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X☐ 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 comments, including corrective actions needed if does not meet standard**

Policy 1080, Chapter 1000, page 12, states that allegations of sexual abuse that are criminal in nature, the Client Sexual Abuse Response Team will refer the allegations to the Sheriff and to the Cleveland Police Department promptly, thoroughly and objectively, including third-party and anonymous reports. The investigators will report directly to the Cleveland Police Department who is responsible for managing the investigation and will direct the internal investigators in the gathering of evidence.

In instances of sexual harassment that are not criminal in nature, Oriana House will gather and preserve direct and circumstantial evidence, including any physical and available electronic data, shall interview victims, suspected perpetrators and witnesses and shall review prior complaints and reports.

The Auditor verified through its interviews with the investigators that this policy is carried out in practice. Investigators verified that they have received specialized training, and the Auditor reviewed the certificates of training documenting the specialized training provided to the investigators. Even if the Cleveland Police Department does not get involved, the agency investigators conduct administrative investigations. Once the investigator receives an Incident Review Report, a case file is developed to initiate the investigation. The Auditor verified through written investigations and confirmed through the interviews that the investigators are prompt in their initiation of the investigations and follow appropriate evidence gathering protocols. DNA evidence is left up to the local law enforcement based on an agreement with them. The investigators confirmed that residents are not subjected to polygraph examinations or other truth-telling devices as a condition of proceeding with the investigation.

The Client Sexual Abuse Review Team (CSART) conducts an administrative review on all investigations ordinarily within 30 days after the completion of the investigator's investigation to determine if staff's actions or failures to act contributed to the sexual abuse. The Auditor reviewed the investigation reports submitted by the investigators and CSART and verified that they conducted these investigations promptly, thoroughly and objectively.

The investigators establish credibility independently through its fact finding and whether the evidence is corroborated.

The investigators will continue their investigations even if the employee is terminated and even if the resident is discharged. Since the investigation policies and protocols go beyond the minimum PREA standard, the Auditor determined that FMLCCTC exceeds the minimum standard.

| **Standard number here** | 115.272 Evidentiary standards for administrative investigations. |
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☐ Exceeds Standard (substantially exceeds requirement of standard)

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

Policy 1080, Chapter 1000, page 12, states that Oriana House will not impose any other standard higher than a preponderance of the evidence in determining whether allegations of sexual abuse or sexual harassment are substantiated. The Auditor verified with the investigators that this standard is applied in determining whether allegations are substantiated.

| **Standard number here** | 115.273 Reporting to residents. |
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☐ Exceeds Standard (substantially exceeds requirement of standard)

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

Policy 1080, Chapter 1000, page 12, item 1, states that following an investigation into a resident's allegation of sexual abuse while in residence at FMLCCTC, the facility will notify the resident whether the allegation was substantiated, unsubstantiated or unfounded. The Auditor reviewed and verified that notification was given to residents of the outcomes of these investigations.

| **Standard number here** | 115.276 Disciplinary sanctions for staff. |
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☐ Exceeds Standard (substantially exceeds requirement of standard)

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

Policy 1080, Chapter 1000, page 13, states that employees shall be subject to disciplinary action up to and including termination. Policy 3037 Employee Discipline Policy, pages 1, 2, 4-6, outlines a progressive and corrective policy of disciplining staff. FMLCCTC had no staff within the past 12 months who violated agency sexual abuse or sexual harassment policies.

Further, agency policy requires FMLCCTC to report to law enforcement agencies and to any relevant licensing bodies all terminations, resignations by employees who would have been terminated for violations of Client Sexual Abuse and Sexual Harassment Prevention, unless the activity was not criminal. The Auditor verified with the investigators that staff is not permitted to resign if they are the subject of an investigation.

| **Standard number here** | 115.277 Corrective action for contractors and volunteers. |
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☐ Exceeds Standard (substantially exceeds requirement of standard)

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

Policy 1080, Chapter 1000, page 13, states that any contractor or volunteer who engages in sexual abuse shall be prohibited from contact with clients. The Auditor reviewed the report of one contract employee and found that this individual was terminated by the contracting agency due to unprofessional boundary issues. The Auditor interviewed the contractor, who confirmed that the staff member had been terminated.

| **Standard number here** | 115.278 Disciplinary sanctions for residents. |
|---|---|

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

Policy 1080, Chapter 1000, page 13, states that residents are subject to disciplinary action up to and including termination from the program following a substantiated allegation against them in sexual abuse or following a criminal finding of guilt for client-on-client sexual abuse. The policy states that the disciplinary process should consider whether a resident's mental disabilities or mental illness contributed to their behavior. Agency policy considers the client's mental disabilities or mental illness that contributed to his/her behavior, the client's disciplinary history and sanctions imposed for comparable offenses by other clients with similar histories, when determining what type of sanction, if any, should be imposed.

The Auditor confirmed through policy review, staff and resident interviews that FMLCCTC addresses the underlying reasons and motivation for the abuse. The agency's policy indicates that to address the underlying reasons and motivations for susceptibility or abusiveness, information from the screening will be used to develop targeted Individual Program Plan (IPP) goals and objectives to address the identified risk and needs assessment indicators. In addition, clients involved in Substance Abuse Treatment will collaborate with the Treatment Counselor to develop an Individual Treatment Plan. The plan will include screening information to target problems, goals, objectives, and activities that address the identified risk and needs assessment indicators, including sexual abuse and sexual harassment indicators. The FMLCCTC Counselor will make the appropriate referral to an outside professional to address and correct the underlying reasons and motivations for susceptibility or for abusiveness.

This Resident Disciplinary Policy indicates that a report of sexual abuse made in good faith based upon a reasonable belief that the alleged conduct occurred, shall not constitute falsely reporting an incident or lying, even if the investigation does not establish evidence sufficient to substantiate the allegation. Policy 1080, Chapter 1000, page 14, item 4, prohibits consensual sexual activity between clients. (All sexual activity violates Oriana House policy).

| **Standard number here** | 115.282 Access to emergency medical and mental health services. |
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☐ Exceeds Standard (substantially exceeds requirement of standard)

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

Policy 1080, Chapter 1000, page 14, indicates that residents who are victimized of sexual abuse shall receive timely, unimpeded access to emergency medical treatment and crisis intervention services, residents who are victims of sexual abuse will be offered medical treatment and offered timely information about and timely access to sexually transmitted infections prophylaxis in accordance with professionally accepted standards of care. Qualified medical and mental health practitioners in the community are available if needed. Further, the policy requires that these medical and mental health services are provided at no cost to the resident.

| **Standard number here** | 115.283 Ongoing medical and mental health care for sexual abuse victims and abusers. |
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☐ Exceeds Standard (substantially exceeds requirement of standard)

X☐ 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 comments, including corrective actions needed if does not meet standard**
Policy 1080, Chapter 1000, page 14, states that Oriana House will offer ongoing medical and mental health evaluations and, as appropriate, treatment to all residents who have been victimized by sexual abuse at no cost to the resident. Residents who have been victimized are offered medical and mental health evaluations and as appropriate, treatment and follow-up care. Interviews with caseworkers indicate that residents are offered on-going mental health treatment in the community, if medically necessary. Residents who are victims of sexual abuse will be offered medical treatment in the community and offered timely information about and timely access to sexually transmitted infections prophylaxis in accordance with professionally accepted standards of care. Policy states that FMLCCTC's treatment providers will conduct a mental health evaluation on resident-on-resident abusers within 60 days of learning of sexual abuse history and offer treatment when deemed appropriate.

| **Standard number here** | 115.286 Sexual abuse incident reviews. |
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☐ Exceeds Standard (substantially exceeds requirement of standard)

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

Policy 1080, Chapter 1000, page 15, states that the Vice President of Administration and Legal Counsel or designee shall activate a Client Sexual Abuse Review within 30 days of the conclusion of every sexual abuse investigation, including where the allegation has not been substantiated, unless the allegation has been determined to be unfounded. At FMLCCTC, the Regional Vice President of Correctional Programs for Oriana House conducts the Client Sexual Abuse Review ordinarily within 30 days after the conclusion of an investigation. The CSART consists of an upper management official designated by the Vice President of Administration and Legal Counsel, the Compliance/Accreditation Manager, the Admissions Manager, with input from a designated Resident Supervisor and/or Caseworker, Clinical Director, Internal Investigator and any other employees deemed appropriate.

The Auditor confirmed through its review of the CSART form, findings from the Client Sexual Abuse Review Team and from the interview with the Chair of the CSART that the CSART considers whether the incident or allegation was motivated by race, ethnicity, gender identify, gay, bisexual, transgender or intersex identification, status or perceived status, gang affiliation or was motivated or caused by other group dynamics. The CSART will assess the location where the sexual abuse occurred; assess the adequacy of the staff per post by examining the incident and circulation reports and the adequacy of the video monitoring.

| **Standard number here** | 115.287 Data collection. |
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☐ Exceeds Standard (substantially exceeds requirement of standard)

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

Policy 1080, Chapter 1000, page 15, item 4, states that Oriana House will track uniform data for every allegation of sexual abuse in all of its community corrections residential programs, and that the data collected answers all of the questions within the latest version of the Survey of Sexual Violence (SSV) conducted by the Department of Justice. The Auditor verified that this form is used by the agency for aggregating the sexual abuse data on an annual basis.

| **Standard number here** | 115.288 Data review for corrective action. |
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☐ Exceeds Standard (substantially exceeds requirement of standard)

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

Policy 1080, Chapter 1000, page 16, states that Oriana House collects and aggregates its data to assess and improve the effectiveness of Oriana House's community corrections residential programs' prevention, detection, and response policies, practices and training to identify problem areas, to take corrective action and to prepare an annual report of its findings. According to this policy, FMLCCTC will publish its annual report at **www.orianahouse.org.** The Vice President of Administration/Legal Counselor and the Vice President of Oriana House

will review and approve the annual report. The Auditor reviewed the agency's Research Policies (Policy 5001 and 5006), and verified that these policies require that personal identifiers and any specific material that would present a clear and specific threat to the safety and security of the facility be redacted.

| **Standard number here** | 115.289. Data storage, publication and destruction. |
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☐ Exceeds Standard (substantially exceeds requirement of standard)

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

Policy 1080, Chapter 1000, page 16, Policy 8006 and Policy 1027, state that all client files are confidential, requires files to be stored in locked storage areas, files will be stored for at least 10 years after the date of its initial collection, that the aggregated sexual abuse data will be published at least annually on the two agency websites, and that all personal identifiers will be redacted. The Auditor reviewed these policies and confirmed that FMLCCTC will store and publish the required sexual abuse data in accordance with the PREA standard.

**AUDITOR CERTIFICATION:**

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

Bobbie Huskey, MSW — April 24, 2015

Auditor Signature — Date