PREA AUDIT REPORT ☐ Interim ☒ Final

COMMUNITY CONFINEMENT FACILITIES

Date of report: 8/22/17

Auditor Information			
Auditor name: Jennifer Morgenstern			
Address: 124 Dennis Drive, Cortland, OH 44410			
Email: bnjmorg@hotmail.com			
Telephone number: 330-219-4453			
Date of facility visit: 7/20/17-7/21/17			
Facility Information			
Facility name: Eastern Ohio Correction Center			
Facility physical address: 470 OH 43, Wintersville, OH 43953			
Facility mailing address: *(if different from above)* Click here to enter text.			
Facility telephone number: 740-765-4324			
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: Eugene Gallo			
Number of staff assigned to the facility in the last 12 months: 50+			
Designed facility capacity: 86 Males / 35 Females			
Current population of facility: 74 Males / 33 Females			
Facility security levels/inmate custody levels: Medium			
Age range of the population: 18+			
Name of PREA Compliance Manager: Kayleen Murray		**Title:** Standards/MIS Manager	
Email address: kmurray@cbcf41.org		**Telephone number:** 740-765-4324 X116	
Agency Information			
Name of agency: Ohio Department of Rehabilitation and Correction			
Governing authority or parent agency: *(if applicable)* Facility Governing Board			
Physical address: 770 West Broad Street, Columbus, OH 43222			
Mailing address: *(if different from above)* Click here to enter text.			
Telephone number: 614-387-0588			
Agency Chief Executive Officer			
Name: Gary Mohr		**Title:** Director	
Email address: gary.mohr@odrc.state.oh.us		**Telephone number:** 614-387-0588	
Agency-Wide PREA Coordinator			
Name: N/A		**Title:** Click here to enter text.	
Email address: Click here to enter text.		**Telephone number:** Click here to enter text.	

AUDIT FINDINGS

NARRATIVE

A Prison Rape Elimination Act (PREA) on-site audit of the Eastern Ohio Correction Center (EOCC), Wintersville, OH was conducted on July 20, 2017 and July 21, 2017, by Jennifer R. Morgenstern, certified through the United States Department of Justice to conduct PREA audits of adult facilities. All pre-audit communication was conducted between myself and Kayleen Murray, the PREA Coordinator. A completed pre-audit questionnaire was completed by Mrs. Murray and submitted to Mrs. Morgenstern in a timely fashion. Documentation included, but is not limited to: facility policies and procedures, training materials, education materials, brochures, pamphlets, employment background checks, conversations with community agencies, and any other material designed to exhibit compliance with the PREA standards. This thorough review of documentation yielded numerous questions from the auditor which were answered promptly by the PREA Coordinator. All pre-audit questionnaire questions were answered thoroughly prior to the onsite audit.

EOCC houses it's male residents in the Wintersville, OH location and it's female residents in it's Lisbon, OH location. An onsite audit of the Wintersville location was conducted on July 20, 2017 and an onsite audit of the Lisbon, OH facility was conducted on July 21, 2017. During both onsite audits, the auditor was provided with a private, key entry office to work out of furnished with a desk and ample seating for confidential interviews. All confidential interviews were conducted with staff and residents only. The facility did not have any contractors or volunteers present at the time of either onsite interview. The auditor picked a random sample of seven (7) male residents and five (5) female residents to interview. Staff interviews included: the PREA Coordinator, facility head, specialized staff inclusive of first responders (security and non-security staff acting as such), intake staff, human resources staff, investigative staff, staff who screen for risk of victimization and abusiveness and staff on the incident review team. All interviews were conducted using the PREA Compliance Audit Instrument Interview Guides for respective staff members. A total of 13 staff members were interviewed representing a variety of treatment and security staff, staff from different shifts, and administrative staff. Similarly, all Resident interviews were conducted using the PREA Compliance Audit Instrument Interview Guide for Residents. Neither location currently housed any residents who were limited English proficient, transgender, intersex, gay, lesbian or bisexual. There were also no residents in either location who reported sexual harassment or sexual abuse. All resident line of questioning was geared toward gauging their knowledge of various reporting mecahnisms provided to them, their knowledge of their rights specifically to be free from sexual harassment, sexual abuse and retaliation for reporting such, the information provided to them at intake, their knowledge of pat down searches of residents, how they know staff of the opposite gender is in the housing area, if they have been victims of sexual harassment or abuse or know of any such abuse in the facility, their knowledge of services available to them should they report sexual abuse and their knowledge of whether the facility can require them to take a polygraph as a condition for proceeding with a sexual abuse investigation. Staff line of questioning was geared around their overall knowledge of the facility's zero tolerance policy, first responder duties and procedures for if a resident or fellow staff member alleges abuse or harassment.

Both onsite tours were conducted by the PREA Coordinator. During the tour, the auditor was able to see camera placement, PREA posters and signeage, notice of the upcoming audit, resident and staff interactions, dormitory and resident room layout, restroom layout, intake area, staff offices, the general areas and the group rooms. Both facility's had at least one PREA poster in each common area as well as in the dormitory and restrooms. Additionally the notice of the upcoming audit could be seen in approximately 4 different locations throughout each facility. The auditor was able to observe an intake during which staff asked the appropriate PREA related questions to the new resident. The auditor also observed the intake packet in which the resident was given a PREA pamphlet and numbers to contact should he feel he is the victim of sexual harassment or sexual abuse. Each restroom in the Wintersville location has a plastic curtain shielding view from the outside of the restroom into the inside. Additionally, each shower stall is equipped with a plastic curtain as well. Each urinal and toilet was separated by a plastic divider and no visibility of the shower or toilet areas is available from outside of the restroom. Similarly in the Lisbon location the restroom has a plastic curtain shielding view from the outside into the inside and each shower is furnished with it's own plastic curtain. The Lisbon location has private restroom stalls with locked doors. Each facility has a shower and toilet area for any transgender resident to be able to shower separately and privately. The auditor was also able to speak to staff and residents informally during the facility tour and other walk throughs of the facility at various times.

The following staff members and facility leadership were present duringn the onsite audit: Gene Gallo, Executive Director, Tracy Walenciej, Deputy Director, Kayleen Murray, Standards/MIS Manager/PREA Coordinator, Todd Cottrell, Operations Officer, Tammy Wolfe, Intake Officer, Patricia Allen, Program Administrator, John Craig, PREA Administrative Investigator and various resident supervisory staff, case managers and programming staff.

DESCRIPTION OF FACILITY CHARACTERISTICS

The Eastern Ohio Correction Center is a Community Based Correctional Facility that is designed to be a viable sentencing option to the surrounding county common pleas courts for it's adult felony offenders. EOCC's daily operations are overseen by the Executive Director, Eugene Gallo who is overseen by a Facility Governing Board. Ohio's community based correctional facility's are a part of the Ohio Department of Rehabilitation and Correction. EOCC services the following Ohio counties: Belmont, Carroll, Columbiana, Guernsey, Harrison, Jefferson, Monroe and Noble. EOCC currently employes a total of 48 staff members between both facility locations. The Wintersville location houses the administrative files and offices as well as the male residents of the facility and the Lisbon facility houses the female residents. The Wintersville location opened in 1990 and has a maximum capacity for 86 male residents aged 18 and above. The Lisbon facility opened in 2000 and was renovated from a county jail. It has a maximum capacity for 35 female residents aged 18 and above.

During the onsite audit, the Wintersville location had 74 male residents. Upon entrance to the facililty, the administrative offices are located in the front part of the facility prior to entering the resident accessible area. Upon entrance to the resident accessible portion of the facility is the kitchen and cafeteria. The kitchen is secure with all doors locked to staff access only. There is a pantry that the facility is looking to add a camera to this fiscal year. The kitchen is equipped with ample camera coverage and no blind spots were detected. The outside area was accessible through the kitchen exit. There is a garage that is locked at all times and only accessible to staff members. Upon entering the visitor entrance to the facility, a sally port area is located with two (2) chairs and a table only. This is the area where the facility has designated any alleged perpetrator will go to ensure no evidence is destroyed while waiting for the local sheriff to arrive to the facility. This room can also be monitored directly from Central Control. The intake room is located off of the sally port and past the resident housing area. All new intakes enter this room and are strip searched in the back of the room out of camera view. It should be noted that an intake was being processed during the tour and this auditor was able to hear the Resident Supervisory staff review the PREA information with the new resident. The facility does have a holding cell, however, the toilet is not accessible from the door and there is a plastic covering on the window to prevent visibility into the holding cell. The nurse's office is located next to the intake room. The nurse is a contract position therefore, the nurse's office is not staffed at all times. Strip searches are also conducted in this room with the nurse conducting them behind a partition so as not in staff's view. The facility has ample group space for counseling and group sessions for the residents as well as individual staff offices for private sessions with case managers and program staff. The day area of the facility has numerous chairs for recreation activities as well as a fenced in recreation outside yard. The housing units are located off of two hallways on each side of the day area. Each hallway has 10 resident rooms with the majority having four (4) beds per room and some with five (5) beds per room. Each hallway is also equipped with it's own restroom so the residents housed in that hallway use those toilet facilities and showers. After the last PREA audit, this facility added a plastic partition to each restroom entrance so the showers and toilet areas are not visitble to anyone passing the restroom. The facility layout allows for easy identification and separation of possible victims from possible abusers. Any resident identified as a possible victim will be placed in the room closest to the staff post. During the tour, this auditor heard a doorbell as well as saw a light flash that indicated there was a female present in the male housing area. Central Control is located off of the resident day area and is accessible to only staff as the door is locked at all times. All resident files are kept in Central Control minus the PREA information which is kept in the respective Case Manager's locked offices. All cameras are accessible and viewable from Central Control. There are a total of 26 cameras in this facility and are placed in all blind spot areas. The camera system is viewable from select staff member's homes as well. Off of Central Control is a row of staff offices which all have a window on the door for inside view of the office and resident group rooms which are all equipped with cameras and glass all around for easy visibility into the rooms. The entire facility is amply staffed and equipped with numerous cameras in an effort to prevent any type of misconduct from occurring. This facility is constantly looking at it's facility layout in order to determine any blind spots or areas that could be improved so as to continue to ensure the safety of all residents and staff. Throughout the facility there were numerous posters with PREA information posted as well as the onsite audit notice posted.

During the onsite audit, the Lisbon facility had 33 female residents in house and two (2) Resident Supervisors (one male, one female) on duty. This facility is typically staffed with two (2) staff members and three (3) staff members on busy operation days such as visitation. The facility has two (2) levels and a full basement as well as a fenced in outside area. Upon entering the facility, you can turn left to access a row of staff offices and the kitchen area. The kitchen is accessible to residents with staff supervision and escort. The kitchen has a camera and a pantry that has a mirror that shows any person in the pantry. The facility has decided to add a camera to the pantry in addition to the mirror so as to continue to cover any blind spots that may exist. To the right of the facility entrance is the sally port to the resident housing area. There is also a door to access the upstairs or downstairs and is locked and only accessible to staff. The main floor of the facility contains staff offices, resident group rooms and a day area. Central control is also located on this floor and has a view of all cameras in the facility. The facility has a total of 27 operable cameras, all of which eliminate any blind spots. There is an intake area off of the sally port where the intakes receive all of their pertinent PREA information and are strip searched. The facility also has a holding cell, however, visibility into it is not clear. The nurse's station has a camera view into it and a restroom off of it which is out of camera view. This restroom serves as the private restroom that any transgender residents can use. Off of the day area is an outside fenced in recreation area that also has cameras strategically placed so as to eliminate any blind spots.

The upstairs of the facility is where the resident dorms are located. The dormitory is divided up into four (4) sections, two (2) of which are in staff view and two (2) of which are not. The residents are not permitted in the dorm area without staff supervision throughout the day and must be buzzed up by staff as the door is locked. There is a staff post centrally located inside the dorm area that has a clear view to half of the dorm. The beds off to the side are for residents who are further along in their program and have earned more privileges.

Any resident identified as a possible victim/abuser is placed in the beds directly in staff view. There are no cameras in the resident dormitory. The beds are placed so there are no blindspots for residents to hide in the sections that are out of staff's view. There is also a laundry room that has a camera it. The restroom on the upper level has plastic curtains blocking off the view to the showers so there is no visibility from outside of the restroom. No male staff enters the dormitory without buzzing the doorbell and knocking and announcing his presence.

The basement of the facility has group rooms and numerous cameras strategically placed throughout. All residents have to be allowed down to the basement as it is locked. All residents in the basement can be viewed from central control through the cameras. There is one blindspot that this auditor detected downstairs and the recommendation was to install a camera so that staff could view that area from central control. The PREA Coordinator immediately met with staff and restricted resident movement to that area until the facility is able to install a camera in that hallway.

The Lisbon facility does a good job restricting the resident's movement and viewing the camera system in order to account for all residents effectively. The facility has a treatment feel to it although it was converted from a jail. There is no feel of a jail in the facility and the staff do a good job of making the best use of the space provided.

SUMMARY OF AUDIT FINDINGS

During the past 12 months, EOCC has had zero (0) reports of sexual harassment or sexual abuse. There was one (1) substantiated claim of staff on resident sexual harassment in 2015 and one (1) unsubstantiated claim of resident on resident sexual harassment in 2015.

All resident interviews verified the facility's diligent efforts in identifying to the residents numerous ways that they can report claims of sexual harassment or sexual abuse. Each resident was able to explain to this auditor in detail how they could report such claims. All residents verified that they were given such material at intake and that they all each still maintained a copy of the brochure that was given to them at intake as well outlining how they could report claims of sexual harassment or sexual abuse. All residents were very familiar with the posters throughout the facility and stated that they all knew they could have a third party report their claims or that they could be made anonymously. Each resident stated that they felt overall safe in this facility and felt that the facility did a good job keeping them safe. Each resident knew of the facility's zero tolerance policy as well.

All staff interviewed were able to explain the training they received on PREA and the facility's zero tolerance policy. Each staff was aware of their role in the facility's coordinated response plan and where they could find a copy of the plan. Each staff additionally could tell this auditor how they incorporate PREA training into their everyday job duties. The one resounding theme that this auditor received from all staff members interviewed is that PREA is part of the culture at EOCC in order to keep everyone safe. EOCC seems to have created a culture where all staff and residents feel comfortable reporting any concerns that they have and trust that these concerns will be taken seriously and investigated.

Number of standards exceeded: 1

Number of standards met: 35

Number of standards not met: 0

Number of standards not applicable: 3

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.

a. The facility has a written policy mandating zero tolerance toward all forms of sexual abuse and sexual harassment. The policy outlines the facility's approach to preventing, detecting and responding to all claims. The policy includes definitions of both sexual abuse and sexual harassment and is clear enough for any staff to understand their role and how it relates to their specific job duties.
b. The facility has designated the Standards/MIS Manager as their PREA Coordinator. This person has ample time to conduct her PREA duties and is given authority by the Executive Director to develop, implement and oversee the facility's efforts to comply with PREA. According to the organizational chart, the PREA Coordinator reports directly to the Executive Director and maintains an open level of communication to make and implement changes as she sees fit. The PREA Coordinator does an excellent job meeting with all staff on a regular basis to address any cocnerns related to PREA or resident safety and implements changes appropriately.

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.

Non-Applicable
EOCC does not contract with other entities for the confinement of it's 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.

a. The facility has a staffing plan that provides for adequate levels of staffing and video monitoring to protect residents against sexual abuse. The facility takes into consideration: the physical layout of the facility, the composition of the resident population, the prevalence of substantiated and unsubstantiated incidents of sexual abuse and any other relevant factors when determining the appropriate staffing levels and the need for video monitoring.
b. The facility documents all deviations and justification for the deviation from the staffing plan. No deviations were made during this reporting period.
c. The staffing plan requires the facility to assess, determine and document whether adjustments are needed to the staffing plan no less frequently than annually. The facility does an excellent job continually trying to find areas in which they can improve upon regarding resident safety. Cameras are continually updated to eliminate any potential blind spots and staff coverage is deployed adequately.

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.

a. The facility does not conduct cross-gender strip searches and body cavity searches are strictly prohibited. Any resident suspected of needing a body cavity search in order to protect the safety and security of the facility is not permitted to remain in residency. All strip searches are conducted by staff of the same sex as the offender. This was verified through all resident and staff interviews.
b. The facility does not permit cross-gender pat down searches. The Lisbon facility is always staffed with one female staff member, therefore, there is never a need for a cross-gender pat down search. All staff are appropriately trained on how to conduct pat down searches, therefore, any female treatment staff could also conduct a pat down search if necessary. Female resident's access to regularly available programming or other outside opportunites is never restricted in order to comply with this standard.
c. The facility has a policy that requires all cross-gender strip searches and cross-gender pat down searches be documented although they are not permitted per the policy.
d. The facility has policies and procedures that enable residents to shower, perform bodily functions and change clothing without nonmedical staff of the opposite gender viewing their breasts, buttocks, or genitalia, except in exigent circumstances or when such viewing is incidental to routine cell checks. Staff is required by policy to announce their presence when entering an area where residents are likely to be showing, performing bodily functions, or changing clothing. The facility goes above and beyond for this portion of the standard as staff of the opposite gender not only knock and audibly announce their presence, they also hit a button that rings a doorbell that can be heard throughout the resident day area and can be seen by a flashing light. All staff and residents, through interviews and this auditor visually observing this were able to explain what the doorbell meant. The facility has also installed plastic curtains leading into the restroom so that no incidental viewing is capable from outside of the restrooms.
e. Policy prohibits staff from searching or physically examininig a transgender or intersex resident for the sole purpose of determining the resident's genital status. If the resident's genital status is unknown, it may be determined during conversations with the resident, by reviewing medical records or, if necessary, by learning that information as part of a broader medical examination conducted in private by a medical practitioner.
f. All staff are trained on how to conduct cross-gender pat down searches and searches of transgender and intersex

residents, in a professional and respectful manner, and in the least intrusive manner possible, consistent with security needs. All staff interviewed were able to exhibit to this auditor how they would conduct a cross gender pat down search of a transgender or intersex resident including what they would say to the resident to explain the process. Again, cross-gender pat down searches are prohibited per policy.

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

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

a. The facility takes appropriate measures to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the facility's efforts to prevent, detect and respond to sexual abuse and sexual harassment. The facility maintains an extensive roster of court interpreters by language if a language barrier exists. The facility provides the residents with numerous ways of receiving PREA information such as viewing a video, receiving written pamphlets and handbooks and hearing the information presented to them from staff members.
b. The facility takes reasonable steps to ensure meaningful access to all aspects of the facility's efforts to prevent, detect and respond to sexual abuse and sexual harassment to residents who are limited English proficient through the use of an extensive roster of court interpreters in numerous languages.
c. Policy prohibits the use of relying upon resident interpreters, resident readers or other types of resident assistants except in limited circumstances where an extended delay in obtaining an effective interpreter could compromise the resident's safety or safety of the facility.

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.

a. The facility does not hire or promote anyone who may have contact with residents, and does not enlist the services of any contractor who may have contact with residents who have engaged in sexual abuse in other confinement facilities, has been convicted of engaging or attempting to engage in sexual activity in the community facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse of if they have been civilly or administratively adjudicated to have engaged in the activity described in paragraph (a)(2) of this standard.

b. The facility considers any incidents of sexual harassment in determining whether to hire or promote anyone, or to enlist the service of any contractor, who may have contact with residents.
c. Prior to hiring new employees who may have contact with residents, the agency: 1. Performs a criminal background records check, 2. Consistent with Federal, State and local law, makes its best efforts to contact all prior institutional employers for information on substantiated allegations of sexual abuse or any resignation during a pending investigation of an allegation of sexual abuse. A random check of eight (8) employee files verified the background records check had been conducted prior to the employee being hired. The files also verified that prior institional agencies had been contacted to verify that the persective employee did not engage in any type of sexual abuse or sexual harassment while employed with their institution.
d. The facility conducts a criminal background records check before enlisting the services of any contractor who may have contact with residents. Volunteer and contractor agreements were provided to verify that the facility conducted a criminal background records check prior to enlisting the services of the contractor or volunteer.
e. The facility conducts a criminal background records check at least every five (5) years of current employees and contractors who may have contact with residents or has a policy that describes a system for otherwise capturing such information for current employees. This information was verified through employee interviews as well as the Deputy Director verifying this process prior to hiring a perspective employee.
f. The facility asks all applicants and employees who may have contact with residents directly about previous misconduct described in paragraph (a) of this standard in written applications or interviews for hiring or promotions and in any interviews or written self-evaluations conducted as part of reviews of current employees. Employee files were provided for staff hired within the past year that verified these questions were asked in a staff Interview Evaluation Form. Facility policy also imposes upon employees a continuing affirmative duty to disclose any such misconduct.
g. Material omissions regarding such misconduct, or the provision of materially false information, shall be grounds for termination as stated in facility policy and provided to all employees.
h. Unless prohibited by law, the facility shall provide information on substantiated allegations of sexual abuse or sexual harassment involving a former employee upon receiving a request from an institutional employer for whom such employee has applied to work.

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.

a. N/A The facility has not acquired any new facility nor is it planning any substantial expansion or modification of it's existing facilities.
b. The facility is constantly looking to upgrade it's video monitoring system to ensure the continued protection of it's staff and residents. In doing so, the facility takes into consideration how such technology may enhance it's ability to protect residents from sexual abuse. During each staffing plan annual update meeting, the facility looks at it's video monitoring system and proposes any changes that should be put into place. The facility is currently looking to add one camera in the Lisbon facility per this auditor's request to eliminate a possible blind spot. It is also looking to add a 360 view camera to the Multi-Purpose Room and a stationary camera to the Recreation yard per the latest staffing plan meeting.

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.

a. All sexual abuse allegations are referred to the local Sheriff's department (Columbiana and Jefferson County) for criminal investigation. The facility asks that the local Sheriff's department follow a uniform evidence protocol that maximizes the potential for obtaining usable physical evidence for administrative proceedings and criminal prosecutions. Each staff memer that this auditor interviewed verified that the local Sheriff's department is to be contacted immediately upon any sexual abuse allegation or act taking place in either facility. The facility also has a Memorandum of Understanding with each Sheriff's Department for conducting such investigations.
b. The protocol the facility uses, was adapted from or otherwise based on the most recent edition of the Department Of Justice's Office on Violence Against Women, "A National Protocol for Sexual Assault Medical Forensic Examinations, Adults/Adolescents," or similarly comprehensive and authoritative protocols developed after 2011.
c. The facility has a policy that offers all victims of sexual abuse access to forensic medical examinations, without financial cost, where evidentiarily or medically appropriate. Such exams will be performed, per policy, by Sexual Assault Forensic Examiners (SAFE) or Sexual Assault Nurse Examiners (SANE) where possible. The facility will document it's efforts to provide SAFE's and SANE's in an instance where the exam could not be performed by one. All staff interviews verified that any resident suffering sexual abuse shall be given the opportunity to be examined by a SAFE or SANE at a local hospital and without cost to the resident.
d. Per policy, the facility makes available a victim advocate in house as well as a victim advocate from a rape crisis center. The facility has two (2) staff members who are trained to be victim advocates should the need arise. Both have extensive history of dealing with sexual assault victims and both have received special victim advocate training. This auditor verified with the local Americal Red Cross chapter that this service is provided to the residents of this facility per the MOU.
e. If requested by the resident, the victim advocate shall accompany and support him/her through the forensic medical examination process and investigatory interviews and shall provide emotional support, crisis intervention, information and referrals. This was verified through numerous staff interviews, facility policy and this auditor speaking with the local American Red Cross chapter who provides these services.
f. Per policy and MOU, EOCC requests that the Columbiana and Jefferson County Sheriff's Departments follow the requirements of paragraphs (a) through (e) of this section when investigating allegations of sexual abuse.

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.

a. EOCC has a policy stating that all sexual abuse and sexual harassment allegations will be investigated both administratively and criminally where applicable. Staff interviews verified that this procedure takes place.
b. EOCC has a policy stating that all sexual abuse allegations will be referred to the Jefferson and Columbiana County Sheriff's Departments for criminal investigation. All sexual harassment allegations will be administratively investigated by specialized staff of EOCC. The agency's zero tolerance policy is published on their website. All sexual abuse and sexual harassment allegations are documented in an investigation file and kept with the PREA Coordinator.
c. The facility's website describes the responsibilities of EOCC as well as the local Sheriff's Department in conducting criminal and administrative investigations.

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.

a. The facility has a detailed employee training curriculum for all staff on PREA. The PREA Coordinator ensures that all staff receive this training and that it includes (1-10) of this section. The training curriculum was provided to this auditor via power point presentation and was very detailed and thorough. The staff interviews also verified that this training takes place and each staff was very well versed on their responsibilities regarding PREA. The facility also does a very good job documenting that all staff receive this training. Additionally, EOCC has a culture that promotes any staff member to approach the PREA Coordinator should they have any questions or concerns regarding PREA.
b. Employee training is tailored to the gender of the resident's at the Wintersville and Lisbon facilities. If a staff member is assigned to both facilities, he/she receives training tailored toward both the female and male residents.
c. The facility has a policy that all current employees will be trained on PREA at the time of hire and will be provided with a refresher training every two years. In the off year that PREA is not provided, EOCC provides the facility's sexual abuse and sexual harassment policies to all staff.
d. All staff training is verified through sign in sheets and staff training records including the subject and date of training. Each staff verifies through their signature that they have received and understand the material provided to them. This was also verified through random review of staff files as well as staff interviews with this auditor.

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.

a. The facility ensures that all volunteers and contractors who have contact with residents will be trained on their responsibilities under the facility's sexual abuse and sexual harassment prevention, detection and response policies and procedures. There were no volunteers or contractors present at the time of the on-site audit to interview to ensure that this is taking place, however, the facility provided numerous volunteer and contractor agreements that included the person's signature verifying they received such training. The staff interviews also verified such training occurs as two of the staff members this auditor interviewed are responsible for conducting the volunteer and contractor training.
b. Per policy, the level and type of training provided to volunteers and contractors is based on the services they provide and level of contact they have with residents. All volunteers and contractors who have contact with residents receive the facility's zero tolerance policy regarding sexual abuse and sexual harassment and are informed on how to report such incidents. This again was verified through staff interviews as well as documentation of the training provided to volunteers and contractors.
c. The facility provided written documentation of each volunteer and contractor receiving such training as it is kept in their file located in administration. The documentation contains the signature of each volunteer and contractor verifiying that they understand the training that they have 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.

a. EOCC goes above and beyond when it comes to educating it's residents on the facility's zero tolerance policy regarding sexual abuse and sexual harassment, how to report such incidents, the resident's rights to be free from sexual abuse and harassment and to be free fom retaliation for reporting such incidents and regarding the facility's polcies and procedures for responding to such incidents. The facility provides each resident with verbal and written material explaining this upon intake. Each intake watches a video on PREA as well that explains everything in this standard. Each resident interview this auditor conducted verified that they understood the education provided to them and explained to me in detail their rights to be free from sexual abuse and harassment and retaliation for reporting such. Each resident stated that they appreciated the lengths that the facility goes to in order to ensure their safety.
b. N/A no residents of EOCC are transferred to a different facility during residency.
c. The facility provides resident education in formats accessible to all residents, including those who are limited English proficient, deaf, visually impaired or otherwise disabled as well as residents who have limited reading skills. During this auditor's walk through, I was able to observe an intake in which the PREA information was provided to the new resident in detail and at a very slow pace that was easy to follow and understand. The resident also watched a video on the PREA education and was provided written material as well. Adjustments are made to any resident's program who may need assistance in understanding the PREA education due to a disability.
d. The facility retains documentation in each Case Manager's office of each resident's receipt and understanding of the PREA education material provided to them.

e. The facility has numerous posters throughout each facility on how the residents are able to report any allegation of sexual abuse or sexual harassment. Such posters also include warning signs to look out for regarding sexual abuse or harassment. The facility also provides such information in the resident's handbook and in written pamphlets given to each resident at intake. This facility does an outstanding job of ensuring each resident is equipped with the knowledge of what sexual abuse and sexual harassment is and what they can do to report such. Each resident this auditor interviewed verified that they had received this training and was able to explain to me what the training entailed and who provided it to them.

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.

a. EOCC conducts all administrative investigations into sexual harassment and sexual abuse. All criminal investigations into sexual abuse are referred to the Columbiana and Jefferson County Sheriff's Departments for investigation. EOCC has two (2) staff members who have received specialized training into conducting such investigations in confinement settings in addition to their general PREA training. Staff interviews and training certificates verified this training took place.
b. Specialized training was provided by the Ohio Department of Rehabilitation and Correction and included techniques for interviewing sexual abuse victims, proper use of Miranda and Garrity Warnings, sexual abuse evidence collection in confinement settings, and the criteria and evidence required to substantiate a case for administrative action or prosecutioral referral.
c. Both staff members who received the specialized investigator training had training certificates in their respective training files. Staff interviews also verified their knowledge of the training provided to them.

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.

a. EOCC ensures that all medical and mental health contracted practitioners who work regularly in it's facilities have been trained in: how to detect and assess signs of sexual abuse and harassment; how to preserve physical evidence of sexual abuse; how to respond effectively and professionally to victims of sexual abuse and sexual harassment and; how to and to whom to report allegations or suspicions of sexual abuse and sexual harassment.

b. Contracted medical staff do not conduct forensic examinations. All forensic examinations are conducted at a local hospital by a qualified medical professional or a SAFE or SANE.
c. Documentation of the content of the specialized medical and mental health care standards training was provided to this auditor along with a training certificate for the contracted staff memers who received such training.
d. All contracted medical and mental health staff members also receive training mandated for contractors and volunteers under 115.232. Verification of their attendance along with a training curriculum and certificated were provided to this auditor and could be found in their respective contractor file.

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.

a. All residents of EOCC are screened for their risk of being sexually abused by other residents or sexually abusive toward other residents immediately upon their intake to the facility.
b. Such screening takes place immediately upon their intake to the facility and if that cannot be done, it is done within 72 hours of the resident's arrival at the facility. Documentation used to verify this standard was a resident's intake date matched up to the date they signed that they received PREA training which was located in their respective Case Manager's offices. Resident interviews also confirmed that all residents interviewed received this training immediately upon their arrival to the facility.
c. The screening is conducted using an objective screening instrument by staff qualified to do so.
d. The intake screening considers, at a minimum, the following criteria to assess the resident's risk for sexual victimization: whether the resident has a mental, physical, or developmental disability; the age of the resident; the physical build of the resident; whether the resident has previously been incarcerated; whether the resident's criminal history is exclusively nonviolent; whether the resident has prior convictions for sex offenses against an adult or child; whether the resident is or is perceived to be gay, lesbian, bisexual, transgender, intersex, or gender nonconforming; whether the resident has previously experienced sexual victimization; and the resident's own perception of vulnerability. This was verified through the facility's policy on the intake screening as well as the actual assessment used and the interview with the staff member who conducts such assessments.
e. The intake screening considers prior acts of sexual abuse, prior convictions for violent offenses and history of prior institutional violence or sexual abuse, as known to the facility, in assessing residents for risk of being sexually abusive.
f. Per policy, the facility will reassess the resident's risk of victimization or abusiveness based upon any additional, relevant information received by the facility since the intake screening.
g. Per policy, a resident's risk level shall be reassessed when warranted due to a referral, request, incident of sexual abuse, or receipt of additional information that bears on the resident's risk of sexual victimization or abusiveness.
h. Per policy, no resident will be disciplined for refusing to answer, or for not disclosing complete information in response to, questions asked pursuant to paragraphs (d)(1), (d)(7), (d)(8), or (d)(9) of this section.
i. The facility retains all PREA documentation in each Case Manager's office for the resident's on their case load. This information is locked in the respective Case Manager's office. Additionally, PREA sensitive information is located on the facility's computer and is only accessible through granted permission with a secure username and password of staff granted such access by the PREA Coordinator.

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.

a. The facility uses the information from the risk screening required by 115.241 to inform housing, bed, work, education and program assignments with the goal of keeping separate those residents at high risk of being sexually victimized from those at high risk of being sexually abusive. During the facility tours, this auditor was able to observe the housing area in which these residents would be placed so they are in a direct line of vision to the staff members. Staff interviews also verified that this information is used according to facility policy.
b. The facility makes individualized determinations about how to ensure the safety of each resident. This auditor reviewed numerous resident risk assessments with the recommendations from staff on whether that resident was at risk of being sexually abusive or abused while in the facility.
c. The facility considers on a case-by-case basis whether a placement of a transgender or intersex resident to the facility for male or female residents would ensure the resident's health and safety, and whether the placement would present management or security problems.
d. Per policy, a transgender or intersex resident's own views with respect to his/her own safety shall be given serious consideration.
e. Per policy, transgender and intersex residents shall be given the opportunity to shower separately from other residents. This auditor was able to view such showers during the facility tours.
f. Per policy, the facility does not place lesbian, gay, bisexual, transgender, or intersex residents in dedicated facilities, units, or wings solely on the basis of such identification or status, unless such placement is in a dedicated facility unit, or wing established in connection with a consent decree, legal settlement, or legal judgment for the purpose of protecting such residents.

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.

a. The facility provides multiple internal ways for residents to privately report sexual abuse and sexual harassment, retaliation by other residents or staff for reporting sexual abuse and sexual harassment, and staff neglect or violation of responsibilities that may have contributed to such incidents. All resident interviews confirmed their knowledge of multiple ways for them to report the above mentioned claims to staff. Additionally, all residents

stated that they felt comfortable coming to staff with any of these claims and felt confident that staff would take them seriously. Numerous posters are hanging throughout the facilities with contact information for the residents to report such claims. Residents are also given this information in writing during orientation and it is also located in their resident handbook.

b. The facility informs residents of at least one way to report abuse or harassment to a public or private entity or office that is not part of the facility and that is able to receive and immediately forward resident reports of sexual abuse and sexual harassment to facility officials, allowing the resident to remain anonymous upon request. Resident interviews also confirmed their knowledge of reporting these claims anonymously to someone other than EOCC staff members. All residents were able to tell me that their phone calls are free if they are reporting these claims and knew the contact information of the people to call. They also knew that they could report these claims anonymously. Posters hanging throughout the facilities also stated such information as well as the brochures and resident handbook they are given at intake.

c. Facility staff accepts reports made verbally, in writing, anonymously and from third parties and shall promptly document any verbal reports. Facility policy as well as staff interviews verified this takes place at both facilities.

d. The facility provides a method for staff to privately report sexual abuse and sexual harassment of residents. All staff interviewed verified that they knew the avenue they could take if they wanted to privately report sexual abuse and sexual harassment claims.

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.

a. N/A EOCC does not use grievances to address sexual abuse. Residents who may write a PREA allegation in the form of a grievance will have the allegation processed like any other PREA report. There is no limitation on when a report can be made.

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.

a. The facility provides residents with access to outside victim advocates for emotional support services related to sexual abuse by giving residents mailing addresses and telephone numbers including toll-free hotline numbers

where available, of local, state or national victim advocacy or rape crisis organizations, and by enabling reasonable communication between residents and these organizations, in as confidential a manner as possible. All residents are given a brochure during their intake with this information contained in it. The information is also posted throughout the facility and in the resident handbook. Additionally, all residents were able to tell this auditor during their interviews that they were knowledgeable of this service and knew that they could use the resident phones to do so toll-free. They also verified that they could go to any staff member with such claims and would be given access to report such claims in an office so as to increase the confidentiality of the claim. This auditor also verified with the phone number listed for the residents that this agency (The American Red Cross) accepts reports of sexual abuse and sexual harassment as well as provides support services listed in this standard.

b. The facility, per policy, informs residents 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. All residents verified with this auditor during interviews that they were aware that all staff are considered mandatory reporters and would report any claims of sexual abuse or harassment. They also stated that they knew they could report these claims via the resident phones anonymously and that such claims would be investigated as the agency they phone will contact the PREA Coordinator for the claims to be investigated.

c. The facility has a Memorandum of Understanding with the American Red Cross to ensure that residents are provide with confidential emotional support services related to sexual abuse. This auditor verified this MOU verbally with the American Red Cross and also in writing through documentation provided by the PREA Coordinator.

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.

Per policy, the facility has a method to receive third-party reports of sexual abuse and sexual harassment and distributes publicly information on how to report sexual abuse and sexual harassment on behalf of a resident. Both facilities have posters with third party reporting information hanging in the lobby that all visitors enter. Additionally each resident is given this information at intake. All residents confirmed during their interviews with this auditor that they were aware that a third party could make a claim on their behalf. EOCC also has this information posted on their website.

Standard 115.261 Staff and agency reporting duties

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These

recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

a. EOCC policy requires all staff to report immediately and according to policy, any knowledge, suspicion, or information regarding an incident of sexual abuse or sexual harassment that occurred in a facility, whether or not it is part of EOCC; retaliation against residents or staff who reported such an incident; and any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation. All staff confirmed in their interviews that they were aware of their duty to report this information immediately.
b. Per policy, apart from reporting to designated supervisors or officials, staff shall not reveal any information related to a sexual abuse report to anyone other than to the extent necessary, as specified in agency policy, to mae treatment, investigation, and other security and management decisions.
c. Unless otherwise precluded by Federal, State, or local law, medical and mental health practitioners shall be required per policy to report sexual abuse pursuant to paragraph (a) of this section and to inform residents of their duty to report, and the limitations of confidentiality, at the initiation of services.
d. Per policy, if the alleged victim is considered a vulnerable adult under a State or local vulnerable persons statute, the facility shall report the allegation to the designated State or local services agency under applicable mandatory reporting laws. The facility does not accept residents uder the age of 18.
e. Per policy, the facility shall report all allegations of sexual abuse and sexual harassment, including third-party and anonymous reports, to the facility's designated investigators. Staff interviews with the facility head as well as the PREA Coordinator and the PREA Special Investigator verified that all claims are reported and documented accordingly.

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.

Per policy, when the facility learns that a resident is subject to a substantial risk of imminent sexual abuse it shall take immediate action to protect the resident. All staff interviews confirmed that any staff learning of a resident's substantial risk of imminent sexual abuse would take immediate action to ensure that resident's safety. All staff were comfortable informing this auditor what steps they would take and did not hesitate to worry about potential consequences for not getting approval from a supervisor. All staff reported that the resident's safety and security is their number one concern at EOCC.

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.

a. Per policy, upon receiving an allegation that a resident was sexually abused while at another facility, the Executive Director or designee shall notify the head of the facility or appropriate office of the agency where the alleged abuse occurred. The PREA Coordinator provided documentation to support this policy.
b. Per policy, such notification shall be provided as soon as possible, but no later than 72 hours after receiving the allegation. Documentation provided verified that the notification occurred within 72 hours of receiving the claim.
c. The PREA Coordinator provided documentation to show that she made such notifications to other agencies and retains them in a special file.
d. Should the facility receive notification from another facility that a resident was assaulted while in residency, the allegation will be investigated in accordance with the PREA standards.

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.

a. In accordance with facility policy, upon learning of an allegation that a resident was sexually abused, the first security staff member to respond to the report shall be required to: separate the alleged victim and abuser, preserve and protect any crime scene until appropriate steps can be taken to collect any evidence; if the abuse occurred within a time period that still allows for the collection of physical evidence, request that the alleged victim and alleged abuser not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating. All staff interviewed including non-security staff were aware of first responder duties in accordance with the PREA standards. Each informed this auditor what they would do should they learn of an allegation that a resident was sexually abused. Additionally, the facilty has first responder duties posted in central control should staff not remember the correct protocol to follow in the situation.
b. If the first responder is not a security staff member, the responder shall be required to request that the alleged victim not take any actions that could destroy physical evidence and then notify security staff. All non-security staff interviewed were aware of their duties as first responders and stated to this auditor in accordance with facility policy what they would do should they come across a resident being sexually abused or having been sexually abused.

Standard 115.265 Coordinated response

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The facility has a written institutional plan to coordinate actions taken in response to an incident of sexual abuse, among staff first responders, medical and mental health practitioners, investigators, and facility leadership. The plan is posted in Central Control for all staff to review should they need it if the situation occurs. All staff interviewed was able to state the plan to this auditor and explain how their roles are important in preserving the scene and protecting the residents from further harm.

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.

N/A EOCC does not enter into collective bargaining agreements.

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.

a. The facility has a policy to protect all residents and staff who report sexual abuse or sexual harassment or cooperate with sexual abuse or sexual harassment investigations from relatiation by other residents or staff and shall designate which staff members or departments are charged with monitoring retaliation. All staff interviewed verified such policy exists and knew their part in ensuring the continued safety of the residents in the facility.
b. The facility employs multiple protection measures, such as housing changes or transfers for resident victims or abusers, removal of alleged staff or resident abusers from contact with victims, and emotional support services for residents or staff who fear retaliation for reporting sexual abuse or sexual harassment or for cooperating with investigations. All treatment staff interviewed gave this auditor numerous examples of protection and support measures the facility would take to protect and treat any resident who reported sexual abuse.
c. Per policy, the facility shall for at least 90 days following a report of sexual abuse, monitor the conduct and

treatment of residents or staff who reported the sexual abuse and of residents who were reported to have suffered sexual abuse to see if there are changes that may suggest possible retaliation by residents or staff, and shall act proptly to remedy any such retaliation. The facility will monitor any resident disciplinary reports, housing or program changes, or negative performance reviews or reassignments of staff. The facility will continue such monitoring beyond 90 days if the initial monitoring indicates a continuing need. No reports of sexual abuse have been made at the facility, therefore, no documentation was provided to verify the policy. All staff interviewed were aware of the policy and their role in ensuring the continued monitoring of the residents or staff who reported sexual abuse.

d. In the case of residents, such monitoring shall also include periodic status checks. All treatment staff interviewed verified that any resident reporting a claim of sexual abuse will continually be monitored to ensure the continued safety and treatment of the resident.
e. If any other individual who cooperates with an investigation expresses a fear of retaliation, the facility will take appropriate measures to protect that individual against retaliation. Both the special PREA investigator and the PREA Coordinator ensured that they would ensure appropriate measures were taken to protect any individual who reported such claims from retaliation.
f. Per policy, the facility's obligation to monitor shall terminate if the facility determines that the allegation is unfounded.

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.

a. All allegations of sexual abuse are referred to the Columbiana County Sheriff's Department and the Jefferson County Sheriff's Department for investigation. The facility conducts an administrative investigation for all allegations of sexual harassment. All investigations are conducted promptly, thoroughly and objectively for all allegations, including third-party and anonymous reports. This auditor was able to verify through the investigation conducted on the facility's substantiated claim of sexual harassment that the investigation was conducted in accordance with this standard. The Special PREA Investigator verified that he conducts all investigations promptly, thoroughly and objectively. The PREA Coordinator also verified such occurs.
b. Where sexual abuse is alleged, the facility uses investigators who have received special training in sexual abuse investigations pursuant to 115.234. All criminal investigations into sexual abuse are handled by the Columbiana and Jefferson County Sheriff's Departments. The facility currently has two (2) staff members, the PREA Coordinator and the Specialized PREA Investigator, both of whom have received special training in sexual abuse investigations pursuant to 115.234.
c. Per policy, investigators shall gather and preserve direct and circumstantial evidence, including any available physical and DNA evidence and any available electronic monitoring data; shall interview alleged victims, suspected perpetrators, and witnesses; and shall review prior complaints and reports of sexual abuse involving the suspected perpetrator.
d. When the quality of evidence appears to support criminal prosecution, the facility shall conduct compelled interviews only after consulting with prosecutors as to whether compelled interviews may be an obstacle for subsequent criminal prosecution.
e. The credibility of an alleged victim, suspect, or witness shall be assessed on an individual basis and shall not be

determined by the person's status as a resident or staff. The facility will not require a resident who alleges sexual abuse to submit to a polygraph or other truth telling device as a condition for proceeding with the investigation of such an allegation.

f. Administrative investigations; 1. Shall include an effort to determine whether staff actions or failures to act contributed to the abuse; and 2. Shall be documented in written reports that include a description of the physical and testimonial evidence, the reasoning behind credibility assessments, and investigative facts and findings. This auditor was able to review the administrative investigation into the sexual harassment allegation that was substantiated. There have been no allegations of sexual abuse at the facility.
g. Criminal investigations shall be documented in a written report that contains a thorough description of physical, testimonial, and documentary evidence and attaches copies of all documentary evidence where feasible.
h. Substantiated allegations of conduct that appears to be criminal shall be referred for prosecution.
i. The facility shall retain all written reports referenced in paragraphs (f) and (g) of this section for as long as the alleged abuser is incarcerated or employed by the facility, plus five (5) years.
j. The departure of the alleged abuser or victim from the employment or control of the facility shall not provide a basis for terminating an investigation.
k. N/A
l. When outside agencies investigate sexual abuse, the facility shall cooperate with outside investigators and shall endeavor to remain informed about the progress of the 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.

EOCC imposes no standard higher than a preponderance of the evidence in determining whether allegations of sexual abuse or sexual harassment are substantiated.

Standard 115.273 Reporting to residents

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

a. Per policy, following an investigation into a resident's allegation of sexual abuse suffered in the facility, the facility shall inform the resident as to whether the allegation has been determined to be substantiated, unsubstantiated, or

unfounded. No allegations of sexual abuse have occurred at this facility. The PREA Coordinator was able to verify this is the policy of the facility during her interview with this auditor.

b. If the facility did not conduct the investigation, it shall request the relevant information from the investigative agency in order to inform the resident.
c. Following the resident's allegation that a staff member has committed sexual abuse against the resident, the agency shall subsequently inform the resident (unless the allegation is determined to be unfounded) whenever: 1. The staff member is no longer posted within the resident's unit; 2. The staff member is no longer employed at the facility; 3. The facility learns that the staff member has been indicted on a charge related to sexual abuse within the facility; or 4. The facility learns that the staff member has been convicted on a charge related to sexual abuse within the facility.
d. Following a resident's allegation that he/she has been sexually abused by another resident, the facility shall subsequently inform the alleged victim whenever: 1. The facility learns that the alleged abuser has been indicted on a charge related to sexual abuse within the facility; or 2. The facility learns that the alleged abuser has been convicted on a charge related to sexual abuse within the facility.
e. All such notifications or attempted notifications shall be documented.
f. The facility's obligation to report under this standard shall terminate if the resident is released from the facility's custody.

Standard 115.276 Disciplinary sanctions for staff

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

a. Per policy, staff are subject to disciplinary sanctions up to and including termination for violating agency sexual abuse or sexual harassment policies. Documentation of this policy was verified through the investigative file of the substantiated claim of sexual harassment of a staff member to a resident. The staff members received disciplinary sanctions for their involvement in the harassment.
b. Initially, facility policy did not state that termination is the presumptive disciplinary sanction for staff who have engaged in sexual abuse. During the onsite portion of the audit, the PREA Coordinator presented this change to the Executive Director for approval. It was approved and sent to this auditor prior to the filing of the final report. Per policy, termination is now the presumptive disciplinary sanction for staff who have engaged in sexual abuse.
c. Disciplinary sanctions for violations of facility policies relating to sexual abuse or sexual harassment (other than actually engaging in sexual abuse) shall be commensurate with the nature and circumstances of the acts committed, the staff member's disciplinary history, and the sanctions imposed for comparable offenses by other staff with similar histories. The staff members involved in the sexual harassment substantiated claim all received disciplinary sanctions commensurate with the nature of the act, their own disciplinary history and the sanctions imposed for comparable offenses by other staff with similar histories.
d. All terminations for violations of facility sexual abuse or sexul harassment policies, or resignations by staff who would have been terminated if not for their resignation, shall be reported to law enforcemnent agencies, unless the activity was clearly not criminal, and to any relevant licensing bodies.

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.

a. Any contractor or volunteer who engages in sexual abuse shall be prohibited from contact with residents and shall be reported to law enforcement agencies, unless the activity was clearly not criminal, and to relevant licensing bodies.
b. The facility shall take appropriate remedial measures, and shall consider whether to prohibit further contact with residents, in the case of any other violation of agency sexual abuse or sexual harassment policies by a contractor or volunteer.

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.

a. Per policy, residents shall be subject to disciplinary sanctions pursuant to a formal disciplinary process following an administrative finding that the resident engaged in resident-on-resident sexual abuse or following a criminal finding of guilt for resident-on-resident sexual abuse.
b. Sanctions will be commensurate with the nature and circumstances of the abuse committed, the resident's disciplinary history, and the sanctions imposed for comparable offenses by other residents with similar histories.
c. The disciplinary process shall consider whether a resident's mental disabilities or mental illness contributed to his or her behavior when determining what type of sanction, if any, should be imposed. Although the facility has had no claims of resident-on-resident harassment or abuse, the PREA Coordinator was able to inform this auditor what the facility would take into consideration should an allegation be reported.
d. EOCC does not offer therapy, counseling, or other interventions designed to address and correct underlying reasons or motivations for sexual abuse.
e. Per policy, the facility will discipline a resident for sexual contact with staff only upon a finding that the staff member did not consent to such contact.
f. For the purpose of disciplinary action, 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 an investigation does not establish evidence sufficient to substantiate the allegation. All resident interviews confirmed that the residents are informed that they will not be sanctioned or receive any disciplinary action if they make a report of sexual abuse in good faith.
g. EOCC prohibits all sexual activity between residents and will discipline residents for such activity. The facility will not, however, deem such activity to constitute sexual abuse if it determines that the activity is not coerced. All residents are informed of the facility's policy prohibiting any sexual contact with each other and it is also listed in their resident handbook that they receive upon

intake.

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.

a. Per policy, any resident victim of sexual abuse will receive timely, unimpeded access to emergency medical treatment and crisis intervention services, the nature and scope of which are determined by medical and mental health practitioners according to their professional judgment. All residents verified in their interviews with this auditor that they knew of their right to receive access to emergency medical treatment and crisis intervention services should they become a victim of sexual abuse.
b. EOCC does not employ full time medical staff. Security staff first responders will take preliminary steps to protect the victim pursuant to 115.262 and will immediately notify the appropriate medical and mental health practitioners. All staff interviewed reported that they would get the victim emergency medical treatment by calling an ambulance and having that resident transported to the nearest hospital. Staff also stated that they would ask the resident if they wanted a victim advocate to accompany them to the hospital. Additionally, all staff were able to inform this auditor what steps they would immediately take to protect the victim pursuant to 115.262.
c. Resident victims of sexual abuse will be offered timely information about and timely access to emergency contraception and sexually transmitted infections prophylaxis, in accordance with professionally accepted standards of care, where medically appropriate. All residents interviewed confirmed that they know they will be offered this information should they become a victim of sexual abuse. All staff interviewed also knew that this right is to be offered to all resident victims of sexual abuse.
d. Treatment services will be provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident. All residents verified that they knew all treatment services will be provided to them without financial cost regardless of whether they name their abuser or cooperate with the investigation. All staff are aware of this resident right as well and verified such through staff interviews with this auditor.

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.

a. Staff will offer a medical and mental health evaluation and, as appropriate, treatment to all residents who have been victimized by sexual abuse in any prison, jail, lockup, or juvenile facility. All treatment staff interviewed confirmed that the resident's treatment plan would include anything that will help the resident's overall wellbeing during their residency.
b. The evaluation and treatment of such victims shall include, as appropriate, follow-up services, treatment plans, and, when necessary, referrals for continued care following their transfer to, or placement in, other facilities, or their release from custody. All treatment staff verified that they would provide referrals for continued care following the resident's release from the facility in order to ensure continuity of care.
c. The facility will provide such victims with medical and mental health services through community providers consistent with the community level of care provided at community based correctional facilities. All residents interviewed were aware that they would receive such treatment if they were a victim of such abuse in any other prior institution. Staff interviewed also stated that anything that could become a potential barrier to the resident's treatment will be a part of their treatment plan so that the resident's overall health is addressed while in residency.
d. Resident victims of sexually absusive vaginal penetration while incarcerated will be offered pregnancy tests per facility policy. All residents interviewed stated that they knew this right provided to them and felt comfortable asking for such service should they become a victim of sexually abusive vaginal penetration. All staff interviewed were aware of this right to be provided to residents as well.
e. If pregnancy results from conduct specified in paragraph (d) of this section, such victims shall receive timely and comprehensive information about and timely access to all lawful pregnancy related medical services. All staff and residents interviewed were aware of this right to be provided to victims of sexual abuse.
f. Resident victims of sexual abuse while incarcerated shall be offered tests for sexually transmitted infections as medically appropriate. All staff and residents interviewed were aware of this right to be provided to them should they become a victim of sexual abuse.
g. Treatment services will be provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident.
h. The facility will attempt to conduct a mental health evaluation of all known resident-on-resident abusers within 60 days of learning of such abuse history and offer treatment when deemed appropriate by mental health practitioners.

Standard 115.286 Sexual abuse incident reviews

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

a. The facility will conduct a sexual abuse incident review at the conclusion of every sexual abuse investigation, including where the allegation has not been substantiated, unless the allegation has been determined to be unfounded. EOCC has a Sexual Abuse Response Team (SART) tasked with conducting such incident reviews. All members of the SART team who were interviewed stated the goal of the SART team.
b. Such review shall ordinarily occur within 30 days of the conclusion of the investigation per facility policy.
c. The review team shall include upper-level management officials, with input from line supervisors, investigators, and medical or mental health practitioners. EOCC's SART team includes upper-level management, the PREA Coordinator, security staff, the PREA Investigator, and medical and mental health staff and any other staff member deemed necessary for each incident review.
d. The review team shall: 1. Consider whether the allegation or investigation indicates a need to change policy or practice to better

prevent, detect, or respond to sexual abuse; 2. Consider whether the incident or allegation was motivated by race; ethnicity; gender identity; lesbian, gay, bisexual, transgender, or intersex identification, status, or perceived status; or gang affiliation; or was motivated or otherwise caused by other group dynamics at the facility; 3. Examine the area in the facility where the incident allegedly occurred to assess whether physical barriers in the area may enable abuse; 4. Assesss the adequacy of staffing levels in that area during different shifts; 5. Assess whether monitoring technology should be deployed or augmented to supplement supervision by staff; and 6. Prepare a report of its findings, including but not necessarily limited to determinations made pursuant to paragraphs (d)(1)-(d)(5) of this section, and any recommendations for improvement, and submit such report to the facility head and PREA Compliance Manager. There have been no allegations of sexual abuse at EOCC therefore, no documentation of SART team reviews were available for review. Staff interviews of the members of the SART team, however, indicated what the SART team would do should an allegation of sexual abuse arise.

e. The facility shall implement the recommendations for improvement, or shall document its reasons for not doing so. EOCC is continuously looking for areas to improve their overall safety of staff and residents. The staffing plan reviews in addition to the SART team allow for constant recommendations for areas of improvement. All staff interviewed stated that they feel they can make recommendations to any member of the management team and they have seen implementation of such recommendations.

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.

a. The facility shall collect accurate, uniform data for every allegation of sexual abuse at the facility using a standardized instrument and set of definitions.
b. The facility shall aggregate the incident-based sexual abuse data at least annually.
c. The incident-based data collected shall include, at a minimum, the data necessary to answer all questions from the most recent version of the Survey of Sexual Violence conducted by the Department of Justice.
d. The facility shall maintain, review, and collect data as needed from all available incident-based documents including reports, investigation files, and sexual abuse incident reviews.
e. N/A EOCC does not contract with any other facility for confinement of it's residents.
f. Upon request, the facility shall provide all such data from the previous calendar year to the Department of Justice no later than June 30. The facility provided documentation of all Survey of Sexual Victimization summary reports for this audit cycle reporting period.

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.

a. Per policy, the facility shall review data collected and aggregated pursuant to 115.287 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training, including: 1. Identifying problem areas; 2. Taking corrective action on an ongoing basis; and 3. Preparing an annual report of its findings and corrective actions for each facility, as well as the agency as a whole.
b. Such report shall include a comparison of the current year's data and corrective actions with those from prior years and shall provide an assessment of the facility's progress in addressing sexual abuse. The facility provided documentation of each Annual Report for this audit cycle. Each report for this audic cycle contained a comparison of the current year's data ad corrective actions with those from prior years and provided an assessment of the facility's progress in addressing sexual abuse. During the most recent calendar year, the facility installed cross gender door bells at both facilities in order to alert residents when a member of the opposite sex is entering the bathroom or room/dorm areas. The facility also obtained a grant that allows them to increase the Digital Video Recording retention time for camera playback. The most recent Annual Report also contained discussion of the facility applying for a grant to cover a blind spot area located in the Wintersville facility's kitchen pantry area.
c. The facility's report shall be approved by the facility head and made readily available to the public through its website or, if it does not have one, through other means. All reports were approved by the Executive Director and were able to be found on EOCC's website.
d. The facility may redact specific material from the reports when publication would present a clear and specific threat to the safety and security of the facility, but must indicate the nature of the material redacted.

Standard 115.289 Data storage, publication, and destruction

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

a. The facility shall ensure that data collected pursuant to 115.287 is securely retained. The PREA Coordinator verified that all data collected pursuant to 115.287 is securely retained.
b. The facility shall make all aggregated sexual abuse data readily available to the public at least annually through its website, or if it does not have one, through other means. Data could be found on EOCC's website which is available to the public.
c. Before making aggregated sexual abuse data publicly available, the facility shall remove all personal identifiers.
d. The facility shall maintain sexual abuse data collected pursuant to 115.287 for at least 10 years after the date of the initial collection unless Federal, State, or local law requires otherwise. The PREA Coordinator was knowledgeable regarding the retention of such data.

AUDITOR CERTIFICATION

I certify that:

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

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

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

Jennifer R. Morgenstern 8/21/17

Auditor Signature Date