

Prison Rape Elimination Act (PREA) Audit Report Community Confinement Facilities

Interim Final

Date of Interim Audit Report: Click or tap here to enter text. N/A

If no Interim Audit Report, select N/A

Date of Final Audit Report: January 20, 2022

Auditor Information

Name: Wallace G. Bump	Email: Wallace.bump@dhs.wisconsin.gov
Company Name: Wisconsin Department of Corrections	
Mailing Address: PO Box 16	City, State, Zip: Winnebago, WI 54985
Telephone: 920-4263410 X4702	Date of Facility Visit: 12/07/2021

Agency Information

Name of Agency: Washington State Department of Corrections			
Governing Authority or Parent Agency (If Applicable): State of Washington, Office of the Governor			
Physical Address: 7345 Linderson Way SE		City, State, Zip: Olympia WA 98504-1100	
Mailing Address: PO Box 41100		City, State, Zip: <small>Click or tap here to enter text.</small>	
The Agency Is:	<input type="checkbox"/> Military	<input type="checkbox"/> Private for Profit	<input type="checkbox"/> Private not for Profit
<input type="checkbox"/> Municipal	<input type="checkbox"/> County	<input checked="" type="checkbox"/> State	<input type="checkbox"/> Federal
Agency Website with PREA Information: http://www.doc.wa.gov/corrections/prea/default.htm			

Agency Chief Executive Officer

Name: Stephen Sinclair, Secretary	
Email: sdsinclair@doc1.wa.gov	Telephone: 360-725-8810

Agency-Wide PREA Coordinator

Name: Beth Schubach, Agency PREA Coordinator	
Email: blschubach1@doc1.wa.gov	Telephone: 360-725-8789
PREA Coordinator Reports to: Deputy Director of Prison Command	Number of Compliance Managers who report to the PREA Coordinator: 30

Facility Information

Name of Facility: Eleanor Chase Work Training Release

Physical Address: 427 W. 7th

City, State, Zip: Spokane, WA. 99204

Mailing Address (if different from above):
Click or tap here to enter text.

City, State, Zip: Click or tap here to enter text.

The Facility Is:

Military

Private for Profit

Private not for Profit

Municipal

County

State

Federal

Facility Website with PREA Information: <http://www.doc.wa.gov/corrections/prea/default.htm>

Has the facility been accredited within the past 3 years? Yes No

If the facility has been accredited within the past 3 years, select the accrediting organization(s) – select all that apply (N/A if the facility has not been accredited within the past 3 years):

ACA

NCCHC

CALEA

Other (please name or describe: Click or tap here to enter text.

N/A

If the facility has completed any internal or external audits other than those that resulted in accreditation, please describe:
Click or tap here to enter text.

Facility Director

Name: Laura Jense, Community Corrections Supervisor

Email: ljjense@doc1.wa.gov

Telephone: 509-319-0688

Facility PREA Compliance Manager

Name: Laura Jense, Community Corrections Supervisor

Email: ljjense@doc1.wa.gov

Telephone: 509-319-0688

Facility Health Service Administrator N/A

Name: Scott Russell, Deputy Director –Health Services Administration

Email: sjrussell@doc1.wa.gov

Telephone: 360-725-8840

Facility Characteristics

Designated Facility Capacity:

55

Current Population of Facility:

14

Average daily population for the past 12 months:	15
Has the facility been over capacity at any point in the past 12 months?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Which population(s) does the facility hold?	<input checked="" type="checkbox"/> Females <input type="checkbox"/> Males <input type="checkbox"/> Both Females and Males
Age range of population:	18 and up
Average length of stay or time under supervision	4 months
Facility security levels/resident custody levels	Minimum (M1)
Number of residents admitted to facility during the past 12 months	35
Number of residents admitted to facility during the past 12 months whose length of stay in the facility was for 72 hours or more:	35
Number of residents admitted to facility during the past 12 months whose length of stay in the facility was for 30 days or more:	35
Does the audited facility hold residents for one or more other agencies (e.g. a State correctional agency, U.S. Marshals Service, Bureau of Prisons, U.S. Immigration and Customs Enforcement)?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Select all other agencies for which the audited facility holds residents: Select all that apply (N/A if the audited facility does not hold residents for any other agency or agencies):	<input type="checkbox"/> Federal Bureau of Prisons <input type="checkbox"/> U.S. Marshals Service <input type="checkbox"/> U.S. Immigration and Customs Enforcement <input type="checkbox"/> Bureau of Indian Affairs <input type="checkbox"/> U.S. Military branch <input type="checkbox"/> State or Territorial correctional agency <input type="checkbox"/> County correctional or detention agency <input type="checkbox"/> Judicial district correctional or detention facility <input type="checkbox"/> City or municipal correctional or detention facility (e.g. police lockup or city jail) <input type="checkbox"/> Private corrections or detention provider <input type="checkbox"/> Other - please name or describe: Click or tap here to enter text. <input checked="" type="checkbox"/> N/A
Number of staff currently employed by the facility who may have contact with residents:	27
Number of staff hired by the facility during the past 12 months who may have contact with residents:	12
Number of contracts in the past 12 months for services with contractors who may have contact with residents:	2
Number of individual contractors who have contact with residents, currently authorized to enter the facility:	15
Number of volunteers who have contact with residents, currently authorized to enter the facility:	0

Physical Plant

<p>Number of buildings:</p> <p>Auditors should count all buildings that are part of the facility, whether residents are formally allowed to enter them or not. In situations where temporary structures have been erected (e.g., tents) the auditor should use their discretion to determine whether to include the structure in the overall count of buildings. As a general rule, if a temporary structure is regularly or routinely used to hold or house residents, or if the temporary structure is used to house or support operational functions for more than a short period of time (e.g., an emergency situation), it should be included in the overall count of buildings.</p>	1
<p>Number of resident housing units:</p> <p>Enter 0 if the facility does not have discrete housing units. DOJ PREA Working Group FAQ on the definition of a housing unit: How is a "housing unit" defined for the purposes of the PREA Standards? The question has been raised in particular as it relates to facilities that have adjacent or interconnected units. The most common concept of a housing unit is architectural. The generally agreed-upon definition is a space that is enclosed by physical barriers accessed through one or more doors of various types, including commercial-grade swing doors, steel sliding doors, interlocking sally port doors, etc. In addition to the primary entrance and exit, additional doors are often included to meet life safety codes. The unit contains sleeping space, sanitary facilities (including toilets, lavatories, and showers), and a dayroom or leisure space in differing configurations. Many facilities are designed with modules or pods clustered around a control room. This multiple-pod design provides the facility with certain staff efficiencies and economies of scale. At the same time, the design affords the flexibility to separately house residents of differing security levels, or who are grouped by some other operational or service scheme. Generally, the control room is enclosed by security glass, and in some cases, this allows residents to see into neighboring pods. However, observation from one unit to another is usually limited by angled site lines. In some cases, the facility has prevented this entirely by installing one-way glass. Both the architectural design and functional use of these multiple pods indicate that they are managed as distinct housing units.</p>	1 with three halls (A,B and C)
<p>Number of single resident cells, rooms, or other enclosures:</p>	0
<p>Number of multiple occupancy cells, rooms, or other enclosures:</p>	18 - Currently no rooms have multiple occupancy
<p>Number of open bay/dorm housing units:</p>	0
<p>Does the facility have a video monitoring system, electronic surveillance system, or other monitoring technology (e.g. cameras, etc.)?</p>	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
<p>Has the facility installed or updated a video monitoring system, electronic surveillance system, or other monitoring technology in the past 12 months?</p>	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
<h3>Medical and Mental Health Services and Forensic Medical Exams</h3>	
<p>Are medical services provided on-site?</p>	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
<p>Are mental health services provided on-site?</p>	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No

<p>Where are sexual assault forensic medical exams provided? Select all that apply.</p>	<input type="checkbox"/> On-site <input checked="" type="checkbox"/> Local hospital/clinic <input type="checkbox"/> Rape Crisis Center <input type="checkbox"/> Other (please name or describe: Click or tap here to enter text.)
<p>Investigations</p>	
<p>Criminal Investigations</p>	
<p>Number of investigators employed by the agency and/or facility who are responsible for conducting CRIMINAL investigations into allegations of sexual abuse or sexual harassment:</p>	<p>0</p>
<p>When the facility received allegations of sexual abuse or sexual harassment (whether staff-on-resident or resident-on-resident), CRIMINAL INVESTIGATIONS are conducted by: Select all that apply.</p>	<input type="checkbox"/> Facility investigators <input type="checkbox"/> Agency investigators <input checked="" type="checkbox"/> An external investigative entity
<p>Select all external entities responsible for CRIMINAL INVESTIGATIONS: Select all that apply (N/A if no external entities are responsible for criminal investigations)</p>	<input checked="" type="checkbox"/> Local police department <input type="checkbox"/> Local sheriff's department <input type="checkbox"/> State police <input type="checkbox"/> A U.S. Department of Justice component <input type="checkbox"/> Other (please name or describe: Click or tap here to enter text.) <input type="checkbox"/> N/A
<p>Administrative Investigations</p>	
<p>Number of investigators employed by the agency and/or facility who are responsible for conducting ADMINISTRATIVE investigations into allegations of sexual abuse or sexual harassment?</p>	<p>742</p>
<p>When the facility receives allegations of sexual abuse or sexual harassment (whether staff-on-resident or resident-on-resident), ADMINISTRATIVE INVESTIGATIONS are conducted by: Select all that apply</p>	<input type="checkbox"/> Facility investigators <input checked="" type="checkbox"/> Agency investigators <input type="checkbox"/> An external investigative entity
<p>Select all external entities responsible for ADMINISTRATIVE INVESTIGATIONS: Select all that apply (N/A if no external entities are responsible for administrative investigations)</p>	<input type="checkbox"/> Local police department <input type="checkbox"/> Local sheriff's department <input type="checkbox"/> State police <input type="checkbox"/> A U.S. Department of Justice component <input type="checkbox"/> Other (please name or describe: Click or tap here to enter text.) <input checked="" type="checkbox"/> N/A

Audit Findings

Audit Narrative

Wallace Bump and Kimberly Betzhold, U.S. Department of Justice probationary Prison Rape Elimination Act (PREA) auditors for adult facilities were selected as the auditors for the PREA Audit of the Eleanor Chase House Work Release (ECHWR) of the Washington Department of Corrections (WADOC). Wallace Bump was selected to be the lead auditor by The Wisconsin Department of Corrections (WIDOC) PREA Coordinator, who represents WIDOC in the Western States Consortium. The On-Site portion of the audit was conducted on 12/7/2021. Due to the preference of WADOC, The audit will be completed using the paper audit portal of the Online Audit System (OAS).

ECHWR was last audited on 8/28-29/2017 by Deborah Striplin.

The onsite portion of this audit was originally planned for 10/21-22/2020. On 8/25/2020, the auditor was notified by the WADOC PREA Coordinator Beth Schubach that the audit would need to be postponed due to restrictions of the Covid-19 pandemic. The WADOC PREA Coordinator requested that the pre-onsite portion of the audit along with telephonic/zoom interviews with staff move forward. On 8/31/2020, the WIDOC PREA Coordinator Leigha Weber notified the auditor that we would move forward and grant the request made by the WADOC PREA Coordinator.

An initial conference call between the facility and the auditor was scheduled for 9/14/2020. On 9/7/2020, The WADOC PREA Coordinator emailed the auditor saying that the Pre-Audit Questionnaire (PAQ) and other supporting documentation would be delivered by mail. The auditor received the PAQ and additional documentation on 9/11/2020. The Documentation was stored on a password protected external drive. On 9/13/2020, the auditor began to review the provided PAQ and documentation.

Kick-Off Meeting: The Kick-Off Meeting was conducted on 9/14/2020, at 10:30 AM (PST). The meeting was conducted via conference call with WADOC PREA Coordinator, ECHWR Facility Supervisor and Lead Auditor Wallace Bump in attendance. Preliminary logistics were discussed to include unimpeded access to the facility, documents, and staff. The facility was given an overview of the audit process, with the desired goal and expectations of the audit. The purpose of corrective action was discussed as an expectation and an opportunity to enhance practices. A communications schedule was completed with the lead auditor responsible for scheduling bi-weekly conference calls until the on-site audit. Following the on-site audit, a communication schedule will be established for the remainder of the audit. Timelines and milestones of the audit were discussed and an audit process map was sent electronically to all participants. Community Corrections Supervisor (CCS) Laura Jense was identified as the point of contact for ECHWR. A temporary notice of the audit was created until a date for the onsite audit could be established.

See, *generally*, Standard 115.401. The methodology of the audit process was discussed to include explanation of the pre-onsite, onsite and post onsite phases of the process.

10/2/2020, the auditor received photos of the new notice and locations where the notice had been displayed. The final notice for the 12/07/2021 onsite audit were posted on 10/22/2021. The auditor was provided time stamped photos of the notice and locations for posting.

November 10th, 2020, telephone interviews of staff from WADOC and ECHWR began.

The following interviews were completed: It should be noted that on 11/30/2020, that a special announcement was put out by the PREA Resource Center titled, "Guidance on Virtual Audits". This guidance prohibited telephone or electronic interviews of non-supervisory staff and offenders.

11/10/2020 – Agency Contract Administrator, WADOC
11/12/2020 – Agency PREA Coordinator, WADOC
12/03/2020 – Facility Head, ECHWR
12/22/2020 – Agency Head, WADOC

On 12/10/2020, a conference call was held between the auditors and the facility. During this call, the WADOC Agency PREA Coordinator notified the auditor that The Department of Justice (DOJ) would be creating a separate OAS site for this audit due to security concerns that WADOC has with electronic transfer of materials. It was also decided during this conference call that the Agency and Facility would provide monthly updated materials to the auditor since it did not appear that travel bans and precautions implemented due to the Covid-19 pandemic would allow for onsite auditing in the near future. The updated materials were uploaded to the alternative OAS site created by the DOJ from 01/2021 – 11/2021.

On 5/15/2021, the travel bans were lifted and the onsite audit date of 9/29/2021 was established.

On 9/21/2021, the onsite audit was once again postponed due to a covid-19 outbreak in Spokane, Washington. The outbreak had infected key members of the ECHWR audit preparation team and risked the health of the auditors and residents. A new date of 12/7/2021 was established.

12/2/2021, a schedule for the onsite audit was finalized between the point of contact at ECHWR and the auditors. The auditors explained that they had a rental vehicle and would be responsible for travel to and from the audit site. Facility Head, CCS Laura Jense agreed to update all previously requested lists and deliver to the auditors prior to the travel date of 12/5/2021. The last of the lists were updated and delivered 12/4/2021.

Pre-Onsite Audit Phase

Request for Identification of Inmates, Staff and Documents: On July 23rd, 2021, the auditor notified the point of contact at the ECHWR of the information and lists that would need to be available for the onsite portion of the audit. The auditor explained the methodology utilized in sampling the information and identifying staff, volunteers, contractors and offenders for interviews. Due to the onsite audit being postponed until 12/07/2021, the below lists were updated and provided to the auditors on 12/04/2021.

From these listings, the auditor selected representative samples for interviews (i.e., inmate and staff) and documented reviews during the onsite portion of the audit. The listings requested by the auditor in the pre-onsite audit phase included:

1. Complete inmate roster (provide based on actual population on the first day of the onsite portion of the audit)
2. Youthful inmates (if any)
3. Inmates with disabilities (i.e., physical disabilities, blind, deaf, hard of hearing, cognitive disabilities)
4. Inmates who are Limited English Proficient (LEP)
5. Lesbian, Gay, Bisexual, Transgender and Intersex (LGBTI) Inmates (identify all inmates in each category)
6. Inmates in segregated housing
7. Inmates who reported sexual abuse

8. Inmates who reported sexual victimization during risk screening
9. Complete staff roster (indicating title, shift, and post assignment)
10. Specialized staff which includes:
 - A. Agency contract administrator
 - B. Intermediate- or higher-level facility staff responsible for conducting and documenting unannounced rounds to identify and deter staff sexual abuse and sexual harassment
 - C. Line staff who supervise youthful inmates, if any
 - D. Education staff who work with youthful inmates, if any
 - E. Program staff who work with youthful inmates, if any
 - F. Medical staff
 - G. Mental health staff
 - H. Non-medical staff involved in cross-gender strip or visual searches
 - I. Administrative (human resources) staff
 - J. SAFE and/or SANE staff
 - K. Volunteers who have contact with inmates
 - L. Contractors who have contact with inmates
 - M. Criminal investigative staff (e.g., at agency level, facility level, external entity, etc.)
 - N. Administrative investigative staff (e.g., at agency level, facility level, external entity, etc.)
 - O. Staff who perform screening for risk of victimization and abusiveness
 - P. Staff who supervise inmates in segregated housing
 - Q. Staff on the sexual abuse incident review team
 - R. Designated staff member charged with monitoring retaliation
 - S. First responders², security staff (individuals who have responded to an incident of sexual abuse)
 - T. First responders³, non-security staff (individuals who have responded to an incident of sexual abuse)
 - U. Intake staff
11. All grievances made in the 12 months preceding the audit
12. All incident reports from the 12 months preceding the audit
13. All allegations of sexual abuse and sexual harassment reported for investigation in the 12 months preceding the audit including:
 - A. Total number of allegations
 - B. Number determined to be substantiated, unsubstantiated, or unfounded
 - C. Number of cases in progress
 - D. Number of criminal cases investigations
 - E. Number of administrative case investigations

14. All hotline calls made during the 12 months preceding the audit

10/22/2021 – Audit Notice posted throughout the facility. Time stamped photos of the notice forwarded to the auditor.

The auditor reviewed the Pre-Audit Questionnaire, policies, procedures and supporting documentation supplied by the agency/facility. Information obtained from this documentation was entered into the Auditor Compliance Tool for community confinement facilities.

Outreach to Advocacy Organizations: The following organizations were contacted by the auditor

Washington Coalition of Sexual Assault Programs (WCSAP). WCSAP did not have any complaints against ECHWR or requests for services from ECHWR residents.

Just Detention who reported that they had not received any complaints against ECHWR.

The Office of Victim Services for the state of Washington. This contact was made to verify that residents could reach this office from the posted number and to identify the services offered and how they are obtained by residents

Onsite Audit Phase

0500 – Arrival:

Upon arrival at ECHWR, auditors were required to complete a rapid covid test prior to entry into the facility. At approximately 0520, a corrections tech from ECHWR notified the auditors that they could enter the facility.

Initial Meeting:

The initial meeting was conducted at 5:30am, on 12/7/2021; between Laura Jense, and auditors Bump and Betzhold. The audit team was notified that the current population of ECHWR is 14 residents, all female and all over the age of 18. Laura Jense had previously provided the audit team with resident community work schedules as well as the employee schedules for 12/07/2021. The audit team and Laura Jense created a schedule for the day's events. Laura Jense provided the audit team two offices to conduct interviews from as well as the contact number to the staff that would be escorting residents to the interview rooms.

Due to the relatively low number of staff employed by ECHWR and residents who would be exiting the facility for work release, the decision was made to begin interviews of staff prior to the site review.

0600-0730 – The audit team conducted interviews of third shift staff and residents who had early work release in the community.

0730 - Site Review – The site review was led by facility head Laura Jense. Auditors were given access to all areas of the facility. Areas and observations of note listed below:

Intake/reception area: Noted that this is where all newly received residents receive their initial PREA education. Laura Jense pointed out the TV where the video is shown and the PREA brochure and handbook given to the resident.

Control Center: Located at the entrance for all employees and visitors. The entrance is electronically locked at all times and controlled by the corrections tech in the control center. The control center manages all ingress and egress from the facility. The corrections tech verifies the work and appointment schedule for all residents before allowing a resident to exit the facility. When verifying these schedules, the corrections tech also notes the time that the resident should be returning to the facility. If a resident doesn't return on time, supervisory notification is made. All residents are pat searched upon returning to the facility. The audit team requested the corrections tech to point out where the PREA response kit was located and to see its contents. The corrections tech immediately located the kit and provided access to the contents.

Resource Room: ECHWR has a resource room which includes a computer with internet access. Residents are allowed to utilize the computer to look for employment or to connect to services in the community. This room also contains a services wall with brochures for community programs for counseling, narcotic and alcohol treatment, trauma and sexual abuse advocates and numerous other services.

Resident Halls: The main floor of ECHWR has staff offices, resident rooms, visiting room and a day space area for residents. Each of the resident rooms are designed for two or three inmates. The audit team took note of the camera monitoring placement as well as additional security items such as mirrors. The audit team did not note any deficiencies in this area. The second story was made up mainly of resident living area. Rooms, community bathrooms/showers and day spaces. The audit team took close observation of Hall A which had been renovated during the last audit period. The audit team observed that the camera monitoring placement and use of mirrors left no blind spots in the area. Overall the audit team observed that ECHWR has made good use of its security resources to provide maximum monitoring coverage of the facility.

Rooms: ECHWR has three wings (A, B and C) with resident rooms. Each of these wings has a sitting area with a television for residents to utilize. Two of the wings have a community bathroom/shower area. Wing B has bathroom and showers in the rooms. All of the 18 rooms at ECHWR are considered multiple occupancy rooms with a maximum capacity of 55. However, due to coronavirus, all 14 residents at ECHWR are housed alone in a room.

Cross gender notification: While on the site review, Laura Jense announced that this male auditor was entering an area where a female resident may be in a state of undress. When entering rooms, Laura Jense made the announcement and waited for the resident to state that they were fully clothed. The residents appeared very comfortable with the announcement and process. The auditor concluded that this is normal practice as no resident seemed confused or unsure why this announcement was being made.

PREA Risk Assessment (PRA): The audit team asked to observe an intake and risk assessment of a newly arriving resident. ECHWR did not have any residents arriving during the onsite audit. A community corrections officer who conducts PRAs with residents walked the audit team through the process which included observation and use of the risk assessment tool.

Audit Notice: The audit team observed that the audit notice as well as PREA posters and postings on how to report sexual abuse and sexual harassment were prominently posted throughout the facility to include resident and public areas.

Informal conversations with residents: the audit team had three informal conversations with three residents during the site review. The residents offered no complaints with ECHWR and one said that this is the best place she has ever been including federal facilities. When asked what the difference was, the resident said that the staff really seem to care.

Document Sampling and Review: The facility provided the auditor the requested listings of documents, files and records. From this information, the auditor selected and reviewed a variety of files, records and documents summarized in the following table and discussed in detail below:

Record Name	Total Number of Records	Number Sampled and Reviewed
Personnel Records	27	8
Volunteers and Contractor Files	0	0

Training Files	27	8
Resident Records	14	14
Medical Records (victims)	0	0
Mental Health Records (victims)	0	0
Incident Reports	6	2
Grievance Forms (All complaints, including SA and SH)	21	1
Investigation Records (SA and SH)	2	2

Personnel and Training Files: The facility has 27 full and part-time staff. The auditor reviewed 8 personnel records that included four individuals hired within the past 12 months as well as four existing staff members. The sample included a variety of job functions and post assignments, including both supervisory and line staff. The facility currently does not have any volunteer staff. Additionally, the auditor reviewed training files for all 27 staff members currently employed by ECHWR.

Inmate Files: On the first day of the onsite phase of the audit, the resident population was 14. A total of 14 resident records were reviewed by the auditor. These records included PREA orientation, PRA and 30 day follow up.

Medical and Mental Health Records: During the past year, there were 0 inmates that reported sexual abuse; there were two inmates that reported prior sexual victimization. ECHWR does not provide medical or mental health services in the facility. All medical and mental health services are provided in the community therefore there are no records to be reviewed.

Incident Reports: ECHWR had a total of six incident reports from the previous 12 months.

Grievances: In the past year, the facility received 22 grievances; the facility identified that one of those grievances alleged sexual abuse or sexual harassment. This one grievance was subsequently categorized as Non-PREA as the allegation stemmed from a pat search that was deemed to have been completed correctly.

Investigation Files: During audit period, there were three total allegations of PREA related misconduct at the facility. The investigation files for all three were provided to and reviewed by the auditor.

Inmate Interviews:

On the day of the onsite audit, ECHWR had a total population of 14. The Auditor handbook reflects that 10 resident interviews, 5 random and 5 specialized are required for community confinement facilities under 50 residents. The audit team conducted the following number of inmate interviews during the onsite phase of the audit:

Category of Inmates	Number of Interviews Conducted
Random Inmates (Total)	7
Targeted Inmates Interviewed	4
Total Inmates Interviewed	11
Breakdown of Targeted Inmate Interviews:	
▪ Youthful Inmates	0
▪ Inmates with a Physical Disability	0

▪ Offenders who are LEP	0
▪ Inmates who are Blind, Deaf, or Hard of Hearing	0
▪ Inmates with a Cognitive Disability	0
▪ Inmates who Identify as Lesbian, Gay, or Bisexual	3
▪ Inmates who Identify as Transgender or Intersex	1
▪ Inmates in Segregated Housing for High Risk of Sexual Victimization	N/A
▪ Inmates Who Reported Sexual Abuse	0
▪ Inmates Who Reported Sexual Victimization During Risk Screening	0
Total Targeted Inmate Interviews*	4

*Note: ECHWR, on the date of audit, had a total population of 14 residents. None of the residents reported as disabled, deaf, blind or limited English proficient. Therefore the auditor could not interview the required number of targeted residents. The auditor therefore interviewed two additional random residents for total of 11 interviews. One resident refused to be interviewed.

Staff Interviews

The audit team conducted interviews with the following agency leadership prior to arrival onsite. These interviews are not reflected in the totals below:

- Agency Head
- Warden
- PREA Coordinator
- PREA Compliance Manager

The audit team conducted the following number of specialized staff interviews during the onsite phase of the audit:

Category of Staff	Number of Interviews Conducted
Random Staff (Total)	7
Specialized Staff* (Total):	7 (8-Protocols)
Total Staff Interviewed	14
Breakdown of Specialized Staff Interviews	
Agency contract administrator	
Intermediate- or higher-level facility staff responsible for conducting and documenting unannounced rounds to identify and deter staff sexual abuse and sexual harassment	1
Line staff who supervise youthful inmates, if any	NA
Medical staff	NA
Mental health staff	NA
Non-Medical staff involved in cross-gender strip or visual searches	NA
Administrative (human resources) staff	1

SAFE and/or SANE staff	NA
Volunteers who have contact with inmates	N/A
Contractors who have contact with inmates	N/A
Investigative staff – agency level	2
Investigative staff – facility level	2
Staff who perform screening for risk of victimization and abusiveness	2
Staff who supervise inmates in segregated housing	NA
Staff on the sexual abuse incident review team	1
Designated staff member charged with monitoring retaliation	1
First responders, security staff	3
First responders, non-security staff	0
Intake staff	2
Total Specialized Staff Interviews	Total Specialized Staff Interviews
	7

***Note:** Due to the size of the facility, staff have taken on multiple specialized staff duties from the above chart. The seven staff interviewed are responsible for 11 protocol interviews in eight separate areas; therefore, the number of specialized staff interviews presented in the table above exceeds the number of specialized staff interviewed.

Post On-Site Audit Phase

12/08/2022 - The audit team began by collecting data from the inmate and staff interviews as well as the site review and entering the information into the Audit Compliance Tool.

The audit team identified a need for additional documentation and information during review. The documentation and information identified was made into a request to obtain from ECHWR. ECHWR provided all requested documentation and information in a timely fashion. The requested materials were:

- a. Form – DOC 02-384 (Rev. 06/21/20) Housing Protocol for Transgender, Intersex, and Gender Non-Conforming Individuals
- b. Completed DOC 02-384 for resident currently housed at ECHWR that identified as transgender
- c. Form – DOC 02-420 (Rev. 07/20/20) Preference Request
- d. Completed Form – DOC 02-420 for resident currently housed at ECHWR that identified as transgender

01/03/2022 - Interview via phone conducted with human resources director which was not able to be coordinated during the onsite audit.

Evidence Review and Final Report:

Using a triangular methodology consisting of submitted documentation and completion of the PAQ by the facility, site review notes and information obtained from targeted interviews of staff and residents; the auditor began to review the evidence for each provision of the standards.

The auditor utilized the ACT, frequently asked questions to the DOJ and the Auditor Handbook in the determination of compliance for each required standard for community confinement facilities.

01/20/2022, the final report was completed and uploaded to the OAS paper audit instrument. ECHWR was notified of the completed report

Facility Characteristics

Eleanor Chase House Work Release (ECHWR) is a community confinement facility located in the City of Spokane in Spokane County, Washington. ECHWR is operated by the Washington Department of Corrections (WADOC). Community Corrections Supervisor Laura Jense, is the head of the facility and manages the security, policy and program operations of the facility. Two Community Corrections Officers are employed at ECHWR who are responsible for case management of all residents. WADOC contracts with The Transition House Inc. (TTH) to staff the remainder of the security custody staff known as Lead Corrections Technicians and Correction Technicians. The priority for ECHWR is to provide community confinement beds and assist state female offenders to successfully transition back to the community. ECHWR houses only minimum custody level adult female offenders.

ECHWR is located in one building consisting of two main floors and a basement. ECHWR is a combination of several old Victorian houses that were renovated and connected over the years. The two main floors are separated into three wings which house residents. The basement consists of office space, maintenance area and the resident laundry.

ECHWR has a total number of 18 resident rooms all which are of a multiple occupancy design. However, due to the coronavirus outbreak, ECHWR currently is housing a single resident per room. ECHWR has a working kitchen but the food served is prepared at the Brownstone Work Release and transported to ECHWR to be served. Residents of ECHWR do not work in the kitchen area as most residents are employed in the community.

ECHWR has an area for the residents to congregate on the main floor and upper floor where resident rooms are located. There is also a rather small visiting room which doubles as the PREA education room for new residents upon intake to ECHWR. ECHWR also provides a media room which allows internet access for residents to find employment opportunities as well as access to community services. This room also has a services wall with brochures for medical, mental health and other services provided through the community. Residents of ECHWR are responsible for general chores of shared areas.

Each resident is assigned to the caseload of a Community Corrections Officer (CCO). With input from the resident, the CCO assists the resident in mapping their release from prison and transition back into the community. This includes housing, employment and continuation of services in the community but also areas the resident should be working on and preparing for while at ECHWR. These areas include education, mental health and drug/alcohol issues. Through this collaborative effort, an accountability plan is created. These plans outline the expectations and goals of the resident as well as pro-social ways for the resident to meet their needs.

Staff profile:

The Community Corrections Supervisor (CCS) is the facility head responsible for supervision of the Community Corrections Officers. The CCS is also responsible for the oversight of budgeting, security and procedures.

Transition House, Inc. Director is responsible for supervising Corrections Techs, transport, food service and maintenance staff. They are responsible for the daily operations of ECHWR.

Community Corrections Officers (CCO) are responsible for case management. In cooperation with the residents they assist in planning the resident's transition from prison back to the community. This includes employment strategies, continuation of services and housing. CCOs also handle all corrective actions concerning residents assigned to the work release.

Correction Techs are responsible for safety and security of the facility and daily operations.

The Food Service Manager is responsible for managing all kitchen activities as well as the supervision of all kitchen workers.

Summary of Audit Findings

The summary should include the number and list of standards exceeded, number of standards met, and number and list of standards not met.

Auditor Note: No standard should be found to be “Not Applicable” or “NA”. A compliance determination must be made for each standard.

Standards Exceeded

Number of Standards Exceeded: 2
List of Standards Exceeded: 115.231, 115.242

Standards Met

Number of Standards Met: 39
115.211, 115.212, 115.213, 115.215, 115.216, 115.217, 115.218, 115.221, 115.222, 115.232, 115.233, 115.234, 115.235, 115.241, , 115.251, 115.252, 115.253, 115.254, 115.261, 115.262, 115.263, 115.264, 115.265, 115.266, 115.267, 115.271, 115.272, 115.273, 115.276, 115.277, 115.278, 115.282, 115.283, 115.286, 115.287, 115.288, 115.289, 115.401, 115.403

Standards Not Met

Number of Standards Not Met: 0
List of Standards Not Met: [Click or tap here to enter text.](#)

PREVENTION PLANNING

Standard 115.211: Zero tolerance of sexual abuse and sexual harassment; PREA coordinator

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.211 (a)

- Does the agency have a written policy mandating zero tolerance toward all forms of sexual abuse and sexual harassment? Yes No
- Does the written policy outline the agency's approach to preventing, detecting, and responding to sexual abuse and sexual harassment? Yes No

115.211 (b)

- Has the agency employed or designated an agency-wide PREA Coordinator? Yes No
- Is the PREA Coordinator position in the upper-level of the agency hierarchy? Yes No
- Does the PREA Coordinator have sufficient time and authority to develop, implement, and oversee agency efforts to comply with the PREA standards in all of its facilities?
 Yes No

Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The following evidence was analyzed in making the compliance determination:

1. **Documents:** (*Policies, directives, forms, files, records, etc.*)
 - a. ECHWR – Answers to the pre-audit questionnaire
 - b. 490.800 Prison Rape Elimination Act (PREA) Prevention and Reporting
 - c. 490.850 Prison Rape Elimination Act (PREA) Response

- d. 490.860 Prison Rape Elimination Act (PREA) Investigation
- e. Prisons Division Organizational Chart
- f. ECHWR Organizational Chart
- g. Position Description for the PREA Coordinator

2. Interviews:

- a. PREA Coordinator

3. Site Review Observations:

- a. PREA Posters
- b. How to report sexual abuse/sexual harassment notices

115.211 (a):

ECHWR has three policies that outline the implementation of the agency's approach to preventing, detecting and responding to sexual abuse and sexual harassment. These three policies, 490.800 Prison Rape Elimination Act (PREA) Prevention, 490.850 Prison Rape Elimination Act (PREA) Response and 490.860 Prison Rape Elimination Act (PREA) Investigation were submitted by the agency and reviewed by the auditor.

Policy 490.800 Prison Rape Elimination Act (PREA) Prevention and Reporting mandates zero tolerance toward all forms of sexual abuse and sexual harassment. This policy also outlines prevention strategies such as maintaining an agency PREA coordinator and facility PREA compliance manager, hiring and promotional practices, staff training and inmate education

Policy 490.850 Prison Rape Elimination Act (PREA) Response outlines how the facility and agency will respond when sexual abuse or sexual harassment are detected. Strategies covered include ways to report, dynamics of sexual abuse training and staff responsibilities when they become aware of sexual abuse or sexual harassment.

Policy 490.860 Prison Rape Elimination Act (PREA) Investigation mandates that all allegations of sexual abuse or sexual harassment are thoroughly investigated, that investigators receive specialized training and that the victim is notified upon conclusion of the investigation.

The discussion of these three policies is not all encompassing of the topics outlined in the policies, it does however demonstrate that WADOC's policies on sexual abuse/sexual harassment are comprehensive and give concrete direction of the agency's approach on preventing, detecting and responding to sexual abuse and sexual harassment.

A final analysis of the evidence indicates the facility is in substantial compliance with this provision.

115.211 (b):

The position description for the Washington Department of Corrections PREA coordinator along with the organizational chart showing the location of the PREA coordinator and the facility being audited within the organization were submitted and reviewed by the auditor. The position description and Organizational chart show that the PREA Coordinator reports to the Deputy Director of Prison Command B.

In the interview with the PREA Coordinator, she stated that she has sufficient time and authority to develop, implement, and oversee agency efforts to comply with the PREA standards. She stated that the Community Corrections Supervisors at the work release/training centers like ECHWR have been

designated as the PREA Compliance Managers and that she works closely with them. I found the Agency PREA Coordinator to be well versed in the PREA Standards, and how they are applied to ECHWR.

A final analysis of the evidence indicates the facility is in substantial compliance with this provision.

Findings:

A final analysis of the evidence indicates the facility is substantially compliant with this standard.

Corrective Action:

There is no corrective action to take.

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

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.212 (a)

- If this agency is public and it contracts for the confinement of its residents with private agencies or other entities including other government agencies, has the agency included the entity's obligation to comply with the PREA standards in any new contract or contract renewal signed on or after August 20, 2012? (N/A if the agency does not contract with private agencies or other entities for the confinement of residents.) Yes No NA

115.212 (b)

- Does any new contract or contract renewal signed on or after August 20, 2012 provide for agency contract monitoring to ensure that the contractor is complying with the PREA standards? (N/A if the agency does not contract with private agencies or other entities for the confinement of residents.) Yes No NA

115.212 (c)

- If the agency has entered into a contract with an entity that fails to comply with the PREA standards, did the agency do so only in emergency circumstances after making all reasonable attempts to find a PREA compliant private agency or other entity to confine residents? (N/A if the agency has not entered into a contract with an entity that fails to comply with the PREA standards.) Yes No NA
- In such a case, does the agency document its unsuccessful attempts to find an entity in compliance with the standards? (N/A if the agency has not entered into a contract with an entity that fails to comply with the PREA standards.) Yes No NA

Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)

- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The following evidence was analyzed in making the compliance determination:

1. **Documents:** (*Policies, directives, forms, files, records, etc.*)
 - a. 490.800 Prison Rape Elimination Act (PREA) Prevention and Reporting
 - b. Contract shell with PREA compliance language included
 - c. ECHWR Contract with WADOC – Transition House Inc., St. Cloud FL.
 - d. Contracts between WADOC and American Behavior Health Systems and Yakima County Jail
 - e. Iowa Department of Corrections and Minnesota Department of Corrections
2. **Interviews:**
 - a. Agency Contract Administrator
 - b. PREA Coordinator
3. **Site Review Observations:**
 - a. American Behavioral Health Systems public website
<https://www.americanbehavioralhealth.net/prea/>
 - b. Yakima County public website <http://yakimacounty.us/1141/Prison-Rape-Elimination-Act>
 - c. Minnesota Department of Corrections public website
 - d. Colorado Department of Corrections public website

115.212 (a):

ECHWR provided contracts for all confinement facilities which were reviewed by the auditor. The agency also provided the monitoring efforts of the agency to ensure compliance with the PREA Standards with all of the contracted facilities. WADOC currently contracts with two organizations and has memorandum of understanding with two organizations. The auditor found during the review of all contracts that the agency included the entity's obligation to comply with the PREA standards.

The auditor, upon checking the public websites for the contracted entities found that they had each achieved compliance during their last PREA audit. The list of organizations and facilities are below.

Contracted Organizations/Facilities:

1. Contracted - American Behavioral Health Systems (Three Facilities Listed Below)
 - A. Cozza – Last PREA audit – 2019 - Met all standards
 - B. Mission - Last PREA audit – 2019 - Met all standards

C. Chehalis – Last PREA audit – 2018 - Met all standards

2. Contracted) - Yakima County Jail - Last PREA audit – 2018 – Met 37 standards and required corrective action for six standards 115.63, 115.65, 115.67, 115.73, 115.86 and 115.87. Through corrective action with the auditor and PREA Coordinator, YCJ was found to be in full compliance on 8/30/2018.
3. MOU - Minnesota Department of Corrections – Found to be in full compliance during the last audit cycle.
4. MOU - Colorado Department of Corrections - Found to be in full compliance during the last audit cycle.

In the interview with the Agency Contract Administrator, it was learned that the responsibility for monitoring PREA compliance of contract facilities fell on the PREA Coordinator. In a memo from the PREA Coordinator, she states that she does indeed monitor these facilities for compliance. It is also clear from the audit report for YCJ that the PREA Coordinator is involved in correcting deficiencies in these facilities

A final analysis of the evidence indicates the facility is in substantial compliance with this provision.

115.212 (b):

The agency provided all contracts and MOUs with all entities which the agency has entered into for the confinement of residents. Two contracts were reviewed by the auditor and found that they both contain the entity's obligation to comply with the PREA standards.

A final analysis of the evidence indicates the facility is in substantial compliance with this provision.

115.212 (c):

N/A - The agency reports that they have not entered into any contracts with entities that are not compliant with the PREA standards. There is no evidence that contradicts the agency's assertions.

A final analysis of the evidence indicates the facility is in substantial compliance with this provision.

Findings:

A final analysis of the evidence indicates the facility is substantially compliant with this standard.

Corrective Action:

There is no corrective action to take

Standard 115.213: Supervision and monitoring

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.213 (a)

- Does the facility have a documented staffing plan that provides for adequate levels of staffing and, where applicable, video monitoring, to protect residents against sexual abuse?

- Yes No In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: The physical layout of each facility?
 Yes No
- In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: The composition of the resident population? Yes No
- In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: The prevalence of substantiated and unsubstantiated incidents of sexual abuse? Yes No
- In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: Any other relevant factors? Yes No

115.213 (b)

- In circumstances where the staffing plan is not complied with, does the facility document and justify all deviations from the plan? (N/A if no deviations from staffing plan.)
 Yes No NA

115.213 (c)

- In the past 12 months, has the facility assessed, determined, and documented whether adjustments are needed to the staffing plan established pursuant to paragraph (a) of this section? Yes No
- In the past 12 months, has the facility assessed, determined, and documented whether adjustments are needed to prevailing staffing patterns? Yes No
- In the past 12 months, has the facility assessed, determined, and documented whether adjustments are needed to the facility's deployment of video monitoring systems and other monitoring technologies? Yes No
- In the past 12 months, has the facility assessed, determined, and documented whether adjustments are needed to the resources the facility has available to commit to ensure adequate staffing levels? Yes No

Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The following evidence was analyzed in making the compliance determination:

1. **Documents:** (*Policies, directives, forms, files, records, etc.*)
 - a. 110.110 WORK RELEASE MANAGEMENT EXPECTATIONS
 - b. Contract No 11573, WADOC and ECHWR
 - c. PREA Vulnerability Assessment
 - d. DOC 300.500 WORK/TRAINING RELEASE SCREENING
 - e. DOC 490.800 PRISON RAPE ELIMINATION ACT (PREA) PREVENTION AND REPORTING
 - f. Transition House Staffing Model
 - g. 2019-21 Biennial Budget Requests
 - h. Yearly Staffing Review 03/26/2019
2. **Interviews:**
 - a. Facility Head
3. **Site Review Observations:**
 - b. Auditors were able to see the staffing levels during the busiest time of day

115.213 (a):

ECHWR's current staffing plan is found in the contract between WADOC and ECHWR #11573 which has been reviewed by the auditor. Laura Jense, Work/Training Release Supervisor for ECHWR, states in her memo, dated 08/01/2020, that ECHWR's staffing pattern is reviewed annually and the following areas are taken into consideration:

- Offender population including the number of offenders and whether or not the facility is co-ed;
- Physical size of each work release facility building;
- Annual review of past staffing plans; and
- Regular reviews of statistics related to critical incidents, including sexual abuse, sexual assault and harassment investigations

During the site review portion of this audit, the auditor reviewed the *Staffing Plan Manual* maintained in the office of the community corrections supervisor's office. The *Staffing Plan Manual* contains the following data which is utilized during the review

- Annual Review Memo
- Organizational Charts
- Staff Schedules for hours of work
- PREA Vulnerability Assessment, and annual reviews
- Budget Requests and Status
- Floor Plans
- Floor Plans with Camera and Mirror locations
- DOC Policy 110.110 Management Expectations

- DOC Policy 300.500 Work Release Screening

Prior to the annual staffing plan review, ECHWR completes a PREA vulnerability assessment. This PREA vulnerability assessment conducted by ECHWR is utilized in the annual staffing pattern review. This assessment documents corrections needed to the physical plant which includes mirrors, emergency lighting and camera systems as well as procedural and policy changes necessary to enhance the sexual safety of staff and residents.

ECHWR's annual review of the staffing plan is driven by two policies. WADOC Policy 490.800 PRISON RAPE ELIMINATION ACT (PREA) PREVENTION AND REPORTING outlines the process for development and annual review of staffing plans in section VI. This section directs all Superintendents and work release community corrections supervisors to utilize the *PREA Compliant Staffing Plan Template*, located on the PREA Audit Sharepoint site, to develop, maintain and to annually review a facility's staffing needs.

Policy 300.500 WORK/TRAINING RELEASE SCREENING outlines what residents are eligible or prohibited from participating in the community confinement programs offered by ECHWR. This defines the composition of the resident population in completing and reviewing the staffing plan for ECHWR.

The auditor interviewed the facility head and PREA coordinator. Both stated that they were involved in the staffing plan creation and annual review. The facility head explained the process for completing the assessment as well as the PREA Complaint Staffing Plan Template. The PREA coordinator explained the annual review process. Additionally, the auditor reviewed the current staffing plan as well as the current PREA Vulnerability Assessment

A final analysis of the evidence indicates the facility is in substantial compliance with this provision.

115.213 (b):

ECHWR reports no deviations from the current staffing plan. In interviews with the facility head and PREA coordinator the auditor could find no evidence that ECHWR deviated from the staffing plan.

A final analysis of the evidence indicates the facility is in substantial compliance with this provision.

115.213 (c):

ECHWR completes a review annually of their PREA vulnerability assessment which the Auditor reviewed. ECHWR utilizes this assessment to determine whether adjustments are needed to the facility's deployment of video monitoring systems and other monitoring technologies or if adjustments are needed to the resources the facility has available to commit to ensure adequate staffing levels. The PREA vulnerability assessment also drives procedural and policy changes necessary to enhance the sexual safety of staff and residents. The auditor asked the facility head if any changes to the facility structure or policy had come from the vulnerability assessment. I was directed to the camera system upgrade which was cited on the vulnerability assessment completed by the facility

The community corrections supervisor maintains the *Staffing Plan Manual*. The auditor reviewed the manual during the onsite portion of the audit. The most current review was conducted on 04/07/2021 with no changes to the current staffing plan. The review includes whether adjustments are needed to the staffing plan or prevailing staffing patterns, facility's deployment of video monitoring systems/monitoring technologies or to the resources the facility has available to commit to ensure adequate staffing levels

A final analysis of the evidence indicates the facility is in substantial compliance with this provision.

Findings:

A final analysis of the evidence indicates the facility is substantially compliant with this standard.

Corrective Action:

There is no corrective action to take

Standard 115.215: Limits to cross-gender viewing and searches

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.215 (a)

- Does the facility always refrain from conducting any cross-gender strip or cross-gender visual body cavity searches, except in exigent circumstances or by medical practitioners?
 Yes No

115.215 (b)

- Does the facility always refrain from conducting cross-gender pat-down searches of female residents, except in exigent circumstances? (N/A if the facility does not have female residents.)
 Yes No NA
- Does the facility always refrain from restricting female residents' access to regularly available programming or other outside opportunities in order to comply with this provision? (N/A if the facility does not have female residents.) Yes No NA

115.215 (c)

- Does the facility document all cross-gender strip searches and cross-gender visual body cavity searches? Yes No
- Does the facility document all cross-gender pat-down searches of female residents? (N/A if the facility does not have female residents). Yes No NA

115.215 (d)

- Does the facility have policies 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? Yes No
- Does the facility have procedures that enables 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? Yes No

- Does the facility require staff of the opposite gender to announce their presence when entering an area where residents are likely to be showering, performing bodily functions, or changing clothing? Yes No

115.215 (e)

- Does the facility always refrain from searching or physically examining transgender or intersex residents for the sole purpose of determining the resident's genital status? Yes No
- If a resident's genital status is unknown, does the facility determine genital status 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? Yes No

115.215 (f)

- Does the facility/agency train security staff in how to conduct cross-gender pat down searches in a professional and respectful manner, and in the least intrusive manner possible, consistent with security needs? Yes No
- Does the facility/agency train security staff in how to conduct searches of transgender and intersex residents in a professional and respectful manner, and in the least intrusive manner possible, consistent with security needs? Yes No

Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The following evidence was analyzed in making the compliance determination:

1. **Documents:** (*Policies, directives, forms, files, records, etc.*)
 - a. DOC Policy 490.700 Transgender, Intersex, and Gender non-conforming Housing and Supervision
 - b. DOC 420.325 SEARCHES AND CONTRABAND FOR WORK/TRAINING RELEASE
 - c. DOC 490.800 PRISON RAPE ELIMINATION ACT (PREA) PREVENTION AND REPORTING

- d. DOC 490.820 PRISON RAPE ELIMINATION ACT (PREA) RISK ASSESSMENTS AND ASSIGNMENTS
- e. "Knock and announce" memo
- f. WADOC Pat Search curriculum and Lesson Plan
- g. Pat Search Training Records

2. Interviews:

- a. Random Sample of Staff
- b. Random Sample of Inmates

3. Site Review Observations

- a. Cross gender notification procedure during the site review
- b. Observed the community and in room bathroom and shower areas

115.215 (a):

Policy DOC 420.325 SEARCHES AND CONTRABAND FOR WORK/TRAINING RELEASE states,

"Strip searches will be conducted when a reasonable suspicion has been established that the individual is carrying contraband dangerous to self or others, or creates the potential to disrupt the orderly operations of the facility. A strip search must be conducted by 2 trained employees and meet the following gender requirements, unless waiting for an employee of the designated gender may result in serious bodily injury:..."

The facility reports that during the audit documentation period, no strip searches have been conducted. Additionally, during the audit documentation period, no cross gender pat searches of female offenders were conducted.

The auditor conducted interviews with a random sample of six staff. The staff responded that cross gender strip searches are not allowed by policy and that there have not been any cross gender strip or body cavity searches completed during this audit period.

The auditor also conducted interviews with a random sample of seven residents. The residents all stated that they have not been searched by an opposite gender staff member. There was no evidence that the facility had conducted any cross-gender strip or cross-gender visual body cavity searches during this documentation period. The auditor accepts this as confirmation.

A final analysis of the evidence indicates the facility is in substantial compliance with this provision.

115.215 (b):

ECHWR reports that there were no cross gender pat searches of female residents during this documentation period. The auditor conducted interviews with a random sample of six staff and seven residents of ECHWR. All six of the staff responded that there have not been any cross gender pat searches at ECHWR during the audit period. These staff also expounded on the question by saying that ECHWR only has one male staff member who would conduct searches as part of his regular job duties.

The seven residents replied that that a female staff member is always available and that they had never been pat searched by a staff member of the opposite gender. There is no evidence that the facility had conducted any cross gender pat searches of female residents during this documentation period. The auditor accepts this as confirmation.

A final analysis of the evidence indicates the facility is in substantial compliance with this provision.

115.215 (c):

Policy DOC 420.325 SEARCHES AND CONTRABAND FOR WORK/TRAINING RELEASE, V (c) requires that all strip searches be documented as a report in the Incident Management Reporting System (IMRS) before the end of the shift. Section III, B, 2 requires that any male employee/contract staff that pat searches a female resident to complete a report in IMRS before the end of the shift with distribution to the agency PREA coordinator.

Since ECHWR reports that no cross gender strip or pat searches occurred during this audit period, the auditor was unable to review any such reports in IMRS. During interviews with a random sample of residents, the residents confirmed that there have been no cross gender searches of any kind during the audit period.

A final analysis of the evidence indicates the facility is in substantial compliance with this provision.

115.215 (d):

ECHWR, per policy DOC 490.800 PRISON RAPE ELIMINATION ACT (PREA) PREVENTION AND REPORTING, VIII. A), B) and C), has established 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.

During the onsite portion of the audit, the auditor observed the physical layout of the facility and the application of these procedures. The privacy barriers such as shower curtains put in place in community bathroom and shower areas provide all residents with sufficient privacy while performing these functions. The room doors do not have windows. This prevents opposite gender staff from unintentionally viewing residents in a state of undress.

During the site review, the process for staff, prior to entering a room, was demonstrated. The staff member knocked on the room door and announced that a male was present and that the staff member wished to enter the room. The staff member also informed the resident to let us know when they were fully clothed. The three residents in the rooms which were occupied seemed comfortable with this practice and did not appear confused as to why the staff member was making this announcement. The audit team concluded that this was because this is an institutionalized practice at ECHWR. The male auditor was also announced upon entering the living area of the female residents which included community shower and bathroom areas.

During interviews with seven random inmates and one inmate identified as transgender, the audit team learned that none of the residents interviewed had ever been viewed in a state of undress, showering or toileting by a staff member of the opposite gender.

A final analysis of the evidence indicates the facility is in substantial compliance with this provision.

115.215 (e):

ECHWR reports that they always refrain from searching or physically examining transgender or intersex residents for the sole purpose of determining the resident's genital status and if a resident's genital status is unknown, the facility determines genital status 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.

ECHWR reports that there has been one resident identifying as transgender in the last 12 month period. During the interviews with six random staff, the auditor was informed that this type of search is prohibited and covered during their initial PREA training. Two of the staff cited the correct policy which covers this type of search. All of the staff stated that they were aware of the policy and that this type of search had not been conducted by any staff at ECHWR. The resident who identified as transgender stated that they have never been strip searched while at ECHWR.

A final analysis of the evidence indicates the facility is in substantial compliance with this provision.

115.215 (f):

The auditor reviewed the training materials as well as records for all current staff that might complete a search as outlined in this standard. The training material adequately covers how to conduct cross-gender pat down searches in a professional and respectful manner, and in the least intrusive manner possible, consistent with security needs?

WADOC has a policy and procedure which allows input from residents, who identify as transgender, in what gender staff member will conduct searches of their person.

490.700 Transgender, Intersex, and Gender Non-Conforming Housing and Supervision - DOC 02-420, Preference Request, is completed for each transgender, intersex and gender non-conforming resident. This form identifies the offender's preferred gender of staff to conduct searches. Unless circumstances do not allow for the preference to be implemented, searches are conducted in accordance with the resident's stated preference. Per the attached Assistant Secretary memorandum, only trained employees will be authorized with Supervisor/Duty Officer approval to conduct strip searches when exigent circumstances exist." When a pat or strip search is not conducted according to the resident's Preference Request, an Incident Management Reporting System (IMRS) report is completed.

During the audit documentation period, one transgender residents has been housed at this facility. ECHWR provided the completed DOC 02-420 for this resident. Review of this preference request shows that this resident identified no preference for staff member gender for searches.

A final analysis of the evidence indicates the facility is in substantial compliance with this provision.

Findings:

A final analysis of the evidence indicates the facility is substantially compliant with this standard.

Corrective Action:

There is no corrective action to take.

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

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.216 (a)

- Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Residents who are deaf or hard of hearing? Yes No
- Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Residents who are blind or have low vision? Yes No
- Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Residents who have intellectual disabilities? Yes No
- Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Residents who have psychiatric disabilities? Yes No
- Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Residents who have speech disabilities? Yes No
- Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Other? (if "other," please explain in overall determination notes.) Yes No
- Do such steps include, when necessary, ensuring effective communication with residents who are deaf or hard of hearing? Yes No
- Do such steps include, when necessary, providing access to interpreters who can interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary? Yes No
- Does the agency ensure that written materials are provided in formats or through methods that ensure effective communication with residents with disabilities including residents who: Have intellectual disabilities? Yes No
- Does the agency ensure that written materials are provided in formats or through methods that ensure effective communication with residents with disabilities including residents who: Have limited reading skills? Yes No
- Does the agency ensure that written materials are provided in formats or through methods that ensure effective communication with residents with disabilities including residents who: Are blind or have low vision? Yes No

115.216 (b)

- Does the agency take reasonable steps to ensure meaningful access to all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment to residents who are limited English proficient? Yes No
- Do these steps include providing interpreters who can interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary? Yes No

115.216 (c)

- Does the agency always refrain from relying on 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, the performance of first-response duties under §115.264, or the investigation of the resident's allegations? Yes No

Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The following evidence was analyzed in making the compliance determination:

1. **Documents:** (*Policies, directives, forms, files, records, etc.*)
 - a. DOC Sign Language Contract for Interpreters and Active Interpreters Language Services
 - b. Telephone Interpreter Contracts with CTS Language Link and Linguistica International
 - c. DOC 310.000 Orientation
 - d. DOC 690.400 OFFENDERS WITH DISABILITIES
 - e. 450.500 LANGUAGE SERVICES FOR LIMITED ENGLISH PROFICIENT INDIVIDUALS
 - f. DOC 490.800 PRISON RAPE ELIMINATION ACT (PREA) PREVENTION AND REPORTING
 - g. Correctional Specialist 3 Deaf Services Coordinator Position Description
 - h. DOC ADA Training Course

2. Interviews:

- a. Agency Head
- b. Residents with Disabilities or Limited English Proficient
- c. Random Sample of Staff

3. Site Review Observations:

- a. Auditor observed educational materials for cognitively challenged and low reading skills residents
- b. Auditor observed electronic equipment for the deaf to communicate in person or via phone
- c. Auditor observed educational materials for LEP residents

115.216 (a):

ECHWR reports that no residents with disabilities or Limited English Proficient (LEP) have been admitted in the last 12 month period. However, ECHWR and WADOC have policies, procedures and contracts in place for residents with disabilities or who are LEP to participate equally in programs, education and opportunities offered. ECHWR submitted the names and contract number for all sign language and language interpreters available to provide services for their residents. WADOC currently contracts with 12 vendors which provide interpretive services in 13 languages.

WADOC also has contracts with CTS Language Link and Linguistica International to provide telephone interpretation.

WADOC employs an Americans with Disabilities Association (ADA) coordinator as well as a deaf services coordinator. WADOC also has policy, DOC 690.400 OFFENDERS WITH DISABILITIES, which provides direction to the facilities when managing residents with disabilities or who may be LEP.

“Offenders with disabilities will be provided reasonable accommodation that allows participation in services, programs, and activities, which may include: 1. Modifying policies, practices, or procedures, when reasonable, 2. Removing barriers to access, and/or 3. Providing auxiliary aids and services.”

ECHWR submitted the ADA training given to all employees which was reviewed by the auditor.

The Agency head as well as a random sampling of staff including two case managers were interviewed. The two case managers both outlined the review process for new residents transferring into the facility. They stated that they are notified well in advance of the resident’s intake which allows them to identify any needs the resident may have prior to transfer to the facility. When asked for an example, the case manager stated that before a resident identified as deaf transferred into the facility that the facility purchased a machine that could be utilized to communicate with individuals within and outside the facility. The case manager provided the auditor a demonstration of the equipment.

A final analysis of the evidence indicates the facility is in substantial compliance with this provision.

115.216 (b):

WADOC and ECHWR have several policies that govern the management of residents who are LEP.

DOC 310.000 ORIENTATION

“When a literacy or language problem exists, employees will assist the individual

in understanding the material per DOC 450.500 Language Services for Limited English Proficient (LEP) Offenders Spanish speaking individuals will attend a Spanish version of the orientation program and be notified of available Spanish translated materials and services Each facility will develop processes for non-Spanish speaking Limited English Proficiency individuals, including those requiring sign language interpretation, to receive orientation in a language they understand.”

Policy 450.500, Language Services for limited English Proficient Individuals, ECHWR and WADOC utilize the Washington Department of Enterprise Services (WADES) to provide language interpreting services. The following contracts for services have been entered into by WADES on behalf of WADOC.

- Contract #03514 provides WADOC offenders that are limited English proficient with access to in-person language interpretation conducted by court certified and non-court certified interpreters
- Contract, #05614, provides WADOC offender with access to Telephone Based Services on an “as needed” basis for limited English proficient clients.

These services are available for use by any staff member to assist limited English proficient offenders in reporting allegations and participating in the investigatory process.

450.500 LANGUAGE SERVICES FOR LIMITED ENGLISH PROFICIENT INDIVIDUALS

“The Department will provide oral interpretation (i.e., telephonic, in-person, video remote) and written translation services through Department and/or contract services at all facilities. The Department will also provide guidelines for interpretation and translation services for Limited English Proficiency (LEP) individuals under the Department’s jurisdiction.”

The auditor interviewed the facility head. During the interview, they stated that there has not been a LEP resident at ECHWR in the 10 years they have worked at the facility. They did however site all of the services in place should they become necessary. In interviews with the case managers, they both gave a detailed explanation of the review process prior to a resident’s transfer to ECHWR and how they would put in place accommodations for the resident.

A final analysis of the evidence indicates the facility is in substantial compliance with this provision.

115.216 (c):

DOC 450.500 Language Services for Limited English Proficient (LEP) Offenders. Offenders are not authorized to use interpretation/translation services from other offenders, family members, or friends for the purposes of reporting allegations and/or participating in investigations of sexual misconduct. During interviews with random staff, all staff stated that resident interpreters are never utilized and were aware of the contracts the agency had entered into to provide these services

A final analysis of the evidence indicates the facility is in substantial compliance with this provision.

Findings:

A final analysis of the evidence indicates the facility is substantially compliant with this standard.

Corrective Action:

There is no corrective action to take.

Standard 115.217: Hiring and promotion decisions

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.217 (a)

- Does the agency prohibit the hiring or promotion of anyone who may have contact with residents who: Has engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility, or other institution (as defined in 42 U.S.C. 1997)? Yes No
- Does the agency prohibit the hiring or promotion of anyone who may have contact with residents who: 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? Yes No
- Does the agency prohibit the hiring or promotion of anyone who may have contact with residents who: Has been civilly or administratively adjudicated to have engaged in the activity described in the question immediately above? Yes No
- Does the agency prohibit the enlistment of services of any contractor who may have contact with residents who: Has engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility, or other institution (as defined in 42 U.S.C. 1997)? Yes No
- Does the agency prohibit the enlistment of services of any contractor who may have contact with residents who: 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? Yes No
- Does the agency prohibit the enlistment of services of any contractor who may have contact with residents who: Has been civilly or administratively adjudicated to have engaged in the activity described in the question immediately above? Yes No

115.217 (b)

- Does the agency consider any incidents of sexual harassment in determining whether to hire or promote anyone who may have contact with residents? Yes No
- Does the agency consider any incidents of sexual harassment in determining whether to enlist the services of any contractor, who may have contact with residents? Yes No

115.217 (c)

- Before hiring new employees who may have contact with residents, does the agency: Perform a criminal background records check? Yes No

- Before hiring new employees who may have contact with residents, does the agency, consistent with Federal State, and local law: Make 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? Yes No

115.217 (d)

- Does the agency perform a criminal background records check before enlisting the services of any contractor who may have contact with residents? Yes No

115.217 (e)

- Does the agency either conduct criminal background records checks at least every five years of current employees and contractors who may have contact with residents or have in place a system for otherwise capturing such information for current employees? Yes No

115.217 (f)

- Does the agency ask all applicants and employees who may have contact with residents directly about previous misconduct described in paragraph (a) of this section in written applications or interviews for hiring or promotions? Yes No
- Does the agency ask all applicants and employees who may have contact with residents directly about previous misconduct described in paragraph (a) of this section in any interviews or written self-evaluations conducted as part of reviews of current employees? Yes No
- Does the agency impose upon employees a continuing affirmative duty to disclose any such misconduct? Yes No

115.217 (g)

- Does the agency consider material omissions regarding such misconduct, or the provision of materially false information, grounds for termination? Yes No

115.217 (h)

- Does the agency 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? (N/A if providing information on substantiated allegations of sexual abuse or sexual harassment involving a former employee is prohibited by law.) Yes No NA

Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)

Does Not Meet Standard (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The following evidence was analyzed in making the compliance determination:

- 1. Documents:** (*Policies, directives, forms, files, records, etc.*)
 - a. ECHWR 810.015 CRIMINAL RECORD DISCLOSURE AND FINGERPRINTING
 - b. DOC 490.800 PRISON RAPE ELIMINATION ACT (PREA) PREVENTION AND REPORTING A
 - c. DOC 810.800 RECRUITMENT, SELECTION, AND PROMOTION
 - d. Employment/volunteer applications
 - e. Reference checks
 - f. Personnel file review
 - g. Contract disclosure statements

- 2. Interviews:**
 - a. Human Resources Director

Site Review Observations:

115.217 (a):

WADOC has established staffing practices which are outlined in DOC 490.800 PRISON RAPE ELIMINATION ACT (PREA) PREVENTION AND REPORTING

1. *To the extent permitted by law, the Department will not knowingly hire, promote, or enlist the services of anyone who:*
 - a. *Has engaged in sexual misconduct in a Prison, jail, lockup, community confinement facility, juvenile facility, or other institution as defined in 42 U.S.C. 1997,*
 - b. *Has engaged in sexual misconduct with an offender on supervision,*
 - c. *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, or*
 - d. *Has been civilly or administratively adjudicated to have engaged in the activity described above.*

The agency and ECHWR have implemented procedures requiring applicants to complete the following documents prior to hire.

DOC 03-506 *Sexual Misconduct and Institutional Employment/Service Disclosure*

DOC 03-031 *Criminal Disclosure*

DOC 05-370 *Request for Criminal History Record Information*

The auditor reviewed the hiring packets for the last two agency hires at ECHWR and found that both disclosure forms and criminal background checks had been completed. WADOC conducts background checks utilizing the Washington Crime Information Center (WACIC) and National Crime Information Center (NCIC).

There is no evidence that ECHWR has hired or promoted any staff member that has engaged in sexual misconduct in a Prison, jail, lockup, community confinement facility, juvenile facility, or other institution as defined in 42 U.S.C. 1997, has engaged in sexual misconduct with an offender on supervision, 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, or has been civilly or administratively adjudicated to have engaged in the activity described above.

A final analysis of the evidence indicates the facility is in substantial compliance with this provision.

115.217 (b):

DOC 490.800 PRISON RAPE ELIMINATION ACT (PREA) PREVENTION AND REPORTING

The Department will consider any incidents of sexual harassment in determining whether to hire, promote, or enlist the services of anyone who may have contact with offenders.

The auditor interviewed the human resources director (HRD) responsible for ECHWR. The HRD stated that the department considers all incidents of sexual misconduct including harassment when making these determinations.

The auditor reviewed the hiring packets for four employees hired by TTH Inc. in the last 12 months. The auditor verified that all background checks were completed as well as the self-disclosure forms. None of the applicants self-disclosed any type of sexual misconduct. The background checks for the applicants also did not reveal any sexual misconduct.

In one instance, the facility learned that an applicant had a legal issue that had not cleared through the legal process. Although the issue was not sexual in nature, through submitted emails, the auditor was able to observe how human resources and facility management make hiring determinations when issues arise from background checks or disclosures. The employee was ultimately hired but certain restrictions were applied until the legal process was closed.

The auditor also noted that each applicant completed a previous facility employment form. None of the applicants identified any previous facility or confinement employment. The HRD did confirm that when there is previous facility employment that they contact that facility to ensure that the applicant wasn't found to have engaged in any sexual misconduct while employed by the facility or left employment under investigation for sexual misconduct.

A final analysis of the evidence indicates the facility is in substantial compliance with this provision.

115.217 (c):

ECHWR reports that 12 new employees were hired by TTH Inc. during the reporting period. The facility head stated that background checks are obtained through one or more of the following: Washington Crime Information Center (WACIC)/National Crime Information Center (NCIC) records checks.

WADOC requires completion of DOC 03-506 Sexual Misconduct and Institutional Employment/Service Disclosure for all agency and contracted employees.

The auditor requested the background check and hiring information for the last four employees hired for ECHWR to include their completed DOC 03-506. All four of the applicants had completed this form prior to employment. None of the applicants identified any previous facility or confinement employment. The HRD did confirm that when there is previous facility employment that they make every effort to contact that facility to ensure that the applicant wasn't found to have engaged in any sexual misconduct while employed by the facility or left employment under investigation for sexual misconduct.

A final analysis of the evidence indicates the facility is in substantial compliance with this provision.

115.217 (d):

WADOC policy requires that all applicants, including former employees/contract staff/volunteers complete DOC 03-031 Criminal Disclosure and DOC 05-370 Request for Criminal History Record Information WASIS/NCIC III Check WACIC/NCIC Check before being offered an initial appointment.

During the last review period, ECHWR has entered into two new contracts that consisted of 15 Individuals working onsite that may have contact with residents. ECHWR provided the information showing that the facility had completed backgrounds checks for all 15 individuals. The information further showed that the facility head had reviewed the checks and cleared these individuals for entry into the facility. The facility head also designated that the contractors would need to be escorted while in the facility.

A final analysis of the evidence indicates the facility is in substantial compliance with this provision.

115.217 (e):

ECHWR provided a memo dated 08/01/2020 outlining the process by which the facility processes the background checks for all employees, volunteers, and contractors at least every five years. ECHWR also provided the spread sheet of completed background checks along with the dates when the next background check is due for the individual employee, volunteer, and contractor. The auditor reviewed the submitted documents and found that ECHWR is up to date with all current employee's background checks.

A final analysis of the evidence indicates the facility is in substantial compliance with this provision.

115.217 (f):

Agency policy states that employees who fail to report an arrest, criminal citation, or any other court-imposed sanction or condition that may affect their fitness for duty or the program of the agency may be subject to disciplinary action, up to and including dismissal.

During the interview with the HRD, they stated that all new hires and promotional interviews include the completion of the DOC 03-506 Sexual Misconduct and Institutional Employment/Service Disclosure by the applicant. They further stated that the agency does impose upon employees a continuing affirmative duty to disclose. Continuing affirmative duty applies for all matters that may affect their fitness for duty. This includes sexual abuse or sexual harassment.

A final analysis of the evidence indicates the facility is in substantial compliance with this provision.

115.217 (g):

Agency policy states that failure to fully divulge criminal information on the part of an individual subsequently employed, promoted, or authorized to provide services for the Department may be cause for disciplinary action, up to and including dismissal or termination of services.

The auditor asked the HRD about this type of incident. The HRD said that if an employee was found to have given false or misleading information during the hiring process that they would be subject to discipline or possible termination.

A final analysis of the evidence indicates the facility is in substantial compliance with this provision.

115.217 (h):

DOC 800.005 PERSONNEL FILES - F. *Employment verification requests from prospective employers from an institution as defined in 42 U.S.C. 1997 will be directed to the Records Custodian/designee, who will coordinate the review and response. To the extent possible, all available information on substantiated allegations of sexual misconduct or harassment will be provided.*

The HRD during their interview stated that they were not aware of any laws prohibiting the transfer of this type of information.

A final analysis of the evidence indicates the facility is in substantial compliance with this provision.

Findings:

A final analysis of the evidence indicates the facility is substantially compliant with this standard.

Corrective Action:

There is no corrective action to take.

Standard 115.218: Upgrades to facilities and technologies

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.218 (a)

- If the agency designed or acquired any new facility or planned any substantial expansion or modification of existing facilities, did the agency consider the effect of the design, acquisition, expansion, or modification upon the agency's ability to protect residents from sexual abuse? (N/A if agency/facility has not acquired a new facility or made a substantial expansion to existing facilities since August 20, 2012, or since the last PREA audit, whichever is later.)
 Yes No NA

115.218 (b)

- If the agency installed or updated a video monitoring system, electronic surveillance system, or other monitoring technology, did the agency consider how such technology may enhance the agency's ability to protect residents from sexual abuse? (N/A if agency/facility has not installed or updated a video monitoring system, electronic surveillance system, or other monitoring technology since August 20, 2012, or since the last PREA audit, whichever is later.)
 Yes No NA

Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The following evidence was analyzed in making the compliance determination:

- 1. Documents:** (*Policies, directives, forms, files, records, etc.*)
 - a. Bid proposal from Pick electric for replacement of 261 existing light fixtures
 - b. Commercial Lighting Incentive Agreement
 - c. Hall-A Remodel Floor Plan
 - d. Camera Install Floor Plan
 - e. Vulnerability Assessment
- 2. Interviews:**
 - a. Agency Head
 - b. Facility Head
- 3. Site Review Observations:**
 - a. Auditor observed the upgrade to Hall A as well as the camera monitoring system

115.218 (a):

WADOC Policy 490.800 Prison Rape Elimination Act (PREA) Prevention and Reporting states that the department will consider possible effects on its ability to protect offenders from sexual misconduct when designing or acquiring a new facility, planning substantial expansions or modifications and installing or updating video monitoring or other monitoring technology.

ECHWR provided an email from the director of capital planning and development. This email states that PREA, ACA and ADA are all considered for all projects. ECHWR also provided all contracts, blue prints and architectural designs for the latest upgrade to Hall A.

A final analysis of the evidence indicates the facility is in substantial compliance with this provision.

115.218 (b):

ECHWR provided all contracts, blue prints and architectural designs for the latest video surveillance upgrades. The upgrade was designated on the PREA vulnerability assessment completed by the facility in 2017. While onsite the auditor reviewed all subsequent vulnerability assessments completed by the facility. This annual assessment is completed specifically to determine the facility is the most

susceptible as it relates to sexual safety. Each vulnerability assessment has areas of concern and solutions listed in the report. The facility lists facility upgrades, technology needs and policy updates necessary to improve the safety of the facility as well as achieve compliance with the PREA standards. These assessments are then reviewed by the appointing authority, PREA coordinator and the agency.

A final analysis of the evidence indicates the facility is in substantial compliance with this provision.

Findings:

A final analysis of the evidence indicates the facility is substantially compliant with this standard.

Corrective Action:

There is no corrective action to take.

RESPONSIVE PLANNING

Standard 115.221: Evidence protocol and forensic medical examinations

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.221 (a)

- If the agency is responsible for investigating allegations of sexual abuse, does the agency follow a uniform evidence protocol that maximizes the potential for obtaining usable physical evidence for administrative proceedings and criminal prosecutions? (N/A if the agency/facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations.)
 Yes No NA

115.221 (b)

- Is this protocol developmentally appropriate for youth where applicable? (N/A if the agency/facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations.) Yes No NA
- Is this protocol, as appropriate, adapted from or otherwise based on the most recent edition of the U.S. Department of Justice’s Office on Violence Against Women publication, “A National Protocol for Sexual Assault Medical Forensic Examinations, Adults/Adolescents,” or similarly comprehensive and authoritative protocols developed after 2011? (N/A if the agency/facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations.) Yes No NA

115.221 (c)

- Does the agency offer all residents who experience sexual abuse access to forensic medical examinations, whether on-site or at an outside facility, without financial cost, where evidentiarily or medically appropriate? Yes No

- Are such examinations performed by Sexual Assault Forensic Examiners (SAFEs) or Sexual Assault Nurse Examiners (SANEs) where possible? Yes No
- If SAFEs or SANEs cannot be made available, is the examination performed by other qualified medical practitioners (they must have been specifically trained to conduct sexual assault forensic exams)? Yes No
- Has the agency documented its efforts to provide SAFEs or SANEs? Yes No

115.221 (d)

- Does the agency attempt to make available to the victim a victim advocate from a rape crisis center? Yes No
- If a rape crisis center is not available to provide victim advocate services, does the agency make available to provide these services a qualified staff member from a community-based organization, or a qualified agency staff member? (N/A if agency *always* makes a victim advocate from a rape crisis center available to victims.) Yes No NA
- Has the agency documented its efforts to secure services from rape crisis centers? Yes No

115.221 (e)

- As requested by the victim, does the victim advocate, qualified agency staff member, or qualified community-based organization staff member accompany and support the victim through the forensic medical examination process and investigatory interviews? Yes No
- As requested by the victim, does this person provide emotional support, crisis intervention, information, and referrals? Yes No

115.221 (f)

- If the agency itself is not responsible for investigating allegations of sexual abuse, has the agency requested that the investigating agency follow the requirements of paragraphs (a) through (e) of this section? (N/A if the agency/facility is responsible for conducting criminal AND administrative sexual abuse investigations.) Yes No NA

115.221 (g)

- Auditor is not required to audit this provision.

115.221 (h)

- If the agency uses a qualified agency staff member or a qualified community-based staff member for the purposes of this section, has the individual been screened for appropriateness to serve in this role and received education concerning sexual assault and forensic examination

issues in general? (N/A if agency *always* makes a victim advocate from a rape crisis center available to victims.) Yes No NA

Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The following evidence was analyzed in making the compliance determination:

1. **Documents:** (*Policies, directives, forms, files, records, etc.*)
 - a. Aggravated Sexual Assault Checklist
 - b. PREA Response and Containment Checklist
 - c. Forensic Medical Examination Protocol
 - d. Uniform evidence protocol
 - e. Meeting Minutes with local SANE providers
 - f. Meeting Minutes with Local Law Enforcement
 - g. MOU with Washington State Patrol
 - h. Email referring Sexual Abuse allegation to SPD
2. **Interviews:**
 - a. Random Sample of Staff
 - b. PREA Coordinator
 - c. Residents who reported Sexual Abuse

3. Site Review Observations:

115.221 (a):

WADOC is responsible for all administrative investigations. WADOC has established a protocol for the entire department to utilize in evidence collection. The protocol is titled *Sexual Assault Evidence Collection: Uniform Evidence Protocol* and was established in July of 2016. The auditor found that the protocol was developed utilizing of the U.S. Department of Justice's Office on Violence Against Women publication, "A National Protocol for Sexual Assault Medical Forensic Examinations, Adults/Adolescents".

ECHWR reports all allegations that may be criminal to the Spokane Police Department Sexual Assault Unit. The auditor was provided the most recent annual meeting minutes between SPD and ECHWR and the last three investigation packets. Each of the investigation reports contained the section for

referral to law enforcement. This section on the reviewed reports was either completed with the dates of referral or reason why it was not referred.

A final analysis of the evidence indicates the facility is in substantial compliance with this provision.

115.221 (b):

In response to an observed or reported sexual assault, ECHWR utilizes an Aggravated Sexual Assault Checklist which was reviewed by the auditor. The departmental protocol on uniform evidence collection is found in the checklist. Although ECHWR does not house residents under the age of 18, the auditor found that the protocol which is recommended by the Department of Justice and the aforementioned checklist are appropriate for youth.

ECHWR does not house offenders under the age of 18.

WADOC's has established a protocol for the entire department to utilize in evidence collection. The protocol is titled *Sexual Assault Evidence Collection: Uniform Evidence Protocol* and was established in July of 2016.

The auditor found that the protocol was developed utilizing of the U.S. Department of Justice's Office on Violence Against Women publication, "A National Protocol for Sexual Assault Medical Forensic Examinations, Adults/Adolescents"

A final analysis of the evidence indicates the facility is in substantial compliance with this provision.

115.221 (c):

Agency policy requires that individual facilities develop relationships, MOUs and contracts with local medical centers and organizations for sexual assault examinations. ECHWR contracts with Multi-Care Deaconess Hospital (MCDH) for location of forensic medical examinations ECHWR contracts with the Lutheran Community Services (LCS) SANE Program as the primary entity to provide examiners to complete the exam. MCDH has agreed to provide an examiner should LCS not have an available examiner. ECHWR also contract with LCS for advocate services.

The auditor reviewed the memorandum of understanding between ECHWR and MCDH and LCS. ECHWR reports no instances of sexual abuse allegations requiring examination during this audit period.

A final analysis of the evidence indicates the facility is in substantial compliance with this provision.

115.221 (d):

WADOC has established offender advocacy support through an interagency agreement with the Department of Commerce, Office of Crime Victim Advocacy. Each facility has been partnered with a Community Sexual Assault Program. The Eleanor Chase House Work/Training Release is partnered with Lutheran Community Services NW. WSDOC requires that all Sexual Assault Programs be accredited by the Washington State Office of Victims Advocacy. Qualified advocates are required to have thirty hours of initial sexual assault/abuse training and twelve hours of ongoing training annually.

ECHWR provided the curriculum utilized in training sexual assault victim advocates. ECHWR also provided documentation demonstrating that this training had been given to the advocates at LCS who serve as the primary victim advocates for ECHWR.

A final analysis of the evidence indicates the facility is in substantial compliance with this provision.

115.221 (e):

The MOU between ECHWR and LCS outlines that ECHWR will contact LCS when an advocate is requested by the resident for forensic examinations. Specially designated and trained advocates from Lutheran Community Services NW will respond to the community health care facility.

ECHWR also has the contact information for LCS posted throughout the facility for residents to contact. ECHWR reports no instances of sexual abuse allegations requiring examination during this audit period.

WADOC provides advocacy services both in person and telephonic for offenders who are victims of sexual abuse. The advocacy services are provided by the Office of Crime Victims Advocacy (OCVA). The auditor called the Victim's Advocacy toll-free number and was informed that OCVA is outside the Department of Corrections, does not record calls from victims and does not report to the DOC. OCVA is not a reporting line but will provide victims with the information needed to report sexual abuse or sexual harassment.

WADOC provided the In-Person Advocacy Guide which outlines the procedures for scheduling advocacy services for offenders. Victims requesting in person services must first contact OCVA or the designated community sexual assault program, LCS for residents of ECHWR. Initial screening is completed by OCVA and a local advocate is notified by OCVA to make arrangements with the facility

A final analysis of the evidence indicates the facility is in substantial compliance with this provision.

115.221 (f):

WADOC Policy 490.800 PRISON RAPE ELIMINATION ACT PREVENTION AND REPORTING requires the administrator of work release facilities to meet annually with the local law enforcement agency responsible for criminal investigation of sexual abuse allegations. ECHWR has submitted the minutes from the most recent meeting with the Spokane Police Department (SPD). These minutes establish that the sexual assault unit will handle sexual abuse allegations referred to SPD. The minutes show that the requirements outlined in the PREA were discussed as well as proper procedures for referral to SPD.

A final analysis of the evidence indicates the facility is in substantial compliance with this provision.

115.221 (g): N/A**115.221 (h):**

WADOC contracts through the Office of Victim Services to provide medical facilities for SAFE/SANE exams and victim advocates from a rape crisis center. The designated medical facility for ECHWR is Deaconess Medical Center. The designated crisis center is Lutheran Community Services NW. DMC and LCS provide 24/7 services. During the audit documentation period, no allegations were received that indicated the need for a forensic medical examination. ECHWR provided the training curriculum for community based advocate service providers which the provider must complete prior to providing services to residents.

A final analysis of the evidence indicates the facility is in substantial compliance with this provision.

Findings:

A final analysis of the evidence indicates the facility is substantially compliant with this standard.

Corrective Action:

There is no corrective action to take.

Standard 115.222: Policies to ensure referrals of allegations for investigations

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.222 (a)

- Does the agency ensure an administrative or criminal investigation is completed for all allegations of sexual abuse? Yes No
- Does the agency ensure an administrative or criminal investigation is completed for all allegations of sexual harassment? Yes No

115.222 (b)

- Does the agency have a policy and practice in place to ensure that allegations of sexual abuse or sexual harassment are referred for investigation to an agency with the legal authority to conduct criminal investigations, unless the allegation does not involve potentially criminal behavior? Yes No
- Has the agency published such policy on its website or, if it does not have one, made the policy available through other means? Yes No
- Does the agency document all such referrals? Yes No

115.222 (c)

- If a separate entity is responsible for conducting criminal investigations, does the policy describe the responsibilities of both the agency and the investigating entity? (N/A if the agency/facility is responsible for conducting criminal investigations. See 115.221(a).) Yes No NA

115.222 (d)

- Auditor is not required to audit this provision.

115.222 (e)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The following evidence was analyzed in making the compliance determination:

1. **Documents:** (*Policies, directives, forms, files, records, etc.*)
 - a. Complaint Log
 - b. Meeting Notes with Local Law Enforcement
 - c. Screen Shot of Public Website
2. **Interviews:**
 - a. Agency Head
 - b. Investigative Staff
3. **Site Review Observations:**
 - a. WADOC Public Website
 - b. Review Referral Log

115.222 (a):

The agency policy 490.860 Prison Rape Elimination Act Investigation requires that all allegations of sexual harassment and sexual abuse are investigated. ECHWR reports three allegations during the recent audit period. The auditor reviewed these investigations and found them to be thoroughly investigated and documented

A final analysis of the evidence indicates the facility is in substantial compliance with this provision.

115.222 (b):

The agency policy 490.860 Prison Rape Elimination Act Investigation requires that all facilities maintain relationship with local law enforcement who will investigate allegations of sexual abuse that may be criminal. ECHWR provided meeting minutes from their annual meeting with Spokane Police Department who is responsible for these investigations. The auditor found that this policy is published on the agency's public website. During the site review, the auditor reviewed the local law enforcement complaint referral log.

Secretary Sinclair in his interview outlined the investigative referral process as follows, “All allegations of sexual abuse or sexual harassment are triaged by the PREA Coordinator. The PREA coordinator in conjunction with the appointing authority decide who should investigate. If the allegation is a possible criminal matter, the local law enforcement agency would be notified.”

The following incident was discovered, corrected and reported by the facility. Documentation reviewed by the auditor shows that the facility has completed a tracking document for all investigations. In reviewing the two investigations for the previous 12 months, ECHWR has made the proper law enforcement referrals. The auditor finds that the facility has taken appropriate action to correct the law enforcement referral process and finds that further corrective action is not warranted.

- 19-18703 – During audit preparation, it was learned that a law enforcement referral was not made when the allegation was reported. To address this deficiency, the management team is working on a tracking and assignment document that will be maintained on the Work Release SharePoint Site. This document will be restricted to the Appointing Authority, Work Release Operations Administrator and the Executive Secretary. These individuals will share the responsibility of tracking a PREA case from initial report through completion, which will include tracking of all indicated law enforcement referrals. In addition, the documents associated with the case will be uploaded to site to ensure proper forms and processes are followed per DOC Policy. PREA Standards 115.21 / 115.221 (a) and (b) This site is currently in development and will be available for review at the onsite audit. It is noted that the administrative investigation was later closed as unsubstantiated.
- 20-19926 – law enforcement referral made 06/23/2020, declined as of 06/30/2020.

A final analysis of the evidence indicates the facility is in substantial compliance with this provision.

115.222 (c):

The auditor found that the policy does describe the responsibility of both the facility/agency and the law enforcement agency. ECHWR also provided the meeting minutes between the facility and Spokane PD.

A final analysis of the evidence indicates the facility is in substantial compliance with this provision.

115.222 (d): N/A

115.222 (e): N/A

Findings:

A final analysis of the evidence indicates the facility is substantially compliant with this standard.

Corrective Action:

There is no corrective action to take.

TRAINING AND EDUCATION

Standard 115.231: Employee training

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.231 (a)

- Does the agency train all employees who may have contact with residents on: Its zero-tolerance policy for sexual abuse and sexual harassment? Yes No
- Does the agency train all employees who may have contact with residents on: How to fulfill their responsibilities under agency sexual abuse and sexual harassment prevention, detection, reporting, and response policies and procedures? Yes No
- Does the agency train all employees who may have contact with residents on: Residents' right to be free from sexual abuse and sexual harassment Yes No
- Does the agency train all employees who may have contact with residents on: The right of residents and employees to be free from retaliation for reporting sexual abuse and sexual harassment? Yes No
- Does the agency train all employees who may have contact with residents on: The dynamics of sexual abuse and sexual harassment in confinement? Yes No
- Does the agency train all employees who may have contact with residents on: The common reactions of sexual abuse and sexual harassment victims? Yes No
- Does the agency train all employees who may have contact with residents on: How to detect and respond to signs of threatened and actual sexual abuse? Yes No
- Does the agency train all employees who may have contact with residents on: How to avoid inappropriate relationships with residents? Yes No
- Does the agency train all employees who may have contact with residents on: How to communicate effectively and professionally with residents, including lesbian, gay, bisexual, transgender, intersex, or gender nonconforming residents? Yes No
- Does the agency train all employees who may have contact with residents on: How to comply with relevant laws related to mandatory reporting of sexual abuse to outside authorities?
 Yes No

115.231 (b)

- Is such training tailored to the gender of the residents at the employee's facility? Yes No

- Have employees received additional training if reassigned from a facility that houses only male residents to a facility that houses only female residents, or vice versa? Yes No

115.231 (c)

- Have all current employees who may have contact with residents received such training? Yes No
- Does the agency provide each employee with refresher training every two years to ensure that all employees know the agency's current sexual abuse and sexual harassment policies and procedures? Yes No
- In years in which an employee does not receive refresher training, does the agency provide refresher information on current sexual abuse and sexual harassment policies? Yes No

115.231 (d)

- Does the agency document, through employee signature or electronic verification, that employees understand the training they have received? Yes No

Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Evidence analyzed in making the compliance determination:

- 1. Documents:** (*Policies, directives, forms, files, records, etc.*)
 - a. PREA Training Curriculum WADOC
 - b. Annual PREA Training Curriculum 2019
 - c. PREA Training Acknowledgement Form
 - d. Training Records for WADOC Employees and Transition House Employees 2018-2021
 - e. DOC 490.800 PRISON RAPE ELIMINATION ACT (PREA) PREVENTION AND REPORTING
- 2. Interviews:**
 - a. Random Sample of Staff

3. Site Review Observations:

a. WADOC Public Website

115.231 (a):

The auditor has reviewed the curriculum provided by the facility and agency and was able to verify that all components of provision (a) are found in the curriculum. The facility also provided the training records for all of the WADOC employees and TTH employees. The auditor also interviewed a random sampling of seven staff. All seven staff answered in the affirmative when asked if the following elements were contained within the training.

- a. Zero-tolerance policy for sexual abuse and sexual harassment
- b. How to fulfill their responsibilities under agency sexual abuse and sexual harassment prevention, detection, reporting, and response policies and procedures
- c. The right of residents and employees to be free from retaliation for reporting sexual abuse and sexual harassment
- d. The dynamics of sexual abuse and sexual harassment in confinement
- e. The common reactions of sexual abuse and sexual harassment victims
- f. How to detect and respond to signs of threatened and actual sexual abuse
- g. How to avoid inappropriate relationships with residents
- h. How to communicate effectively and professionally with residents, including lesbian, gay, bisexual, transgender, intersex, or gender nonconforming residents
- i. How to comply with relevant laws related to mandatory reporting of sexual abuse to outside authorities

A final analysis of the evidence indicates the facility is in substantial compliance with this provision.

115.231 (b):

The auditor, in review of the provided curriculum, found that the training covers all genders regardless of the current population. The auditor also found that all staff receive annual update for this training. This requirement exceeds the expectation outlined in the standards

A final analysis of the evidence indicates the facility exceeds compliance expectations with this provision.

115.231 (c):

The training records provided by the facility shows that all current staff received their initial training and have received yearly updates.

A final analysis of the evidence indicates the facility is in substantial compliance with this provision.

115.231 (d):

The agency requires signature or electronic verification that employees understand the training they have received. ECHWR uses electronic verification as their PREA training is computer based.

A final analysis of the evidence indicates the facility is in substantial compliance with this provision.

Findings:

A final analysis of the evidence indicates the facility substantially exceeds requirements of the standard. The agency requires annual training for all staff with signature or electronic verification. This is beyond what is required by the standard.

Corrective Action:

There is no corrective action to take.

Standard 115.232: Volunteer and contractor training

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.232 (a)

- Has the agency ensured that all volunteers and contractors who have contact with residents have been trained on their responsibilities under the agency's sexual abuse and sexual harassment prevention, detection, and response policies and procedures? Yes No

115.232 (b)

- Have all volunteers and contractors who have contact with residents been notified of the agency's zero-tolerance policy regarding sexual abuse and sexual harassment and informed how to report such incidents (the level and type of training provided to volunteers and contractors shall be based on the services they provide and level of contact they have with residents)? Yes No

115.232 (c)

- Does the agency maintain documentation confirming that volunteers and contractors understand the training they have received? Yes No

Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The following evidence was analyzed in making the compliance determination:

- 1. Documents:** (*Policies, directives, forms, files, records, etc.*)
 - a. DOC 490.800 PRISON RAPE ELIMINATION ACT (PREA) PREVENTION AND REPORTING
 - b. DOC 530.100 VOLUNTEER PROGRAMS
 - c. PREA Training Curriculum WADOC
 - d. PREA Training Acknowledgement Form
 - e. Training Records for Transition House Employees 2017-2020
 - f. Training Records for Contractors 2017-2020 (Interpretive Services, Construction, etc...)
- 2. Interviews:**
 - a. Volunteers and Contractors
- 3. Site Review Observations:**
 - a. None noted for this provision

115.232 (a):

The auditor has reviewed the curriculum provided by the facility and agency policy 490.800 and 530.100. The policies require that all contractors and volunteers receive training commensurate to their exposure to residents. ECHWR currently does not have any volunteers for their facility. The auditor reviewed the training records for all contract staff specifically for the staff who provide interpretive services for the facility. The auditor was able to verify that all contract staff have received training and completed the appropriate acknowledgement form.

115.232 (b):

The auditor in review of the provided curriculum found that the training covers the agency's zero tolerance policy and how to report these incidents.

A final analysis of the evidence indicates the facility is in substantial compliance with this provision.

115.232 (c):

The agency requires signature or electronic verification that employees understand the training they have received. ECHWR uses electronic verification for on-site staff and a hard copy acknowledgement for off-site contractors. ECHWR provided electronic and hard copy verifications for selected employees and contractors when requested by the auditor.

A final analysis of the evidence indicates the facility is in substantial compliance with this provision.

Findings:

A final analysis of the evidence indicates the facility is substantially compliant with this standard.

Corrective Action:

There is no corrective action to take.

Standard 115.233: Resident education**All Yes/No Questions Must Be Answered by the Auditor to Complete the Report****115.233 (a)**

- During intake, do residents receive information explaining: The agency's zero-tolerance policy regarding sexual abuse and sexual harassment? Yes No
- During intake, do residents receive information explaining: How to report incidents or suspicions of sexual abuse or sexual harassment? Yes No
- During intake, do residents receive information explaining: Their rights to be free from sexual abuse and sexual harassment? Yes No
- During intake, do residents receive information explaining: Their rights to be free from retaliation for reporting such incidents? Yes No
- During intake, do residents receive information regarding agency policies and procedures for responding to such incidents? Yes No

115.233 (b)

- Does the agency provide refresher information whenever a resident is transferred to a different facility? Yes No

115.233 (c)

- Does the agency provide resident education in formats accessible to all residents, including those who: Are limited English proficient? Yes No
- Does the agency provide resident education in formats accessible to all residents, including those who: Are deaf? Yes No
- Does the agency provide resident education in formats accessible to all residents, including those who: Are visually impaired? Yes No
- Does the agency provide resident education in formats accessible to all residents, including those who: Are otherwise disabled? Yes No
- Does the agency provide resident education in formats accessible to all residents, including those who: Have limited reading skills? Yes No

115.233 (d)

- Does the agency maintain documentation of resident participation in these education sessions? Yes No

115.233 (e)

- In addition to providing such education, does the agency ensure that key information is continuously and readily available or visible to residents through posters, resident handbooks, or other written formats? Yes No

Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Evidence analyzed in making the compliance determination:

- 1. Documents:** (*Policies, directives, forms, files, records, etc.*)
 - a. DOC 310.000 ORIENTATIONS
 - b. DOC 490.800 PRISON RAPE ELIMINATION ACT (PREA) PREVENTION AND REPORTING
 - c. WADOC PREA Orientation for Work Release Offenders Brochure
 - d. Resident Orientation Handbook
 - e. Orientation Record for all 73 residents received during this auditing period
 - f. Sample of 23 orientation checklist signed by the resident
 - g. Transcript of PREA Orientation Video for deaf residents
 - h. End Silence Facilitators Guide for residents with comprehension and reading deficiencies
- 2. Interviews:**
 - a. Random Sample of Residents
 - b. Intake Staff
- 3. Site Review Observations:**

115.233 (a):

DOC 310.000 requires all newly incarcerated individuals receive initial orientation within four weeks of admission to a Reception Diagnostics Center. This policy further requires individuals arriving to a Work Release facility to receive an orientation to that facility within 48 hours of arrival. Information on PREA is required to be presented during these orientation sessions. Documentation is kept of resident attendance at orientation sessions.

DOC 490.800 indicates the required content of the PREA information that is to be provided to residents which includes information on the Department's zero tolerance stance and ways to report sexual misconduct. Information is to be presented in a way to allow residents to ask questions of the facilitators during the presentation.

A final analysis of the evidence indicates the facility is in substantial compliance with this provision.

115.233 (b):

ECHWR provides each resident a WADOC PREA Orientation for Work Release Offenders Brochure and a Resident Orientation Handbook. The Brochure and handbook explain the agency's and facility's zero tolerance policy, how to report incidents or suspicions of sexual abuse or sexual harassment, their rights to be free from sexual abuse and sexual harassment, their rights to be free from retaliation for reporting such incidents and the agency policies and procedures for responding to such incidents.

Residents view a PREA education video upon arrival to ECHWR. The video contains multiple references to the Department's zero tolerance policy for sexual abuse and sexual harassment. The video contains information on how to report sexual abuse and sexual harassment including: reporting verbally to any staff member, calling the PREA hotline, sending a kite or message through the kiosk, sending legal mail to the Attorney General, Governor, Law Enforcement or the PREA coordinator at headquarters, sending a report to the PREA reporting office, submitting a grievance or having others report on behalf of a resident. The video notifies residents of their right to be free from sexual abuse and sexual harassment and their right to be free from retaliation for reporting sexual abuse or sexual harassment. Finally, the video explains the agency's policies and procedures for responding to reports of sexual abuse and sexual harassment.

All 11 residents interviewed during the onsite audit indicated they received PREA information on the same day they arrived at ECHWR. All residents interviewed indicated they were aware of their right to be free from sexual abuse and harassment, they had a right not to be punished for reporting sexual abuse or harassment and indicated they were informed how to report sexual abuse or harassment. Residents indicated they are aware of their rights concerning PREA due to education they received at ECHWR via video, the resident handbook and posters hanging up around the facility.

A final analysis of the evidence indicates the facility is in substantial compliance with this provision.

115.233 (c):

ECHWR provides orientation materials via various methods to meet the needs of their residents. The facility offers a transcript of their PREA orientation video for deaf residents. The video transcript is available in both English and Spanish. The End Silence Facilitators Guide for Residents with Comprehension and Reading Deficiencies is available for staff to use to provide one-on-one PREA education to residents with limited reading skills. The WADOC PREA Orientation for Work Release Offenders Brochure and is offered in Spanish. Policy 490.88 also allows for professional interpreter or translation services to allow residents to understand PREA information.

A final analysis of the evidence indicates the facility is in substantial compliance with this provision.

115.233 (d):

Documentation of these education sessions is the responsibility of the individual facility. ECHWR provided documentation showing all 73 residents of the facility attended the orientation session during the pre-onsite period and provided 23 orientation checklists signed by residents who received their orientation during the pre-onsite period.

A final analysis of the evidence indicates the facility is in substantial compliance with this provision.

115.233 (e):

PREA education posters in both English and Spanish are located throughout the ECHWR facility and were observed in multiple locations during the auditors' site review of the facility. These posters

provide notice that residents have the right to be free from sexual abuse, assault and harassment, indicate that DOC has zero tolerance for sexual misconduct in any form, provide definitions of sexual misconduct, and list a toll free phone number, email and mailing address that can be contacted to report sexual misconduct. This information is also located in the resident handbook which was provided by ECHWR.

A final analysis of the evidence indicates the facility is in substantial compliance with this provision.

Findings:

A final analysis of the evidence indicates the facility is substantially compliant with this standard.

Corrective Action:

There is no corrective action to take.

Standard 115.234: Specialized training: Investigations

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.234 (a)

- In addition to the general training provided to all employees pursuant to §115.231, does the agency ensure that, to the extent the agency itself conducts sexual abuse investigations, its investigators receive training in conducting such investigations in confinement settings? (N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.221(a).)
 Yes No NA

115.234 (b)

- Does this specialized training include: Techniques for interviewing sexual abuse victims? (N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.221(a).) Yes No NA
- Does this specialized training include: Proper use of Miranda and Garrity warnings? (N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.221(a).) Yes No NA
- Does this specialized training include: Sexual abuse evidence collection in confinement settings? (N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.221(a).) Yes No NA
- Does this specialized training include: The criteria and evidence required to substantiate a case for administrative action or prosecution referral? (N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.221(a).)
 Yes No NA

115.234 (c)

- Does the agency maintain documentation that agency investigators have completed the required specialized training in conducting sexual abuse investigations? (N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.221(a.)
 Yes No NA

115.234 (d)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Evidence analyzed in making the compliance determination:

1. **Documents:** (*Policies, directives, forms, files, records, etc.*)
 - a. DOC 490.800 PRISON RAPE ELIMINATION ACT (PREA) PREVENTION AND REPORTING
 - b. DOC 490.860 PRISON RAPE ELIMINATION ACT (PREA) INVESTIGATION
 - c. 880.100 CORRECTIONS TRAINING AND DEVELOPMENT
 - d. Sexual Assault Evidence Collection: Uniform Evidence Protocol
 - e. PREA Investigator Curriculum
 - f. Training Records for PREA Investigators assigned to ECHWR
2. **Interviews:**
 - a. Investigative Staff
3. **Site Review Observations:**

115.234 (a):

DOC 490.800 PRISON RAPE ELIMINATION ACT (PREA) PREVENTION AND REPORTING (V., H (1-7) requires that agency and facility investigators be trained in the following areas

1. Crime scene management/investigation, including evidence collection in Prisons and Work Releases,
2. Confidentiality of all investigation information,
3. Miranda and Garrity warnings, compelled interviews, and the law enforcement referral process,

4. Crisis intervention,
5. Investigating sexual misconduct,
6. Techniques for interviewing sexual misconduct victims, and
7. Criteria and evidence required to substantiate administrative action or prosecution referral.

A final analysis of the evidence indicates the facility is in substantial compliance with this provision.

115.234 (b):

The auditor requested the curriculum for investigator training provided by WADOC which was provided. In reviewing this curriculum, the auditor found that the training covers techniques for interviewing sexual abuse victims, the 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 prosecution referral.

Interviews with two certified PREA investigators were conducted during the onsite audit period. Both of the investigators verified that the training contains the topics outlined above

A final analysis of the evidence indicates the facility is in substantial compliance with this provision.

115.234 (c):

ECHWR provided a print out from the training data base which logs employees that have completed the PREA Investigator's training. ECHWR has two employees certified as investigators. The training records for the two employees were requested and provided. The auditor reviewed the training records and found that both employees have completed the specialized training required.

A final analysis of the evidence indicates the facility is in substantial compliance with this provision.

115.234 (d): N/A

Findings:

A final analysis of the evidence indicates the facility is substantially compliant with this standard.

Corrective Action:

There is no corrective action to take.

Standard 115.235: Specialized training: Medical and mental health care

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.235 (a)

- Does the agency ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in: How to detect and assess signs of sexual abuse and sexual harassment? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners who work regularly in its facilities.)
 Yes No NA
- Does the agency ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in: How to preserve physical evidence of

sexual abuse? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners who work regularly in its facilities.) Yes No NA

- Does the agency ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in: How to respond effectively and professionally to victims of sexual abuse and sexual harassment? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners who work regularly in its facilities.) Yes No NA
- Does the agency ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in: How and to whom to report allegations or suspicions of sexual abuse and sexual harassment? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners who work regularly in its facilities.) Yes No NA

115.235 (b)

- If medical staff employed by the agency conduct forensic examinations, do such medical staff receive appropriate training to conduct such examinations? (N/A if agency does not employ medical staff or the medical staff employed by the agency do not conduct forensic exams.) Yes No NA

115.235 (c)

- Does the agency maintain documentation that medical and mental health practitioners have received the training referenced in this standard either from the agency or elsewhere? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners who work regularly in its facilities.) Yes No NA

115.235 (d)

- Do medical and mental health care practitioners employed by the agency also receive training mandated for employees by §115.231? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners employed by the agency.) Yes No NA
- Do medical and mental health care practitioners contracted by and volunteering for the agency also receive training mandated for contractors and volunteers by §115.232? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners contracted by or volunteering for the agency.) Yes No NA

Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Evidence analyzed in making the compliance determination:

1. **Documents:** (*Policies, directives, forms, files, records, etc.*)
 - a. 490.800 PRISON RAPE ELIMINATION ACT (PREA) PREVENTION AND REPORTING
 - b. 610.025 HEALTH SERVICES MANAGEMENT OF ALLEGED SEXUAL MISCONDUCT CASES
 - c. 880.100 CORRECTIONS TRAINING AND DEVELOPMENT

2. **Interviews:**
 - a. Medical and Mental Health Staff

3. Site Review Observations:

115.235 (a)

Agency Policy DOC 490.800 PRISON RAPE ELIMINATION ACT PREVENTION AND REPORTING requires the following for the training of health services employees

Health Services employees/contract staff, with the exception of medical records, clerical, pharmacy personnel, the Dietary Services Manager, and the Psychologist assigned exclusively to sex offender treatment programming, will be trained in:

1. Detecting and assessing signs of sexual misconduct,
2. Responding effectively and professionally to sexual misconduct victims,
3. Completing DOC 02-348 Fight/Assault Activity Review,
4. Preserving physical evidence,
5. Reporting sexual misconduct, and
6. Counseling and monitoring procedures.

The auditor verified through review of the PREA training curriculum that all components as specified in the policy are present. All staff, before being allowed to meet with residents unescorted, are required to complete this training.

A final analysis of the evidence indicates the facility is in substantial compliance with this provision.

115.235 (b):

N/A – WADOC requires forensic examinations be conducted in community medical facilities.

A final analysis of the evidence indicates the facility is in substantial compliance with this provision.

115.235 (c):

WADOC utilizes the Staff Training and Tracking Information System (STATIS) to document all official Department training. ECHWR does not employ any health services employees. All medical and mental health services are community based.

A final analysis of the evidence indicates the facility is in substantial compliance with this provision.

115.235 (d):

WADOC requires all staff including medical and mental health staff to participate in initial PREA training and required annual update.

A final analysis of the evidence indicates the facility is in substantial compliance with this provision.

Findings:

A final analysis of the evidence indicates the facility is substantially compliant with this standard.

Corrective Action:

There is no corrective action to take.

SCREENING FOR RISK OF SEXUAL VICTIMIZATION AND ABUSIVENESS

Standard 115.241: Screening for risk of victimization and abusiveness

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.241 (a)

- Are all residents assessed during an intake screening for their risk of being sexually abused by other residents or sexually abusive toward other residents? Yes No
- Are all residents assessed upon transfer to another facility for their risk of being sexually abused by other residents or sexually abusive toward other residents? Yes No

115.241 (b)

- Do intake screenings ordinarily take place within 72 hours of arrival at the facility?
 Yes No

115.241 (c)

- Are all PREA screening assessments conducted using an objective screening instrument?
 Yes No

115.241 (d)

- Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: Whether the resident has a mental, physical, or developmental disability? Yes No
- Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: The age of the resident? Yes No
- Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: The physical build of the resident? Yes No
- Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: Whether the resident has previously been incarcerated? Yes No
- Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: Whether the resident's criminal history is exclusively nonviolent? Yes No
- Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: Whether the resident has prior convictions for sex offenses against an adult or child? Yes No
- Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: Whether the resident is or is perceived to be gay, lesbian, bisexual, transgender, intersex, or gender nonconforming (the facility affirmatively asks the resident about his/her sexual orientation and gender identity AND makes a subjective determination based on the screener's perception whether the resident is gender non-conforming or otherwise may be perceived to be LGBTI)? Yes No
- Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: Whether the resident has previously experienced sexual victimization? Yes No
- Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: The resident's own perception of vulnerability? Yes No

115.241 (e)

- In assessing residents for risk of being sexually abusive, does the initial PREA risk screening consider, when known to the agency: prior acts of sexual abuse? Yes No
- In assessing residents for risk of being sexually abusive, does the initial PREA risk screening consider, when known to the agency: prior convictions for violent offenses? Yes No
- In assessing residents for risk of being sexually abusive, does the initial PREA risk screening consider, when known to the agency: history of prior institutional violence or sexual abuse? Yes No

115.241 (f)

- Within a set time period not more than 30 days from the resident's arrival at the facility, does the facility reassess the resident's risk of victimization or abusiveness based upon any additional, relevant information received by the facility since the intake screening? Yes No

115.241 (g)

- Does the facility reassess a resident's risk level when warranted due to a: Referral?
 Yes No
- Does the facility reassess a resident's risk level when warranted due to a: Request?
 Yes No
- Does the facility reassess a resident's risk level when warranted due to a: Incident of sexual abuse? Yes No
- Does the facility reassess a resident's risk level when warranted due to a: Receipt of additional information that bears on the resident's risk of sexual victimization or abusiveness?
 Yes No

115.241 (h)

- Is it the case that residents are not ever 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? Yes No

115.241 (i)

- Has the agency implemented appropriate controls on the dissemination within the facility of responses to questions asked pursuant to this standard in order to ensure that sensitive information is not exploited to the resident's detriment by staff or other residents? Yes No

Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Evidence analyzed in making the compliance determination:

1. **Documents:** (*Policies, directives, forms, files, records, etc.*)
 - a. DOC 490.820 PRISON RAPE ELIMINATION ACT (PREA) RISK ASSESSMENTS AND ASSIGNMENTS
 - b. OMNI PREA RISK ASSESSMENT
 - c. DOC Form 07-019 PREA Risk Assessment
 - d. PRA HOUSING GUIDE
2. **Interviews:**
 - a. PREA Coordinator
 - b. Staff Responsible for Risk Screening
 - c. Random Sample of Residents
3. **Site Review Observations:**
 - a. Audit team was shown the PRA tool, how it is completed and how the information obtained is utilized within the facility

115.241 (a) (b):

DOC Policy 490.820 indicates a PREA Risk Assessment (PRA) is to be completed within 72 hours of arrival to a facility and a follow-up PRA will be completed between 21-30 calendar days after a resident's arrival at the facility. This policy indicates For-cause PRAs will be completed within 10 business days.

All 11 residents interviewed during the onsite audit indicated they recalled being asked questions related to risk for sexual victimization upon their arrival to ECHWR. Two residents indicated that, due to past incidents at previous facilities in which they were incarcerated, their Community Corrections Officer has met with them monthly since their arrival at ECHWR to reassess their risk.

ECHWR provided documentation showing the arrival date/initial PRA completion date/scheduled PRA follow-up date/and actual date follow-up PRA completed for 70 residents who arrived to ECHWR during the audit period. In all cases, the initial PRA was completed within 72 hours.

A final analysis of the evidence indicates the facility is in substantial compliance with this provision.

115.241 (c):

Offender Management Network Information system (OMNI) PREA Risk Assessment is used to complete the initial and follow-up risk assessments. The OMNI is a computer based application. PREA Risk Assessments are completed in a restricted area of OMNI.

During the site review the auditors were able to observe the Offender Management Network Information system (OMNI) which houses the PRA and the database which is kept to document resident arrival dates, initial PRA completion date, PRA follow-up due date, and PRA follow-up completion date. It was explained that the system prompts the employee to complete the initial PRA within three days of the resident's arrival to the facility and to complete the follow-up PRA 21 days after the resident's arrival to the facility.

A final analysis of the evidence indicates the facility is in substantial compliance with this provision.

115.241 (d):

The PREA Risk Assessment used by ECHWR is an objective screening instrument. Questions related to a resident's potential for sexual victimization include:

- Is this the offender's first prison incarceration as an adult?
- Is the offender under the age of 25 or over the age of 65?
- Is the offender small in stature?
 - Males: Under 5'8" and/or under 140 pounds
 - Females: Under 5'0" and/or under 115 pounds
- Has the offender ever been sexually assaulted/abused while incarcerated in any type of facility?
- Has the offender ever been convicted of a sex offense or a crime with sexual motivation in which the victim was a child of 13 years or younger or elderly person of 65 years or older?
- Does offender identify as gay/lesbian or bisexual?
 - If no, does the offender seem to be gender non-conforming to you/others?
- Does offender identify as transgender or intersex?
- Does offender identify as gender non-conforming?
 - If no, does the offender seem to be gender non-conforming to you/others?
- Does the offender express feelings of being at risk of being sexually abused?
- Has the offender's criminal history been exclusively non-violent?
- Does the offender have any mental illness or impairment that increases vulnerability?
- Does the offender have any developments, intellectual, or physical disability that increases vulnerability?
- For males only: Has the offender ever been the victim of sexual abuse/assault in the community?

A final analysis of the evidence indicates the facility is in substantial compliance with this provision.

115.241 (e):

The following questions related to a resident's potential for sexual predation are included in the OMNI PREA Risk Assessment:

- Does the offender have any previous prison incarcerations as an adult?
- Has the offender ever committed sexual assault/abuse while incarcerated in any type of facility to include jails or other state corrections agencies?
- Has the offender ever committed any other violent act while incarcerated in any type of facility to include jails or other state corrections agencies?
- Has the offender ever been convicted of a sexual offense or a crime with sexual motivation in which the victim was between 14 and 65 years old?
- Has the offender ever been convicted of a violent offense?

A final analysis of the evidence indicates the facility is in substantial compliance with this provision.

115.241 (f):

DOC Policy 490.820 indicates a PREA Risk Assessment (PRA) is to be completed within 72 hours of arrival to a facility and a follow-up PRA will be completed between 21-30 calendar days after a

resident's arrival at the facility. This policy indicates For-cause PRAs will be completed within 10 business days.

ECHWR provided documentation showing the arrival date/initial PRA completion date/scheduled PRA follow-up date/and actual date follow-up PRA completed for 70 residents who arrived to ECHWR during the audit period. In all cases, the initial PRA was completed within 72 hours. In all but two cases the follow-up PRA was completed between 21-30 days. In one case the PRA was completed late by five days and in another case the PRA was completed early by one day. Auditors reviewed 23 completed initial PRAs that were completed during the audit period and 23 follow-up PRAs also completed during the audit period.

A final analysis of the evidence indicates the facility is in substantial compliance with this provision.

115.241 (g):

DOC Policy 490.820 indicates that for-cause PRAs will be completed within 10 business days and includes the following language concerning For-cause PRAs:

1. For-cause PRAs will be completed within 10 business days by the assigned Classification Counselor/CCO:
 - a. When additional information is received suggesting potential for victimization or predation (e.g., reports of behavior while in jail or on the bus in transit, court documents, Pre-Sentence Investigations).
 - b. If the offender self-discloses information that could impact assessed risk (e.g., previously unreported prior abuse, sexual orientation/identity).
 - c. When there is a finding of guilt on certain infractions listed in the PRA, including violent infractions and infractions for sexual assault/abuse.
 - d. When an employee/contract staff observes offender behavior suggesting potential for victimization or predation.
 - e. For substantiated allegations of offender-on-offender sexual abuse/ assault or staff sexual misconduct.

ECHWR indicated there were no circumstances present to prompt a PRA reassessment due to a referral, request, or incident of sexual abuse or receipt of additional information that bears on the resident's risk of sexual victimization or abusiveness during the audit period.

A final analysis of the evidence indicates the facility is in substantial compliance with this provision.

115.241 (h):

DOC Policy 490.820 indicates residents are not obligated to answer assessment questions.

During the on-site portion of the audit, the audit team interviewed two employees responsible for completing PREA risk assessments with the residents. Both employees stated that they inform the resident prior to the assessment that the resident is not required to participate in the assessment.

115.241 (i):

The OMNI PREA Risk Assessment is used to complete the initial and follow-up risk assessments. The OMNI is a computer based application. PREA Risk Assessments are completed in a restricted area of OMNI and are accessible only to the following employees:

- Classification Counselors and Work Release Community Corrections Officers responsible for the completion of assessments.
- Correctional Unit Supervisors, Community Corrections Supervisors, Correctional Program Managers, Associate Superintendents, Superintendents, and the Work Release Program Administrator responsible for override approval and ensuring assessments are completed as required in agency policy.
- Staff as identified by the facility Superintendent and the Work Release Program Administrator responsible for oversight of risk assessment for offenders who do not have an assigned Classification Counselor or Community Corrections Officer generally due to a vacancy.
- Identified Information Technology and PREA Unit staff responsible for system maintenance.

DOC Policy 490.820 indicates *Information related to allegation/incidents of sexual misconduct is confidential and will only be disclosed when necessary for related treatment, investigations and security and management decisions. Staff who breach confidentiality may be subject to corrective or disciplinary action.*

A final analysis of the evidence indicates the facility is in substantial compliance with this provision.

Findings:

A final analysis of the evidence indicates the facility is substantially compliant with this standard.

Corrective Action:

There is no corrective action to take.

Standard 115.242: Use of screening information

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.242 (a)

- Does the agency use information from the risk screening required by § 115.241, with the goal of keeping separate those residents at high risk of being sexually victimized from those at high risk of being sexually abusive, to inform: Housing Assignments? Yes No
- Does the agency use information from the risk screening required by § 115.241, with the goal of keeping separate those residents at high risk of being sexually victimized from those at high risk of being sexually abusive, to inform: Bed assignments? Yes No

- Does the agency use information from the risk screening required by § 115.241, with the goal of keeping separate those residents at high risk of being sexually victimized from those at high risk of being sexually abusive, to inform: Work Assignments? Yes No
- Does the agency use information from the risk screening required by § 115.241, with the goal of keeping separate those residents at high risk of being sexually victimized from those at high risk of being sexually abusive, to inform: Education Assignments? Yes No
- Does the agency use information from the risk screening required by § 115.241, with the goal of keeping separate those residents at high risk of being sexually victimized from those at high risk of being sexually abusive, to inform: Program Assignments? Yes No

115.242 (b)

- Does the agency make individualized determinations about how to ensure the safety of each resident? Yes No

115.242 (c)

- When deciding whether to assign a transgender or intersex resident to a facility for male or female residents, does the agency consider on a case-by-case basis whether a placement would ensure the resident's health and safety, and whether a placement would present management or security problems (NOTE: if an agency by policy or practice assigns residents to a male or female facility on the basis of anatomy alone, that agency is not in compliance with this standard)? Yes No
- When making housing or other program assignments for transgender or intersex residents, does the agency consider on a case-by-case basis whether a placement would ensure the resident's health and safety, and whether a placement would present management or security problems? Yes No

115.242 (d)

- Are each transgender or intersex resident's own views with respect to his or her own safety given serious consideration when making facility and housing placement decisions and programming assignments? Yes No

115.242 (e)

- Are transgender and intersex residents given the opportunity to shower separately from other residents? Yes No

115.242 (f)

- Unless 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 lesbian, gay, bisexual, transgender, or intersex residents, does the agency always refrain from placing: lesbian, gay, and bisexual residents in dedicated facilities, units, or wings solely on the basis of such identification or status? (N/A if the agency has a dedicated facility, unit, or wing solely for

the placement of LGBT or I residents pursuant to a consent decree, legal settlement, or legal judgement.) Yes No NA

- Unless 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 lesbian, gay, bisexual, transgender, or intersex residents, does the agency always refrain from placing: transgender residents in dedicated facilities, units, or wings solely on the basis of such identification or status? (N/A if the agency has a dedicated facility, unit, or wing solely for the placement of LGBT or I residents pursuant to a consent decree, legal settlement, or legal judgement.) Yes No NA

- Unless 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 lesbian, gay, bisexual, transgender, or intersex residents, does the agency always refrain from placing: intersex residents in dedicated facilities, units, or wings solely on the basis of such identification or status? (N/A if the agency has a dedicated facility, unit, or wing solely for the placement of LGBT or I residents pursuant to a consent decree, legal settlement, or legal judgement.) Yes No NA

Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)

- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)

- Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Evidence analyzed in making the compliance determination:

1. **Documents:** (*Policies, directives, forms, files, records, etc.*)
 - a. DOC 490.700 TRANSGENDER, INTERSEX, AND/OR GENDER NON CONFORMING HOUSING AND SUPERVISION
 - b. DOC 300.380 CLASSIFICATION AND CUSTODY FACILITY PLAN REVIEW
 - c. DOC 490.820 PRISON RAPE ELIMINATION ACT (PREA) RISK ASSESSMENTS AND ASSIGNMENTS
 - d. The PRA HOUSING GUIDE

2. **Interviews:**
 - a. PREA Coordinator
 - b. Staff Responsible for Risk Screening

c. Transgender/Intersex Residents

3. Site Review Observations:

- a. Audit team observed that in cell and community bathrooms and showers provide privacy for all individuals utilizing them.

115.242 (a):

The PREA Risk Assessment (PRA) Housing Guide outlines how the screening information is to be used in making housing, bed, work, and education and programming decisions. The PRA HOUSING GUIDE also instructs staff how to complete a screening and how to find screening information in the OMNI PREA Risk Assessment (PRA) for making decisions concerning the items listed within this standard. ECHWR reports one resident who was admitted and identified as a potential victim following the risk screening. A monitoring plan was developed and a staff member assigned to ensure the resident's safety.

Per DOC 300.380 and DOC 490.820 when inmates/residents are transferred from one facility to another, the sending facility notifies the receiving facility of any history of predatory violence or predatory sexual violence, history of medical/mental health needs, safety/security concerns that impact housing or programming and appropriateness of specific work assignments. This screening is documented in the electronic OMNI system and entitled the Incoming Transport Job Screening (ITJS). Inmates/residents who display an increased vulnerability for sexual victimization are also identified and notes concerning their risk are placed in OMNI.

A final analysis of the evidence indicates the facility is in substantial compliance with this provision.

115.242 (b):

ECHWR provided 21 examples of chronological entries made in the OMNI system during the audit period. The entries documented ECHWR staff reviews of each resident's PRA score and whether their risk score was compatible with the other resident they were to be housed with. Each resident who arrives at ECHWR receives a similar review of their PRA score and chronological notes are entered into the OMNI system documenting the compatibility of the resident's PRA score with their roommate's PRA score. Specific names of the residents to be housed together are documented in the chronological notes.

ECHWR provided one example of a PREA monitoring plan for a resident whose PRA score placed her at a higher risk of sexual victimization. Documentation shows ECHWR staff met with the resident about once every 30 days during the audit period to review her treatment plan and self-identified feelings of safety.

A final analysis of the evidence indicates the facility substantially exceeds the requirements for this provision. Specifically the implementation of monitoring plans for residents who were identified as at risk of abuse during their PRA. The facility assigns an employee to act as the monitor and with input from the resident develop a monitoring plan.

115.242 (c):

ECHWR 490.820 requires housing and programming assignments for all transgender and intersex offenders to be made on a case by case basis, to include individual shower arrangements, putting priority on the offender's health and safety. The housing review process also takes into account management or security problems that may result from placement options. Housing review are documented on DOC form 02-384, Protocol for the Housing of Transgender and Intersex Offenders, by

a local multi-disciplinary team with housing recommendations forwarded to the Deputy Director of Prisons Command A for final approval. A formal review is also conducted at least every 6 months for each offender or when a change in housing assignments is indicated.

During the audit period, there was one resident at ECWR who identified as transgender. ECWR provided the form 02-384 that was completed for this resident. The form considers how the resident's medical and mental health needs are affected by their placement, the length of their incarceration, history of victimization, likelihood of the individual being taken advantage of based on their placement, the individual's ability to stand up for themselves and several other factors to determine whether a men's facility or women's facility is the best placement for the individual. The DOC 02-420 Preferences Request was also provided for this resident which indicates how the person identifies them self, their preferred pronouns and whether they feel safe to be housed in general population. It should be noted that this resident was interviewed during the onsite portion of the audit and identified as "lesbian" to the interviewer.

A final analysis of the evidence indicates the facility is in substantial compliance with this provision.

115.242 (d):

DOC 490.700 indicates offenders who identify as transgender, intersex or gender non-conforming can complete a form DOC 02-420 Preferences Request to notate their desired placement and whether they feel safe to be placed in general population. The policy indicates that residents in work release facilities shall be housed in a single person room or room with a person assessed as "No Risk".

DOC 490.700 indicates each facility should have a Multidisciplinary Team (MDT). This team is charged with ensuring all individuals under Department supervision have equal access to programs and services; Convene within 10 days if an individual discloses transgender, intersex, and/or gender nonconforming identity at any time during their incarceration; Review housing and programming assignments and make recommendations per the Housing and Programming Reviews section of the policy; Ensure local management decisions are properly executed in a timely manner. At ECHWR the MDT is to consist of the assigned case manager, CCS and Work/Training release Administrator/designee. The policy further indicates transgender, intersex and gender non-conforming residents can appeal housing review decisions in writing.

A final analysis of the evidence indicates the facility is in substantial compliance with this provision.

115.242 (e):

ECHWTR 490.820 indicates: CCS/designee will address housing/showering issues for transgender, intersex, or gender non-conforming offenders using DOC 02-384 Protocol for the Housing of Transgender and Intersex Offenders to allow transgender and intersex offenders the opportunity to shower and dress/undress separately from other offenders. This may include individual shower stalls, separate shower times, or other procedures based on facility design.

1. Residents will be assigned a daily shower schedule to meet their needs.
2. Identified offenders will be allowed to use the ADA bathroom or single bathrooms.
3. All offenders on the floor will use a sign-up sheet for the ADA bathroom to ensure privacy. All showers will have curtains in the bathrooms.
4. The CCS/designee will meet with all transgender and intersex offenders regarding showering and room concerns.

Transgender or intersex offenders may report housing/showering issues to the CCS or CCO.

A final analysis of the evidence indicates the facility is in substantial compliance with this provision.

115.242 (f):

The facility does not have a dedicated housing area for the assignment of only lesbian, gay, bisexual, transgender, or intersex (LGBTI) offenders. The agency is also not under any related consent decree, legal settlement or legal judgement. Housing and program / job assignments are made based on PREA Risk Assessment identifiers and programming needs. Though not explicitly detailed in policy, the Washington Department of Corrections (WADOC) prohibits housing based solely on an offender's identification or status as a lesbian, gay, bisexual, transgender or intersex individual.

ECHWR provided a sample of housing assignments for 12 residents, all who identified as bisexual, who were housed at ECHWR during the audit period. Their housing assignments demonstrated the residents were placed in rooms throughout the facility and were not limited to one housing unit. During the onsite portion of the audit, interviews were conducted of two residents who identified as LGBTI. Both residents indicated they did not feel their housing assignment was made due to their identification as LGBTI.

A final analysis of the evidence indicates the facility is in substantial compliance with this provision. See analysis 115.242 (b).

Findings:

A final analysis of the evidence indicates the facility substantially exceeds requirements of the standard.

Corrective Action:

There is no corrective action to take.

REPORTING

Standard 115.251: Resident reporting

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.251 (a)

- Does the agency provide multiple internal ways for residents to privately report: Sexual abuse and sexual harassment? Yes No
- Does the agency provide multiple internal ways for residents to privately report: Retaliation by other residents or staff for reporting sexual abuse and sexual harassment? Yes No
- Does the agency provide multiple internal ways for residents to privately report: Staff neglect or violation of responsibilities that may have contributed to such incidents? Yes No

115.251 (b)

- Does the agency also provide at least one way for residents to report sexual abuse or sexual harassment to a public or private entity or office that is not part of the agency? Yes No
- Is that private entity or office able to receive and immediately forward resident reports of sexual abuse and sexual harassment to agency officials? Yes No
- Does that private entity or office allow the resident to remain anonymous upon request? Yes No

115.251 (c)

- Do staff members accept reports of sexual abuse and sexual harassment made verbally, in writing, anonymously, and from third parties? Yes No
- Do staff members promptly document any verbal reports of sexual abuse and sexual harassment? Yes No

115.251 (d)

- Does the agency provide a method for staff to privately report sexual abuse and sexual harassment of residents? Yes No

Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)

- Does Not Meet Standard** (Requires Corrective Action)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Evidence analyzed in making the compliance determination:

- 1. Documents:** (Policies, directives, forms, files, records, etc.)
 - a. DOC 490.800 PRISON RAPE ELIMINATION ACT (PREA) PREVENTION AND REPORTING
 - b. DOC 490.850 PRISON RAPE ELIMINATION ACT (PREA) RESPONSE
 - c. MOU with Colorado DOC
 - d. PREA Posters/Brochures
 - e. Resident Orientation Handbook
- 2. Interviews:**
 - a. PREA Coordinator
 - b. Random Sample of Staff
 - c. Random Sample of Residents
- 3. Site Review Observations:**
 - a. PREA Posters
 - b. Postings of how to report sexual abuse/sexual harassment

115.251 (a):

The auditor found that the agency has established several ways for residents to privately report sexual abuse or sexual harassment. These are outlined in section B of Policy 490.800 Prison Rape elimination Act Prevention and Reporting. During the onsite portion of the audit. The auditor interviewed a random sample of both staff and residents. All six of the staff and all seven of the residents were able to give multiple examples of ways that residents could privately report sexual abuse and sexual harassment.

During the site review, the auditor found posters and postings with hotline numbers and other means to report sexual abuse and sexual harassment.

115.251 (b):

The auditor found that the agency provides a way for residents to report sexual abuse or sexual harassment to a public or private entity that is not part of the agency as outlined in Policy 490.800 Prison Rape Elimination Act Prevention and Reporting (*Section B., 3. E.*).

ECHWR also submitted a memorandum of understanding with the Colorado Department of Corrections to act as this entity. The auditor interviewed the WADOC PREA Coordinator who stated that she is the point of contact for CODOC when they receive reports from WADOC residents. The PREA Coordinator further stated that the resident may remain anonymous if they wish.

A final analysis of the evidence indicates the facility is in substantial compliance with this provision.

115.251 (c):

The auditor found that the agency mandates that staff accept verbal reports of sexual abuse and sexual harassment from residents. The auditor also found that the agency has established a reporting process for their staff. ECHWR submitted this process which is an attachment (#5) to Policy 490.850 Prison Rape Elimination Act Response.

During the onsite portion of the audit. The auditor interviewed six random staff and seven random residents. All of the staff interviewed were able to articulate what was required of them if they were receiving the verbal report. All of the residents stated that they could verbally report to a staff member as one of the ways to report sexual abuse and sexual harassment.

A final analysis of the evidence indicates the facility is in substantial compliance with this provision.

115.251 (d):

In review of the reporting process, the auditor found that staff may privately report sexual abuse or sexual harassment of a resident by either contacting the appointing authority directly or the state wide duty officer after hours or on weekends.

During the onsite portion of the audit. The auditor interviewed a random sample of six staff. The majority of the staff interviewed knew and were able to articulate this process. The staff who were unsure of who the contact was were still able to articulate that they could privately report and stated that they would contact a supervisor.

A final analysis of the evidence indicates the facility is in substantial compliance with this provision.

Findings:

A final analysis of the evidence indicates the facility is substantially compliant with this standard.

Corrective Action:

There is no corrective action to take.

Standard 115.252: Exhaustion of administrative remedies

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.252 (a)

- Is the agency exempt from this standard? NOTE: The agency is exempt ONLY if it does not have administrative procedures to address resident grievances regarding sexual abuse. This does not mean the agency is exempt simply because a resident does not have to or is not ordinarily expected to submit a grievance to report sexual abuse. This means that as a matter of explicit policy, the agency does not have an administrative remedies process to address sexual abuse. Yes No

115.252 (b)

- Does the agency permit residents to submit a grievance regarding an allegation of sexual abuse without any type of time limits? (The agency may apply otherwise-applicable time limits to any portion of a grievance that does not allege an incident of sexual abuse.) (N/A if agency is exempt from this standard.) Yes No NA
- Does the agency always refrain from requiring a resident to use any informal grievance process, or to otherwise attempt to resolve with staff, an alleged incident of sexual abuse? (N/A if agency is exempt from this standard.) Yes No NA

115.252 (c)

- Does the agency ensure that: A resident who alleges sexual abuse may submit a grievance without submitting it to a staff member who is the subject of the complaint? (N/A if agency is exempt from this standard.) Yes No NA
- Does the agency ensure that: Such grievance is not referred to a staff member who is the subject of the complaint? (N/A if agency is exempt from this standard.) Yes No NA

115.252 (d)

- Does the agency issue a final agency decision on the merits of any portion of a grievance alleging sexual abuse within 90 days of the initial filing of the grievance? (Computation of the 90-day time period does not include time consumed by residents in preparing any administrative appeal.) (N/A if agency is exempt from this standard.) Yes No NA
- If the agency determines that the 90-day timeframe is insufficient to make an appropriate decision and claims an extension of time (the maximum allowable extension of time to respond is 70 days per 115.252(d)(3)) , does the agency notify the resident in writing of any such extension and provide a date by which a decision will be made? (N/A if agency is exempt from this standard.) Yes No NA
- At any level of the administrative process, including the final level, if the resident does not receive a response within the time allotted for reply, including any properly noticed extension, may a resident consider the absence of a response to be a denial at that level? (N/A if agency is exempt from this standard.) Yes No NA

115.252 (e)

- Are third parties, including fellow residents, staff members, family members, attorneys, and outside advocates, permitted to assist residents in filing requests for administrative remedies relating to allegations of sexual abuse? (N/A if agency is exempt from this standard.) Yes No NA
- Are those third parties also permitted to file such requests on behalf of residents? (If a third-party files such a request on behalf of a resident, the facility may require as a condition of processing the request that the alleged victim agree to have the request filed on his or her behalf, and may also require the alleged victim to personally pursue any subsequent steps in the administrative remedy process.) (N/A if agency is exempt from this standard.) Yes No NA

- If the resident declines to have the request processed on his or her behalf, does the agency document the resident's decision? (N/A if agency is exempt from this standard.)
 Yes No NA

115.252 (f)

- Has the agency established procedures for the filing of an emergency grievance alleging that a resident is subject to a substantial risk of imminent sexual abuse? (N/A if agency is exempt from this standard.) Yes No NA
- After receiving an emergency grievance alleging a resident is subject to a substantial risk of imminent sexual abuse, does the agency immediately forward the grievance (or any portion thereof that alleges the substantial risk of imminent sexual abuse) to a level of review at which immediate corrective action may be taken? (N/A if agency is exempt from this standard.)
 Yes No NA
- After receiving an emergency grievance described above, does the agency provide an initial response within 48 hours? (N/A if agency is exempt from this standard.) Yes No NA
- After receiving an emergency grievance described above, does the agency issue a final agency decision within 5 calendar days? (N/A if agency is exempt from this standard.)
 Yes No NA
- Does the initial response and final agency decision document the agency's determination whether the resident is in substantial risk of imminent sexual abuse? (N/A if agency is exempt from this standard.) Yes No NA
- Does the initial response document the agency's action(s) taken in response to the emergency grievance? (N/A if agency is exempt from this standard.) Yes No NA
- Does the agency's final decision document the agency's action(s) taken in response to the emergency grievance? (N/A if agency is exempt from this standard.) Yes No NA

115.252 (g)

- If the agency disciplines a resident for filing a grievance related to alleged sexual abuse, does it do so ONLY where the agency demonstrates that the resident filed the grievance in bad faith? (N/A if agency is exempt from this standard.) Yes No NA

Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)

Does Not Meet Standard (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Evidence analyzed in making the compliance determination:

1. **Documents:** (*Policies, directives, forms, files, records, etc.*)
 - a. DOC 490.800 PRISON RAPE ELIMINATION ACT (PREA) PREVENTION AND REPORTING
 - b. DOC 490.860 PRISON RAPE ELIMINATION ACT (PREA) INVESTIGATIONS
 - c. DOC 550.100 OFFENDER GRIEVANCE PROGRAM
 - d. Offender Grievance Program Manual – English/Spanish
 - e. Memo - PREA allegations received through grievance systems

2. **Interviews:**

3. **On-Site Observations:**

115.252 (a):

The agency has a grievance/complaint process and procedure which was submitted to the auditor and is therefore subject to this standard. On page 9 of the *Department of Corrections Grievance Program Manual* it states that offenders may file a grievance for any type of sexual abuse including staff on inmate sexual abuse. The manual further states in section III that grievances received alleging sexual abuse are not processed through the grievance procedure and forwarded to the agency PREA coordinator.

A final analysis of the evidence indicates the facility is in substantial compliance with this provision.

115.252 (b):

Agency policy does not impose any time limits for residents to report sexual abuse in any form to include the grievance program. In a memo dated January, 10th, 2019, Secretary Sinclair outlines the process for received grievances alleging sexual abuse by residents. The memo states,

” Complaints and grievances alleging any form of sexual assault, sexual abuse, sexual harassment and/or employee sexual misconduct are immediately processed in accordance with DOC policy 490.800, Prison Rape Elimination Act (PREA) Prevention and Reporting.”

The agency process of removing the report of sexual abuse or sexual harassment from the grievance procedure ensures that no informal grievance procedure will be applied to the report.

A final analysis of the evidence indicates the facility is in substantial compliance with this provision.

115.252 (c):

The agency has established several avenues for residents to report sexual abuse or sexual harassment. The agency does not require residents to report through a grievance procedure that may find the subject of the allegation in possession of the grievance. Residents may report with an outside agency, through the hotline or by reporting to any staff member.

Since sexual abuse allegations received through the grievance program are not processed but rather forwarded to the PREA coordinator, The PREA coordinator can ensure that the grievance would not be referred to the subject of the allegation.

A final analysis of the evidence indicates the facility is in substantial compliance with this provision.

115.252 (d):

The agency does not process allegations of sexual abuse filed through the grievance program. These allegations are processed using the procedure outlined in DOC Policy 490.800 Prison Rape Elimination Act Prevention and Reporting. This process calls for resolution of the allegation within 30 days of assignment for investigation.

A final analysis of the evidence indicates the facility is in substantial compliance with this provision.

115.252 (e):

Agency policy, *DOC 490.800 PRISON RAPE ELIMINATION ACT (PREA) PREVENTION AND REPORTING*, allows for third parties, including fellow residents, staff members, family members, attorneys, and outside advocates, shall be permitted to assist residents in filing requests for administrative remedies relating to allegations of sexual abuse, and shall also be permitted to file such requests on behalf of residents.

Agency policy does not require the alleged victim to agree to have the request filed. Third party requests are reviewed and processed in the same manner as any other request.

A final analysis of the evidence indicates the facility is in substantial compliance with this provision.

115.252 (f):

Agency policy regarding processing of grievances alleging sexual abuse or sexual harassment does not include timeframes associated with the resolution or corrective action. These grievances are not processed through the grievance system but rather forwarded to the agency PREA coordinator for resolution.

In review of the grievance program the auditor found that the grievance procedure allows for residents to mark a grievance as emergency. By marking the grievance as an emergency, the grievance is forwarded to the grievance manager and will be resolved within the next 8 hours

A final analysis of the evidence indicates the facility is in substantial compliance with this provision.

115.252 (g):

Agency policy states that the hearing officer must find that the resident acted in bad faith in filing the report of sexual abuse or sexual harassment in order for the resident to be disciplined. Policy 490.860 on page 10 states.

- b. *A report of sexual abuse made in good faith will not constitute providing false information, even if the investigation does not establish sufficient evidence to substantiate the allegation.*

A final analysis of the evidence indicates the facility is in substantial compliance with this provision.

Findings:

A final analysis of the evidence indicates the facility is substantially compliant with this standard.

Corrective Action:

There is no corrective action to take.

Standard 115.253: Resident access to outside confidential support services

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.253 (a)

- Does the facility provide 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? Yes No
- Does the facility enable reasonable communication between residents and these organizations and agencies, in as confidential a manner as possible? Yes No

115.253 (b)

- Does the facility inform 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? Yes No

115.253 (c)

- Does the agency maintain or attempt to enter into memoranda of understanding or other agreements with community service providers that are able to provide residents with confidential emotional support services related to sexual abuse? Yes No
- Does the agency maintain copies of agreements or documentation showing attempts to enter into such agreements? Yes No

Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)

- Does Not Meet Standard** (Requires Corrective Action)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Evidence analyzed in making the compliance determination:

1. **Documents:** (Policies, directives, forms, files, records, etc.)
 - a. DOC 490.800 PRISON RAPE ELIMINATION ACT (PREA) PREVENTION AND REPORTING
 - b. OCVA Brochure – English and Spanish
 - c. PREA Victim Advocate Meeting Minutes 05/12/2020
 - d. Community Sexual Assault Programs Brochure WADOC
 - e. In-Person Victim Advocacy Services Guide
 - f. Washington Coalition of Sexual Assault Programs. May 2016
2. **Interviews:**
 - a. Random Sample of Residents
3. **Site Review Observations:**
 - a. Posted information and brochures with contact information for victim advocacy

115.253 (a):

The auditor found that all residents housed at ECHWR have access to a cellular phone from 5am to 11pm daily. The resident may have a personal cell phone or a loaned state cell phone which must be turned in at 11pm every evening and then retrieved again at 5am the next morning. This allows the resident to have confidential communication with organizations providing victim advocate and emotional support services.

ECHWR displays information about organizations who provide these services in the resource room, resident handbook and the visiting room. This information includes phone numbers and addresses.

A final analysis of the evidence indicates the facility is in substantial compliance with this provision.

115.253 (b):

ECHWR does not monitor communications between residents and outside service providers. Resident communication with service providers is conducted via cell phone and is not recorded by the facility. The auditor in his contact with OCVA learned that OCVA does not record any of their communication with residents. The brochure for services provided by OCVA states that their services are confidential and that they are not associated with the DOC. Resident appointments for outside services are coordinated with the facility for scheduling and resident management. The content of the appointment is not shared with the facility or the DOC.

Since neither the agency nor the facility are providing services, only access to services, they are not the entity which would be required to educate the resident on mandatory reporting or level of confidentiality within the appointment. This responsibility would fall to the provider.

During interviews with a random sample of seven residents, the auditor found that most of the residents did not know if this communication was confidential or not. Most expressed that they believed the communication would be confidential. Two of the residents stated that their individual outside provider had explained to them the extent of confidentiality and their mandatory reporting responsibilities.

A final analysis of the evidence indicates the facility is in substantial compliance with this provision.

115.253 (c):

ECHWR provided the auditor with copies of the MOU which they have entered into with OCVA and Lutheran Services to provide confidential emotional support services related to sexual abuse. Neither OCVA nor LCS are affiliated with the DOC or ECHWR and the MOUs do not require the provider to report to the DOC or ECHWR.

A final analysis of the evidence indicates the facility is in substantial compliance with this provision.

Findings:

A final analysis of the evidence indicates the facility is substantially compliant with this standard.

Corrective Action:

There is no corrective action to take.

Standard 115.254: Third-party reporting

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.254 (a)

- Has the agency established a method to receive third-party reports of sexual abuse and sexual harassment? Yes No
- Has the agency distributed publicly information on how to report sexual abuse and sexual harassment on behalf of a resident? Yes No

Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Evidence analyzed in making the compliance determination:

1. **Documents:** (*Policies, directives, forms, files, records, etc.*)
 - a. WaDOC public website <http://www.doc.wa.gov/corrections/prea/resources.htm#reports>.
 - b. Brochure for Family and Friends
 - c. Posters within the facility
2. **Interviews:**
3. **Site Review Observations:**
 - a. Poster and Information with contact information in public areas for third parties to report

115.254 (a):

In reviewing the agency website, the auditor found that the agency has established methods for the public/third parties to report sexual misconduct. The website provides a tab titled Report Sexual Misconduct. When pressed, the methods for third parties to report are presented and give the individual the ability to print the information. Three ways are presented, mail, phone or email.

During the site review, the auditor observed posters in public areas and brochures for family and friends on the Prison Rape Elimination Act and how to report.

A final analysis of the evidence indicates the facility is in substantial compliance with this provision.

Findings:

A final analysis of the evidence indicates the facility is substantially compliant with this standard.

Corrective Action:

There is no corrective action to take

OFFICIAL RESPONSE FOLLOWING A RESIDENT REPORT

Standard 115.261: Staff and agency reporting duties

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.261 (a)

- Does the agency require all staff to report immediately and according to agency 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 the agency? Yes No

- Does the agency require all staff to report immediately and according to agency policy any knowledge, suspicion, or information regarding retaliation against residents or staff who reported an incident of sexual abuse or sexual harassment? Yes No
- Does the agency require all staff to report immediately and according to agency policy any knowledge, suspicion, or information regarding any staff neglect or violation of responsibilities that may have contributed to an incident of sexual abuse or sexual harassment or retaliation? Yes No

115.261 (b)

- Apart from reporting to designated supervisors or officials, do staff always refrain from revealing any information related to a sexual abuse report to anyone other than to the extent necessary, as specified in agency policy, to make treatment, investigation, and other security and management decisions? Yes No

115.261 (c)

- Unless otherwise precluded by Federal, State, or local law, are medical and mental health practitioners required to report sexual abuse pursuant to paragraph (a) of this section? Yes No
- Are medical and mental health practitioners required to inform residents of the practitioner's duty to report, and the limitations of confidentiality, at the initiation of services? Yes No

115.261 (d)

- If the alleged victim is under the age of 18 or considered a vulnerable adult under a State or local vulnerable persons statute, does the agency report the allegation to the designated State or local services agency under applicable mandatory reporting laws? Yes No

115.261 (e)

- Does the facility report all allegations of sexual abuse and sexual harassment, including third-party and anonymous reports, to the facility's designated investigators? Yes No

Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Evidence analyzed in making the compliance determination:

1. Documents: (*Policies, directives, forms, files, records, etc.*)

- a. DOC 490.850 PREA Response
- b. DOC 490.860 PREA Investigation
- c. ECHWR Complaint Log
- d. Case 19-18073 Referral for Investigation

2. Interviews:

- a. PREA Coordinator
- b. Facility Head
- c. Random Sample of Staff
- d. Medical and Mental Health Staff

3. Site Review Observations:

115.261 (a):

Agency policy *DOC 490.850 PRISON RAPE ELIMINATION ACT (PREA) RESPONSE* requires all staff to immediately report any knowledge, suspicion, or information regarding an incident of sexual abuse or sexual harassment that occurred in a facility. This includes retaliation or neglect on the part of a staff member.

The auditor interviewed seven random staff during the on-site portion of the audit. All staff interviewed stated that they were aware of the agency policy and their requirements for reporting

A final analysis of the evidence indicates the facility is in substantial compliance with this provision.

115.261 (b):

Agency policy *DOC 490.850 PRISON RAPE ELIMINATION ACT (PREA) RESPONSE (Section II. A.)* requires all staff not to reveal any information related to a sexual abuse report to anyone other than to the extent necessary, as specified in agency policy, to make treatment, investigation, and other security and management decisions.

The auditor interviewed seven random staff during the on-site portion of the audit. All staff interviewed stated that they would not discuss the information with anyone unless it was necessary.

A final analysis of the evidence indicates the facility is in substantial compliance with this provision.

115.261 (c):

WADOC addresses this in policy *DOC 490.850 PRISON RAPE ELIMINATION ACT (PREA) RESPONSE*. However ECHWR does not employ onsite medical and mental health staff.

A final analysis of the evidence indicates the facility is in substantial compliance with this provision.

115.261 (d):

WADOC outlines in policy *DOC 350.550 REPORTING ABUSE AND NEGLECT/MANDATORY REPORTING* the requirements for reporting when the victim of sexual abuse is under the age of 18. ECHWR does not house residents under the age of 18.

A final analysis of the evidence indicates the facility is in substantial compliance with this provision.

115.261 (e):

WADOC outlines the processes and procedures for reporting for investigative purposes in policy *DOC 490.860 PREA – Investigations*. WADOC does not require reporting to in-house facility investigators. Rather the process in place requires reporting to the appointing authority and then the agency PREA coordinator. Investigators are then assigned. Assigning investigators from another facility is the general practice employed by the agency.

A final analysis of the evidence indicates the facility is in substantial compliance with this provision.

Findings:

A final analysis of the evidence indicates the facility is substantially compliant with this standard.

Corrective Action:

There is no corrective action to take.

Standard 115.262: Agency protection duties

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.262 (a)

- When the agency learns that a resident is subject to a substantial risk of imminent sexual abuse, does it take immediate action to protect the resident? Yes No

Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The following evidence was analyzed in making the compliance determination:

- 1. Documents:** (*Policies, directives, forms, files, records, etc.*)

- a. DOC 490.820 PREA RISK ASSESSMENTS AND ASSIGNMENTS
- b. DOC 490.850 PREA Response
- c. Individual Monitoring Report
- d. Movement History Report showing PREA Compatibility Review
- e. ECHWR List of Potential Victims

2. Interview:

- a. Agency Head
- b. Facility Head
- c. Random Sample of Staff

3. Site Review Observations:

115.262 (a):

The following tools are utilized by the agency and ECHWR to reduce the likelihood of imminent sexual abuse and to protect residents when imminent risk of sexual abuse is reported. The auditor found that the use of the screening information and the listed tools, to increase monitoring of residents at a higher risk of victimization, has likely decreased opportunity and likelihood of sexual abuse among the residents.

ECHWR List of Potential Victims – Potential Victims added to auditor’s interview list.

DOC 490.820 PREA RISK ASSESSMENTS AND ASSIGNMENTS – Section III. Monitoring plans outlines the actions to be taken when it is determined that the offender is at substantial risk of immediate sexual assault or abuse.

DOC 490.850 PREA Response – Section V. – Appointing Authority Response outlines the response that shall be taken by the appointing authority upon receipt of an allegation of offender-on-offender sexual abuse or sexual harassment as well as a receipt of an allegation of staff sexual misconduct.

Individual Monitoring Report – This report shows ECHWR’s efforts to protect and remain in constant contact with an offender who has been determined to be at risk for being abused sexually

Movement History Report showing PREA Compatibility Review – This report shows how ECHWR uses screening information in making housing and program decisions.

The auditor reviewed response plans submitted by ECHWR. This plan shows that the safety of the potential victim is the first level of response when receiving information that a resident is in imminent danger of being sexually abused. Separating the victim from the abuser and increasing staff contact with the potential victim are the first step followed by appropriate supervisory notification.

In interviews with the facility head and a random sampling of six staff members, it was evident that safety of the potential victim was foremost. All staff stated that separating the victim and abuser was the first thing they would do. Four stated that they would contact the residents CCO to increase contact with staff. Three of the staff stated that they would put the potential victim in a room or area where staff monitoring efforts would be increased.

A final analysis of the evidence indicates the facility is in substantial compliance with this provision.

Findings:

A final analysis of the evidence indicates the facility is substantially compliant with this standard.

Corrective Action:

There is no corrective action to take.

Standard 115.263: Reporting to other confinement facilities

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.263 (a)

- Upon receiving an allegation that a resident was sexually abused while confined at another facility, does the head of the facility that received the allegation notify the head of the facility or appropriate office of the agency where the alleged abuse occurred? Yes No

115.263 (b)

- Is such notification provided as soon as possible, but no later than 72 hours after receiving the allegation? Yes No

115.263 (c)

- Does the agency document that it has provided such notification? Yes No

115.263 (d)

- Does the facility head or agency office that receives such notification ensure that the allegation is investigated in accordance with these standards? Yes No

Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Evidence analyzed in making the compliance determination:

1. **Documents:** (*Policies, directives, forms, files, records, etc.*)

- a. DOC 490.850 PREA Response
- b. DOC 490.860 PREA – Investigation
- c. Laura Jense Memo #1 8/1/2020
- d. Laura Jense Memo #2 8/1/2020

2. Interviews:

- a. Agency Head
- b. Facility Head

3. Site Review

115.263 (a):

WADOC requires in policy 490.850 PREA Response – Section III. (D.) The Appointing Authority will notify the appropriate Appointing Authority or facility administrator within 72 hours of receipt of an allegation when the alleged incident:

1. Occurred in another Department location or another jurisdiction
2. Involved a staff who reports through another Appointing Authority

DOC 490.860 PREA – Investigation – Section I. (A. – B.) The Department will thoroughly, promptly, and objectively investigate all allegations of sexual misconduct involving offenders under the jurisdiction or authority of the Department.

1. Investigations will be completed even if the offender is no longer under Department jurisdiction or authority and/or the accused staff, if any, is no longer employed by or providing services to the Department.
2. Allegations may be referred to law enforcement agencies for criminal investigation.
- 3.

ECHWR reports that there have been no instances of a resident reporting that they were sexually abused while confined at another facility during this report period. The facility head stated that if the facility had received an allegation that the appointing authority would have made notification within 72 hours as required by the standard.

A final analysis of the evidence indicates the facility is in substantial compliance with this provision.

115.263 (b):

Agency policy requires that an allegation that a resident was sexually abused while confined at another facility will be reported to the head of that facility within 72 hours of receiving the allegation. Policy for community confinement facilities identifies the community confinement administrator as the individual making notification.

ECHWR reports that there have been no instances of a resident reporting that they were sexually abused while confined at another facility during this report period. The facility head stated, that if the facility had received an allegation, the appointing authority would have made notification within 72 hours as required by the standard.

A final analysis of the evidence indicates the facility is in substantial compliance with this provision.

115.263 (c):

Laura Jense Memo #1 8/1/2020 – Memo states that there were 0 occurrences of the facility being notified by another appointing authority of an allegation of sexual abuse or sexual harassment. Both the agency head and facility head in their interviews with the auditor stated that this notification is documented on a PREA allegation report which is forwarded to the PREA coordinator.

A final analysis of the evidence indicates the facility is in substantial compliance with this provision.

115.263 (d):

Laura Jense Memo #2 8/1/2020 - Memo states that there were 0 occurrences of the facility receiving an allegation of sexual abuse or sexual harassment requiring notification to another appointing authority during this audit period. The auditor learned through interviews with the facility head and agency head that these types of allegations are documented and forwarded to the PREA Coordinator for review and assigning of investigators.

A final analysis of the evidence indicates the facility is in substantial compliance with this provision.

Findings:

A final analysis of the evidence indicates the facility is substantially compliant with this standard.

Corrective Action:

There is no corrective action to take.

Standard 115.264: Staff first responder duties

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.264 (a)

- Upon learning of an allegation that a resident was sexually abused, is the first security staff member to respond to the report required to: Separate the alleged victim and abuser?
 Yes No
- Upon learning of an allegation that a resident was sexually abused, is the first security staff member to respond to the report required to: Preserve and protect any crime scene until appropriate steps can be taken to collect any evidence? Yes No
- Upon learning of an allegation that a resident was sexually abused, is the first security staff member to respond to the report required to: Request that the alleged victim not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating, if the abuse occurred within a time period that still allows for the collection of physical evidence? Yes No
- Upon learning of an allegation that a resident was sexually abused, is the first security staff member to respond to the report required to: Ensure that the alleged abuser does not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating, if the abuse occurred within a time period that still allows for the collection of physical evidence? Yes No

115.264 (b)

- If the first staff responder is not a security staff member, is the responder required to request that the alleged victim not take any actions that could destroy physical evidence, and then notify security staff? Yes No

Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Evidence analyzed in making the compliance determination:

1. **Documents:** (*Policies, directives, forms, files, records, etc.*)
 - a. DOC 490.850 PREA Response
 - b. Aggravated Sexual Assault Checklist
 - c. ECHWR Case Report
2. **Interviews:**
 - a. Security/Non-Security 1st Responders
 - b. Random Sample of staff
3. **Site Review Observations:**

115.264 (a):

The auditor reviewed the cases requested concerning reported sexual abuse or sexual harassment. The auditor found that none of the case involved the need for preservation of evidence in an area or on any person. During the interview of three potential first responders, the auditor found that that the staff knew that their first responsibility was to separate the victim from abuser. All three of the staff responded that they would not be collecting evidence but that they would preserve any evidence or crime scene. All three of the staff also made reference to the *Aggravated Sexual Assault Checklist*. This checklist provides first responders with direction and list of notifications that need to be made.

Directions on the checklist include preservation of evidence by requesting the victim not to take any action that may destroy evidence. A list of those actions is included.

The Checklist also gives the direction to not allow the abuser to destroy evidence. ECHWR being a minimum community confinement facility, their plan involves notifying local law enforcement

immediately to collect and preserve evidence. The checklists ensures that all steps are followed including the time a task started and when it was completed.

A final analysis of the evidence indicates the facility is in substantial compliance with this provision.

115.264 (b):

Non Security staff are trained in the same manner as security staff when it comes to staff responsibilities when receiving an allegation of sexual abuse. The auditor reviewed the training received by all staff employed at ECHWR. This training outlines the responsibilities of staff receiving an allegation of sexual abuse. Included in this training is asking the victim not to take any actions that might destroy evidence. Non-security staff also have access to the checklists found in the PREA response kit.

A final analysis of the evidence indicates the facility is in substantial compliance with this provision.

Findings:

A final analysis of the evidence indicates the facility is substantially compliant with this standard.

Corrective Action:

There is no corrective action to take..

Standard 115.265: Coordinated response

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.265 (a)

- Has the facility developed a written institutional plan to coordinate actions among staff first responders, medical and mental health practitioners, investigators, and facility leadership taken in response to an incident of sexual abuse? Yes No

Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The following evidence was analyzed in making the compliance determination:

1. Documents: (*Policies, directives, forms, files, records, etc.*)

- a. DOC 490.850 – PREA Response
- b. ECHWR PREA Response Plan

2. Interviews:

3. Site Review Observations:

- a. Observed the location to the PREA response plan

115.265 (a):

ECHWR submitted their PREA response plan which was reviewed by the auditor. The auditor, during the site review, verified the location of the plan. The plan was located in the PREA response kit in the control center area of the facility. The review of the plan revealed that it provides checklists for first responders, investigators, supervisors and facility head.

In her interview the facility head stated that the primary goals of the plan are for staff to follow an emergency check list, protect victims by separating them from the perpetrator and to collect and preserve evidence. Included in this plan are the notifications to be made which include local law enforcement, medical centers and community based advocacy organizations.

A final analysis of the evidence indicates the facility is in substantial compliance with this provision.

Findings:

A final analysis of the evidence indicates the facility is substantially compliant with this standard.

Corrective Action:

There is no corrective action to take.

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

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.266 (a)

- Are both the agency and any other governmental entities responsible for collective bargaining on the agency’s behalf prohibited from entering into or renewing any collective bargaining agreement or other agreement that limits the agency’s ability to remove alleged staff sexual abusers from contact with any residents pending the outcome of an investigation or of a determination of whether and to what extent discipline is warranted? Yes No

115.266 (b)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

Exceeds Standard (*Substantially exceeds requirement of standards*)

- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The following evidence was analyzed in making the compliance determination:

1. **Documents:** (*Policies, directives, forms, files, records, etc.*)
 - a. Collective Bargaining Agreement between WaDOC and the Washington Federation of State Employees
2. **Interviews:**
 - a. Agency Head
3. **Site Review Observations:**

Provision (a):

The auditor reviewed the current collective bargaining agreement and found that there is nothing contained within the agreement that limits the agency's ability to remove alleged staff sexual abusers from contact with any residents pending the outcome of an investigation or of a determination of whether and to what extent discipline is warranted.

During his interview, the Agency Director stated that PREA has become an established component of our collective bargaining agreements and the agency has the right to remove any employee while an investigation is ongoing through the disciplinary process.

A final analysis of the evidence indicates the facility is in substantial compliance with this provision.

Findings:

A final analysis of the evidence indicates the facility is substantially compliant with this standard.

Corrective Action:

There is no corrective action to take.

Standard 115.267: Agency protection against retaliation

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.267 (a)

- Has the agency established 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 retaliation by other residents or staff? Yes No
- Has the agency designated which staff members or departments are charged with monitoring retaliation? Yes No

115.267 (b)

- Does the agency employ 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? Yes No

115.267 (c)

- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor the conduct and treatment of residents or staff who reported the sexual abuse to see if there are changes that may suggest possible retaliation by residents or staff? Yes No
- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor the conduct and treatment 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? Yes No
- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Act promptly to remedy any such retaliation? Yes No
- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor any resident disciplinary reports? Yes No
- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor resident housing changes? Yes No
- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor resident program changes? Yes No
- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor negative performance reviews of staff? Yes No
- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor reassignments of staff? Yes No

- Does the agency continue such monitoring beyond 90 days if the initial monitoring indicates a continuing need? Yes No

115.267 (d)

- In the case of residents, does such monitoring also include periodic status checks?
 Yes No

115.267 (e)

- If any other individual who cooperates with an investigation expresses a fear of retaliation, does the agency take appropriate measures to protect that individual against retaliation?
 Yes No

115.267 (f)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Evidence analyzed in making the compliance determination:

1. **Documents:** (*Policies, directives, forms, files, records, etc.*)
 - a. DOC 490.860 PRISON RAPE ELIMINATION ACT (PREA) INVESTIGATION
 - b. Monthly Retaliation Monitoring Report
 - c. Reporters and Named Victims List

2. Interviews:

3. Site Review Observations:

Since the last audit of ECHWR in October of 2017, ECHWR reports that there was a period of time where there were lapses in retaliation monitoring. ECHWR discovered these lapses during their yearly PREA evaluation leading up to the originally scheduled audit on October 22, 2020.

During the time period of October, 2020 and the actual completed audit on December 7th, 2021, ECHWR provided documentation of the implementation they had made to prevent these lapses from occurring in the future. The auditor reviewed the 12 month period leading up to the onsite portion of the audit and found no lapses in monitoring.

ECHWR should be commended for recognizing and correcting this issue without any prompting from an outside entity. The notes that follow are for only the 12 month period leading up to the audit as the auditor finds 12 consecutive months sufficient to demonstrate that correction has been achieved.

115.267 (a):

DOC 490.860 PREA – Investigation (Section II - Retaliation) outlines the process and procedures to protect all residents and staff who report sexual abuse or sexual harassment or cooperate with sexual abuse or sexual harassment investigations from retaliation by other residents or staff. At ECHWR the designated staff member whose responsibility it is to monitor retaliation at the facility is the facility head.

A final analysis of the evidence indicates the facility is in substantial compliance with this provision.

Provision (b):

The agency director in his interview stated, “We have a retaliation monitoring process. Staff assigned to monitor residents who have reported or are the alleged victims of sexual abuse. We also utilize our ability to separate victims and abusers.”

The facility head stated in her interview, “We establish a monitoring plan which includes how often to meet, review of the resident’s programming and employment. A Case Manager is assigned as the monitor who completes an electronic monitoring report.”

The auditor interviewed the staff member charged with monitoring retaliation at ECHWR. This staff member explained how a schedule is prepared, how a staff member is assigned to meet with the reporter of sexual abuse and how this staff member with input from the resident design a plan to maintain the safety of the reporter and prevent retaliation. This process is also outlined in the policy *DOC 490.860 PREA – Investigation (Section II - Retaliation)*.

ECHWR also provides access to support services through OCVA, LCS and other advocate programs in the community.

A final analysis of the evidence indicates the facility is in substantial compliance with this provision.

115.267 (c):

In my interview with the staff member designated to monitor retaliation, the auditor found that monitoring plans are initially created for a 90 day period. At the end of the 90 day period the need for further monitoring is reviewed and may be extended.

The auditor found that the policy cited above and the review of monitoring plans show that staff assigned as monitors are trained to recognize changes by residents and staff that may suggest possible retaliation. Monitoring plans include monitoring of reassignments of staff, negative performance reviews of staff, resident program changes, housing changes and resident disciplinary reports which may indicate some form of retaliation.

A final analysis of the evidence indicates the facility is in substantial compliance with this provision.

115.267 (d):

ECHWR provided examples of monitoring plans which were reviewed by the auditor. The auditor found that a regular schedule of check-ins were scheduled into the plan.

A final analysis of the evidence indicates the facility is in substantial compliance with this provision.

115.267 (e):

Both the Agency Head and Facility Head stated in their interview that any resident or staff member who were at risk or felt they were at risk would be placed onto a monitoring plan.

A final analysis of the evidence indicates the facility is in substantial compliance with this provision.

Findings:

A final analysis of the evidence indicates the facility is substantially compliant with this standard.

Corrective Action:

There is no corrective action to take

INVESTIGATIONS

Standard 115.271: Criminal and administrative agency investigations

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.271 (a)

- When the agency conducts its own investigations into allegations of sexual abuse and sexual harassment, does it do so promptly, thoroughly, and objectively? (N/A if the agency/facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations. See 115.221(a).) Yes No NA

- Does the agency conduct such investigations for all allegations, including third party and anonymous reports? (N/A if the agency/facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations. See 115.221(a).) Yes No NA

115.271 (b)

- Where sexual abuse is alleged, does the agency use investigators who have received specialized training in sexual abuse investigations as required by 115.234? Yes No

115.271 (c)

- Do investigators gather and preserve direct and circumstantial evidence, including any available physical and DNA evidence and any available electronic monitoring data? Yes No

- Do investigators interview alleged victims, suspected perpetrators, and witnesses?
 Yes No
- Do investigators review prior reports and complaints of sexual abuse involving the suspected perpetrator? Yes No

115.271 (d)

- When the quality of evidence appears to support criminal prosecution, does the agency conduct compelled interviews only after consulting with prosecutors as to whether compelled interviews may be an obstacle for subsequent criminal prosecution? Yes No

115.271 (e)

- Do agency investigators assess the credibility of an alleged victim, suspect, or witness on an individual basis and not on the basis of that individual's status as resident or staff?
 Yes No
- Does the agency investigate allegations of sexual abuse without requiring a resident who alleges sexual abuse to submit to a polygraph examination or other truth-telling device as a condition for proceeding? Yes No

115.271 (f)

- Do administrative investigations include an effort to determine whether staff actions or failures to act contributed to the abuse? Yes No
- Are administrative investigations documented in written reports that include a description of the physical evidence and testimonial evidence, the reasoning behind credibility assessments, and investigative facts and findings? Yes No

115.271 (g)

- Are criminal investigations documented in a written report that contains a thorough description of the physical, testimonial, and documentary evidence and attaches copies of all documentary evidence where feasible? Yes No

115.271 (h)

- Are all substantiated allegations of conduct that appears to be criminal referred for prosecution?
 Yes No

115.271 (i)

- Does the agency retain all written reports referenced in 115.271(f) and (g) for as long as the alleged abuser is incarcerated or employed by the agency, plus five years? Yes No

115.271 (j)

- Does the agency ensure that the departure of an alleged abuser or victim from the employment or control of the agency does not provide a basis for terminating an investigation?
 Yes No

115.271 (k)

- Auditor is not required to audit this provision.

115.271 (l)

- When an outside entity investigates sexual abuse, does the facility cooperate with outside investigators and endeavor to remain informed about the progress of the investigation? (N/A if an outside agency does not conduct administrative or criminal sexual abuse investigations. See 115.221(a).) Yes No NA

Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Evidence analyzed in making the compliance determination:

1. **Documents:** (*Policies, directives, forms, files, records, etc.*)
 - a. DOC 490.800 PREA – Prevention and Reporting
 - b. DOC 490.860 PREA – Investigation
 - c. DOC 420.365 – Polygraph Testing of Offenders
 - d. DOC 420.365 Evidence Management for Work/Training Release
 - e. WaDOC List of PREA Investigators
 - f. Training Records for ECHWR PREA Investigators
 - g. PREA Investigator Training Curriculum
 - h. PREA for Appointing Authorities
 - i. E-Mails documenting Referral to outside Law Enforcement
 - j. PREA Investigation Review Checklist

k. ECHWR List of PREA Cases – Audit Period

2. Interviews:

3. Site Review Observations:

115.271 (a):

The investigative procedure is outlined in agency policy *DOC 490.860 PRISON RAPE ELIMINATION ACT (PREA) – Investigation*. The auditor also interviewed two investigative staff employed at ECHWR. Both staff stated that assigned investigations are expected to be closed within 30 days. If the investigation is complex the investigator may ask for an extension. When asked, both investigators stated that they would not handle an investigation that began from an anonymous or third party report any differently than any other investigation.

A final analysis of the evidence indicates the facility is in substantial compliance with this provision.

115.271 (b):

The auditor has reviewed the training curriculum for agency PREA investigators as well as the training records for the two investigators employed at ECHWR. The auditor found that the curriculum is in compliance with the standards and that the two employees from ECHWR have completed this training. In their interviews, the two investigators both stated that they had received the specialized training and one stated that there is a review conducted every two years.

A final analysis of the evidence indicates the facility is in substantial compliance with this provision.

115.271 (c):

The auditor reviewed the two investigation reports for ECHWR for this audit period. The auditor found that the areas outlined in this provision are found on the investigation report as well as the investigation checklist provided to all investigator in completing a thorough investigation. During the interviews with two investigators employed by ECHWR, the investigators informed the auditor that if there is a crime scene and potentially criminal acts have taken place that they would secure the crime scene and preserve the evidence for local law enforcement to collect. Both investigators elaborated on how to conduct a proper investigation which included interviewing all parties that may have information regarding the incident and a review of the involved individuals.

A final analysis of the evidence indicates the facility is in substantial compliance with this provision.

115.271 (d):

The auditor found in the review of the curriculum for training PREA Investigators that if at any time the investigator believes that a criminal act may have occurred that they are to stop their investigation and contact the appointing authority. The appointing authority will contact local law enforcement. The appointing authority will notify the investigator how to proceed. Facility head Laura Jense stated in her interview that compelled interviews would not be completed until the criminal investigation had been completed.

A final analysis of the evidence indicates the facility is in substantial compliance with this provision.

115.271 (e):

In interviews with investigators and the facility head, the auditor has found that investigators collect evidence and conduct interviews. The appointing authority assesses credibility and make the final

determination. WADOC has established training for appointing authorities titled, *PREA for Appointing Authorities*. In reviewing this curriculum, the auditor found that assessing credibility is a key component of the training.

DOC Policy 400.360 POLYGRAPH TESTING OF OFFENDERS (Section III) prohibits asking or requiring offenders who are alleged victims, reporters, or witnesses in Prison Rape Elimination Act (PREA) investigations to submit to a polygraph examination regarding the alleged misconduct under investigation.

A final analysis of the evidence indicates the facility is in substantial compliance with this provision.

115.271 (f):

The auditor reviewed two investigation reports as well as the investigation checklist utilized by investigator. The auditor found that included in the report is a section for the investigator to document whether staff actions or failures to act contributed to the abuse. The auditor also found that the report contains an evidence log which includes descriptions of the evidence and an area to summarize testimonial evidence. The report also includes a findings section where the appointing authority assesses credibility and documents their findings.

A final analysis of the evidence indicates the facility is in substantial compliance with this provision.

115.271 (g):

Facility head Laura Jense stated that local law enforcement are required to provide the appointing authority of the requesting facility with a copy of the investigation report once any criminal investigation has been completed.

A final analysis of the evidence indicates the facility is in substantial compliance with this provision.

115.271 (h):

Agency investigators do not have the authority to refer for prosecution. If an investigator believes that a criminal act has occurred, the appointing authority is notified. The appointing authority contacts local law enforcement. Local law enforcement has the authority to refer for prosecution.

A final analysis of the evidence indicates the facility is in substantial compliance with this provision.

115.271 (i):

The DOC Records and Retention Schedule provided by the agency shows that the record retention for all PREA investigation materials is set at 50 years. Laura Jense in her written correspondence to the auditor stated that at the end of the 50 years the record is reviewed to ensure no resident remains in the custody of WADOC or employee is still employed prior to destruction of the record.

A final analysis of the evidence indicates the facility is in substantial compliance with this provision.

115.271 (j):

DOC 490.860 PRISON RAPE ELIMINATION ACT (PREA) INVESTIGATION (Section I (A-B) states Investigations will be completed even if the offender is no longer under department jurisdiction or authority and/or the accused staff, if any, is no longer employed by or providing services to the department.

During the interviews with investigators, both investigators stated that an investigation would continue if a resident transferred or was released from custody. Both investigators said that this would be true as well if an employee under investigation left state service or transferred to another facility.

A final analysis of the evidence indicates the facility is in substantial compliance with this provision.

115.271 (k): N/A

115.271 (l):

In interviewing two investigators and the facility head at ECHWR, the auditor was informed that Spokane PD handles criminal investigations for ECHWR. The appointing authority is responsible for liaising with Spokane PD and investigators are responsible for obtaining any records, data or reports and assist Spokane PD with access to the facility.

A final analysis of the evidence indicates the facility is in substantial compliance with this provision.

Findings:

A final analysis of the evidence indicates the facility is substantially compliant with this standard.

Corrective Action:

There is no corrective action to take.

Standard 115.272: Evidentiary standard for administrative investigations

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.272 (a)

- Is it true that the agency does not impose a standard higher than a preponderance of the evidence in determining whether allegations of sexual abuse or sexual harassment are substantiated? Yes No

Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The following evidence was analyzed in making the compliance determination:

- 1. Documents:** (*Policies, directives, forms, files, records, etc.*)
 - a. DOC 490.860 PREA – Investigation
 - b. RCW 72.09.225 Section 2. (a)
 - c. PREA for Appointing Authorities – Includes a section on determination of findings which describes preponderance of evidence.
- 2. Interviews:**
- 3. Site Review Observations:**

115.272 (a):

WADOC Policy DOC 490.800 PRISON RAPE ELIMINATION ACT RESPONSE AND REPORTING has imposed the standard of a preponderance of the evidence in determining whether allegations of sexual abuse or sexual harassment are substantiated.

The auditor reviewed curriculum submitted by ECHWR titled PREA for Appointing Authorities which includes how the appointing authority makes a determination of findings. This section describes preponderance of evidence as the only standard for determination of PREA allegations.

A final analysis of the evidence indicates the facility is in substantial compliance with this provision.

Findings:

A final analysis of the evidence indicates the facility is substantially compliant with this standard.

Corrective Action:

There is no corrective action to take.

Standard 115.273: Reporting to residents

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.273 (a)

- Following an investigation into a resident’s allegation that he or she suffered sexual abuse in an agency facility, does the agency inform the resident as to whether the allegation has been determined to be substantiated, unsubstantiated, or unfounded? Yes No

115.273 (b)

- If the agency did not conduct the investigation into a resident’s allegation of sexual abuse in the agency’s facility, does the agency request the relevant information from the investigative agency in order to inform the resident? (N/A if the agency/facility is responsible for conducting administrative and criminal investigations.) Yes No NA

115.273 (c)

- Following a resident's allegation that a staff member has committed sexual abuse against the resident, unless the agency has determined that the allegation is unfounded, or unless the resident has been released from custody, does the agency subsequently inform the resident whenever: The staff member is no longer posted within the resident's unit? Yes No
- Following a resident's allegation that a staff member has committed sexual abuse against the resident, unless the agency has determined that the allegation is unfounded, or unless the resident has been released from custody, does the agency subsequently inform the resident whenever: The staff member is no longer employed at the facility? Yes No
- Following a resident's allegation that a staff member has committed sexual abuse against the resident, unless the agency has determined that the allegation is unfounded, or unless the resident has been released from custody, does the agency subsequently inform the resident whenever: The agency learns that the staff member has been indicted on a charge related to sexual abuse in the facility? Yes No
- Following a resident's allegation that a staff member has committed sexual abuse against the resident, unless the agency has determined that the allegation is unfounded, or unless the resident has been released from custody, does the agency subsequently inform the resident whenever: The agency learns that the staff member has been convicted on a charge related to sexual abuse within the facility? Yes No

115.273 (d)

- Following a resident's allegation that he or she has been sexually abused by another resident, does the agency subsequently inform the alleged victim whenever: The agency learns that the alleged abuser has been indicted on a charge related to sexual abuse within the facility?
 Yes No
- Following a resident's allegation that he or she has been sexually abused by another resident, does the agency subsequently inform the alleged victim whenever: The agency learns that the alleged abuser has been convicted on a charge related to sexual abuse within the facility?
 Yes No

115.273 (e)

- Does the agency document all such notifications or attempted notifications? Yes No

115.273 (f)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)

Does Not Meet Standard (Requires Corrective Action)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Evidence analyzed in making the compliance determination:

1. Documents: (Policies, directives, forms, files, records, etc.)

- a. DOC 490.860 PRISON RAPE ELIMINATION ACT (PREA) – Investigation
- b. Case Log
- c. Notification Tracking Log
- d. DOC 02-400 Notice of PREA Investigation Findings
- e. Sample notification Letter

2. Interviews:

3. Site Review Observations

115.273 (a):

WADOC policy DOC 490.860 PRISON RAPE ELIMINATION ACT (PREA) – Investigation states that the resident alleging sexual abuse is notified in person in a confidential manner when applicable. In instances where the resident is no longer under the supervision of the WADOC, then a letter is sent to the residents last known address. The notification is documented in the investigation report packet. ECHWR received two resident allegations of abuse during this audit period.

The auditor reviewed both investigation packets and found that in both instances a letter was sent to the last known address as both residents had released from ECHWR into the community.

A final analysis of the evidence indicates the facility is in substantial compliance with this provision.

115.273 (b):

The auditor interviewed facility head Laura Jense. She stated that external agencies who complete criminal investigations of sexual abuse forward completed investigation findings to the appointing authority. The appointing authority ensures that an administrative investigation is subsequently completed.

A final analysis of the evidence indicates the facility is in substantial compliance with this provision.

115.273 (c):

ECHWR submitted the WADOC tracking log for required notifications due to findings in sexual abuse investigations. ECHWR did not have any unsubstantiated or substantiated allegations of sexual abuse by staff during this audit period. The auditor did review the Operational Memorandum for ECHWR, ECHWTR 490.860. The following concerning ongoing notifications is found in this memorandum:

VIII. Ongoing Notifications to Alleged Victims

A. The Department will make the following notifications, in writing, to alleged victims until they are no longer under Department jurisdiction:

1. Offender-on-Offender Allegations of Sexual Assault or Abuse

a. The alleged victim will be notified if the Department learns that the accused has been indicted on or convicted of a charge related to sexual assault or abuse within the facility.

b. The PREA Coordinator/designee will track all cases and make required notifications.

2. Substantiated/Unsubstantiated Allegations of Staff Sexual Misconduct against employees

a. The alleged victim will be notified:

1) When the accused employee is no longer regularly assigned to the offender's housing unit,

2) When the accused employee no longer works at the same facility as the offender, and

3) If the Department learns that the accused employee has been indicted on or convicted of any charge related to staff sexual misconduct within the facility.

b. The **Work Release Administrator** will track all cases, make required notifications, and forward copies to the PREA Coordinator.

B. Notifications will be provided to alleged victims in a confidential manner through legal mail or by another method determined by the Appointing Authority.

A final analysis of the evidence indicates the facility is in substantial compliance with this provision.

115.273 (d):

ECHWR did not have any allegations of resident on resident sexual abuse during this audit period. The auditor did review the Operational Memorandum for ECHWR, ECHWTR 490.860. The following concerning ongoing notifications is found in this memorandum:

VIII. Ongoing Notifications to Alleged Victims

A. The Department will make the following notifications, in writing, to alleged victims until they are no longer under Department jurisdiction:

1. Offender-on-Offender Allegations of Sexual Assault or Abuse

a. The alleged victim will be notified if the Department learns that the accused has been indicted on or convicted of a charge related to sexual assault or abuse within the facility.

- a. The PREA Coordinator/designee will track all cases and make required notifications.

A final analysis of the evidence indicates the facility is in substantial compliance with this provision.

115.273 (e):

Work Training Release facilities maintain a current list of notifications and documentation of completed notifications. ECHWR currently does not have any residents who require continuing notification.

Provision (f): N/A

Findings:

A final analysis of the evidence indicates the facility is substantially compliant with this standard.

Corrective Action:

There is no corrective action to take.

DISCIPLINE

Standard 115.276: Disciplinary sanctions for staff

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.276 (a)

- Are staff subject to disciplinary sanctions up to and including termination for violating agency sexual abuse or sexual harassment policies? Yes No

115.276 (b)

- Is termination the presumptive disciplinary sanction for staff who have engaged in sexual abuse? Yes No

115.276 (c)

- Are disciplinary sanctions for violations of agency policies relating to sexual abuse or sexual harassment (other than actually engaging in sexual abuse) 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? Yes No

115.276 (d)

- Are all terminations for violations of agency sexual abuse or sexual harassment policies, or resignations by staff who would have been terminated if not for their resignation, reported to: Law enforcement agencies unless the activity was clearly not criminal? Yes No
- Are all terminations for violations of agency sexual abuse or sexual harassment policies, or resignations by staff who would have been terminated if not for their resignation, reported to: Relevant licensing bodies? Yes No

Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Evidence analyzed in making the compliance determination:

1. **Documents:** (*Policies, directives, forms, files, records, etc.*)
 - a. DOC 450.050 PROHIBITED CONTACT
 - b. DOC 490.800 PRISON RAPE ELIMINATION ACT (PREA) PREVENTION AND REPORTING
 - c. DOC 490.860 PRISON RAPE ELIMINATION ACT (PREA) INVESTIGATION

2. Interviews:

3. Site Review Observations:

115.276 (a):

State law requires that the secretary of the department shall immediately institute proceedings to terminate the employment of state employees or contractors who have been found administratively or criminally guilty of sexual abuse. Excerpt Below.

RCW 72.09.225, "Sexual misconduct by state employees, contractors" states in relevant part: "The Secretary shall immediately institute proceedings to terminate the employment of any person: (a) Who is found by the department, based on a preponderance of the evidence, to have had sexual intercourse or sexual contact with the inmate; or (b) Upon a guilty plea or conviction for any crime specified in chapter 9A.44 RCW when the victim was an inmate."

A final analysis of the evidence indicates the facility is in substantial compliance with this provision.

115.276 (b):

As above. State law requires termination proceedings to begin immediately for staff who have engaged in sexual abuse.

A final analysis of the evidence indicates the facility is in substantial compliance with this provision.

115.276 (c):

DOC 490.860 PRISON RAPE ELIMINATION ACT (PREA) INVESTIGATION Section IV (A-B) states that employees may be subject to disciplinary action, up to and including termination, for violating Department PREA policies. ECHWR reports that there were no violations of staff sexual misconduct during this audit period for the auditor to review.

A final analysis of the evidence indicates the facility is in substantial compliance with this provision.

115.276 (d):

DOC 490.860 PRISON RAPE ELIMINATION ACT (PREA) INVESTIGATION Section I., L. (1-2) requires the appointing authority to notify local law enforcement and relevant licensing bodies when an allegation is criminal in nature. ECHWR reports that there were no violations of staff sexual misconduct during this audit period for the auditor to review.

A final analysis of the evidence indicates the facility is in substantial compliance with this provision.

Findings:

A final analysis of the evidence indicates the facility is substantially compliant with this standard.

Corrective Action:

There is no corrective action to take.

Standard 115.277: Corrective action for contractors and volunteers

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.277 (a)

- Is any contractor or volunteer who engages in sexual abuse prohibited from contact with residents? Yes No
- Is any contractor or volunteer who engages in sexual abuse reported to: Law enforcement agencies unless the activity was clearly not criminal? Yes No
- Is any contractor or volunteer who engages in sexual abuse reported to: Relevant licensing bodies? Yes No

115.277 (b)

- In the case of any other violation of agency sexual abuse or sexual harassment policies by a contractor or volunteer, does the facility take appropriate remedial measures, and consider whether to prohibit further contact with residents? Yes No

Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The following evidence was analyzed in making the compliance determination:

1. **Documents:** (*Policies, directives, forms, files, records, etc.*)
 - a. RCW 72.09.225 Section 2. (a)
 - b. MEMO – Volunteers with Criminal Backgrounds (Robert Herzog, Assistant Secretary)
 - c. MEMO – Former Volunteers and Visitation Requirements (Robert Herzog, Assistant Secretary)
 - d. DOC 450.050 PROHIBITED CONTACT

e. DOC 490.860 PRISON RAPE ELIMINATION ACT (PREA) INVESTIGATION

2. Interviews:

a. Director

3. Site Review Observations:

115.277 (a):

DOC 490.860 PRISON RAPE ELIMINATION ACT (PREA) INVESTIGATION section L. (1-2) states Any contractor or volunteer who engages in sexual abuse is 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.

ECHWR reports that there have been no instances of contact with law enforcement or licensing boards for contractors/volunteers engaging in sexual abuse of residents.

A final analysis of the evidence indicates the facility is in substantial compliance with this provision.

115.277 (b):

In the interview with the director, she stated that the contractor/volunteer would not be allowed on site until the investigation was concluded. The facility would gauge what measures needed to be taken. They would not necessarily be prohibited from contact with residents. She said that depending on the nature of the incident there could be some re-training.

A final analysis of the evidence indicates the facility is in substantial compliance with this provision.

Findings:

A final analysis of the evidence indicates the facility is substantially compliant with this standard.

Corrective Action:

There is no corrective action to take

Standard 115.278: Interventions and disciplinary sanctions for residents

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.278 (a)

- Following an administrative finding that a resident engaged in resident-on-resident sexual abuse, or following a criminal finding of guilt for resident-on-resident sexual abuse, are residents subject to disciplinary sanctions pursuant to a formal disciplinary process? Yes No

115.278 (b)

- Are sanctions 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? Yes No

115.278 (c)

- When determining what types of sanction, if any, should be imposed, does the disciplinary process consider whether a resident's mental disabilities or mental illness contributed to his or her behavior? Yes No

115.278 (d)

- If the facility offers therapy, counseling, or other interventions designed to address and correct underlying reasons or motivations for the abuse, does the facility consider whether to require the offending resident to participate in such interventions as a condition of access to programming and other benefits? Yes No

115.278 (e)

- Does the agency discipline a resident for sexual contact with staff only upon a finding that the staff member did not consent to such contact? Yes No

115.278 (f)

- For the purpose of disciplinary action does a report of sexual abuse made in good faith based upon a reasonable belief that the alleged conduct occurred NOT constitute falsely reporting an incident or lying, even if an investigation does not establish evidence sufficient to substantiate the allegation? Yes No

115.278 (g)

- If the agency prohibits all sexual activity between residents, does the agency always refrain from considering non-coercive sexual activity between residents to be sexual abuse? (N/A if the agency does not prohibit all sexual activity between residents.) Yes No NA

Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Evidence analyzed in making the compliance determination:

1. **Documents:** (*Policies, directives, forms, files, records, etc.*)
 - a. DOC 460.135 DISCIPLINARY PROCEDURES FOR WORK RELEASE
 - b. Chapter 137-28 WAC Discipline-Prisons
 - c. Chapter 137-28-310 WAC Discipline-Prisons (Decision of Hearing Officer)
 - d. Chapter 137-28-360 WAC Discipline-Prisons (Sanctions and Mental Status)

Chapter 137-25-020 WAC Discipline-Prisons (Definitions)

2. Interviews:

3. Site Review Observations:

115.278 (a):

DOC 460-135 DISCIPLINARY PROCEDURES FOR WORK RELEASE, section V (A-D) outline procedures for disciplinary action for resident found to have engaged in resident-on-resident sexual abuse or following a criminal finding of guilt for resident-on-resident sexual abuse.

ECHWR reports that there were no allegations of resident on resident sexual abuse during this audit period. In interviews with staff and residents, the auditor found no evidence of resident on resident sexual abuse. As such, there were no disciplinary reports of this kind for the audit team to review.

A final analysis of the evidence indicates the facility is in substantial compliance with this provision.

115.278 (b):

DOC 460-135 DISCIPLINARY PROCEDURES FOR WORK RELEASE, section V (A-D). ECHWR reports that there were no allegations of resident on resident sexual abuse during this audit period.

The facility head stated in their interview that the residents overall behavior history as well as the sanctions imposed for recent infractions by other residents of a similar nature are considered in the disciplinary portion of the process. They stated that this would be true for all disciplinary matters.

A final analysis of the evidence indicates the facility is in substantial compliance with this provision.

115.278 (c):

DOC 460-135 DISCIPLINARY PROCEDURES FOR WORK RELEASE, section VI C. 1. C provides for a hearing officer to stay the hearing for a mental health evaluation.

DOC disciplinary guidelines offers the following: Chapter 137-25-020 WAC Discipline-Prisons (Definitions): In determining an appropriate sanction, the hearing officer should consider the offender's mental health and his/her intellectual, emotional, and maturity levels and what effect a particular sanction might have on the offender in light of such factors.

The facility head stated during their interview that mental health is absolutely considered as serious infractions could lead to program and housing reassignments and potential termination from work release.

A final analysis of the evidence indicates the facility is in substantial compliance with this provision.

115.278 (d):

DOC 460-135 DISCIPLINARY PROCEDURES FOR WORK RELEASE Section IX, A. provides for programming and therapy for residents found to have engaged in abuse of another resident.

During interviews with two case managers at ECHWR, the auditor was informed that the perpetrator of abuse would be rescreened utilizing the PREA Risk Screening Tool and referred to a mental health practitioner immediately.

A final analysis of the evidence indicates the facility is in substantial compliance with this provision.

115.278 (e):

DOC 490.860 PRISON RAPE ELIMINATION ACT (PREA) INVESTIGATION section V., B., 1 states that a resident may not be disciplined for sexual contact with a staff member unless it is found that the staff member did not consent to such contact.

A final analysis of the evidence indicates the facility is in substantial compliance with this provision.

115.278 (f):

DOC 490.860 PRISON RAPE ELIMINATION ACT (PREA) INVESTIGATION section V., B., 2. States that a resident who reports sexual abuse 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.

In review of investigations during this audit period, the audit team found no instances of a resident being disciplined following an unfounded or unsubstantiated claim. It was clear to the auditor, from review of the reports, that the investigators believed that the resident was reporting in good faith.

A final analysis of the evidence indicates the facility is in substantial compliance with this provision.

115.278 (g)

The agency differentiates between sexual abuse and consensual sexual activity in its definition section of policy *DOC 490.800 Prison Rape Elimination Act Prevention and Reporting*.

A final analysis of the evidence indicates the facility is in substantial compliance with this provision.

Findings:

A final analysis of the evidence indicates the facility is substantially compliant with this standard.

Corrective Action:

There is no corrective action to take.

MEDICAL AND MENTAL CARE

Standard 115.282: Access to emergency medical and mental health services

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.282 (a)

- Do resident victims of sexual abuse 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?
 Yes No

115.282 (b)

- If no qualified medical or mental health practitioners are on duty at the time a report of recent sexual abuse is made, do security staff first responders take preliminary steps to protect the victim pursuant to § 115.262? Yes No
- Do security staff first responders immediately notify the appropriate medical and mental health practitioners? Yes No

115.282 (c)

- Are resident victims of sexual abuse 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? Yes No

115.282 (d)

- Are treatment services 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?
 Yes No

Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The following evidence was analyzed in making the compliance determination:

1. **Documents:** (*Policies, directives, forms, files, records, etc.*)
 - a. DOC 490.850 PRISON RAPE ELIMINATION ACT (PREA) RESPONSE

- b. DOC 610.300 HEALTH SERVICES FOR WORK RELEASE OFFENDERS
- c. Aggravated Sexual Assault Checklist (Attachment 1)
- d. Aggravated Sexual Assault Medical Follow-Up Checklist (Attachment 2)

2. Interviews:

- a. Medical/Mental Health Staff – ECHWR does not provide onsite medical/mental health services
- b. Residents who reported sexual abuse – ECHWR did not house any residents who reported sexual abuse at the time of the onsite audit.
- c. Security/Non Security staff 1st responders

3. Site Review Observations:

- a. Review of PREA response kit

115.282 (a):

ECHWR provided the *Aggravated Sexual Assault Checklist (ASAC)* which outlines the process for responding to incidents of sexual abuse. The ASAC states that resident victims of sexual abuse shall 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. .

ECHWR does not provide medical or mental health services within the facility. ECHWR provides access to community based services. ECHWR reports no instances of sexual abuse requiring these services during the audit period. The audit team in reviewing documentation and interview of staff and residents found no evidence of sexual abuse incidents.

A final analysis of the evidence indicates the facility is in substantial compliance with this provision.

115.282 (b):

The ASAC outlines the procedures for first responders including steps to protect the victim and to notify and provide medical and mental health services.

The audit team interviewed three first responders while onsite at ECHWR. All three first responders interviewed stated that their first priority is the safety of the victim. All three stated that they would utilize the PREA response kit which maintains the above noted checklist.

This audit team reviewed the PREA response kit and checklist and found it very comprehensive.

A final analysis of the evidence indicates the facility is in substantial compliance with this provision.

115.282 (c):

ECHWR does not provide in house medical or mental health services but does provide community access to these services. The appropriateness of treatment is decided between the resident and the community provider not the facility.

A final analysis of the evidence indicates the facility is in substantial compliance with this provision.

115.282 (d)

Agency policy governing community correction health and mental health services states that no victim of sexual misconduct will incur a financial cost for services due to the misconduct.

A final analysis of the evidence indicates the facility is in substantial compliance with this provision.

Findings:

A final analysis of the evidence indicates the facility is substantially compliant with this standard.

Corrective Action:

There is no corrective action to take

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

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.283 (a)

- Does the facility offer 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? Yes No

115.283 (b)

- Does the evaluation and treatment of such victims 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? Yes No

115.283 (c)

- Does the facility provide such victims with medical and mental health services consistent with the community level of care? Yes No

115.283 (d)

- Are resident victims of sexually abusive vaginal penetration while incarcerated offered pregnancy tests? (N/A if “all-male” facility. *Note: in “all-male” facilities, there may be residents who identify as transgender men who may have female genitalia. Auditors should be sure to know whether such individuals may be in the population and whether this provision may apply in specific circumstances.*) Yes No NA

115.283 (e)

- If pregnancy results from the conduct described in paragraph § 115.283(d), do such victims receive timely and comprehensive information about and timely access to all lawful pregnancy-related medical services? (N/A if “all-male” facility. *Note: in “all-male” facilities, there may be residents who identify as transgender men who may have female genitalia. Auditors should be sure to know whether such individuals may be in the population and whether this provision may apply in specific circumstances.*) Yes No NA

115.283 (f)

- Are resident victims of sexual abuse while incarcerated offered tests for sexually transmitted infections as medically appropriate? Yes No

115.283 (g)

- Are treatment services 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? Yes No

115.283 (h)

- Does the facility 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? Yes No

Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Evidence analyzed in making the compliance determination:

- 1. Documents:** (*Policies, directives, forms, files, records, etc.*)
 - a. DOC 490.850 PRISON RAPE ELIMINATION ACT (PREA) RESPONSE
 - b. DOC 630.500 MENTAL HEALTH SERVICES
 - c. DOC 610.300 HEALTH SERVICES FOR WORK RELEASE OFFENDERS
- 2. Interviews:**
 - a. Medical/Mental Health Staff – ECHWR does not provide onsite medical/mental health services
 - b. Residents who reported sexual abuse – ECHWR did not house any residents who reported sexual abuse at the time of the onsite audit.

3. Site Review Observations:

115.283 (a):

The auditor found that the agency has outlined the process to provide medical and mental health evaluation and, as appropriate, treatment to all residents who have been victimized by sexual abuse in policy *DOC 610.300 HEALTH SERVICES FOR WORK RELEASE OFFENDERS*.

ECHWR reports that there have been no victims of sexual victimization during this audit period. The audit team in reviewing documentation and interviewing staff and residents found no evidence of sexual abuse incidents during this audit period.

A final analysis of the evidence indicates the facility is in substantial compliance with this provision.

115.283 (b)

The auditor found that the agency has stated in *DOC 610.300 HEALTH SERVICES FOR WORK RELEASE OFFENDERS* that the a victim of sexual misconduct will not have debt added to his/her account for any medical or mental health treatment received as a result of reported sexual misconduct.

This would imply that these services would continue after transfer or release.

A final analysis of the evidence indicates the facility is in substantial compliance with this provision.

115.283 (c):

ECHWR does not provide onsite medical or mental health services. Since all medical and mental health services are provided in the community this provision has been met.

A final analysis of the evidence indicates the facility is in substantial compliance with this provision.

115.283 (d):

DOC 610.300 HEALTH SERVICES FOR WORK RELEASE OFFENDERS provides for these tests. Because all services are provided in the community, the need for a pregnancy test and completion of said test would be decided between the medical practitioner and the resident.

A final analysis of the evidence indicates the facility is in substantial compliance with this provision.

115.283 (e):

DOC 610.300 HEALTH SERVICES FOR WORK RELEASE OFFENDERS provides for these services. ECHWR provides information for planned parenthood to provide specific counseling and services.

A final analysis of the evidence indicates the facility is in substantial compliance with this provision.

115.283 (f):

DOC 610.300 HEALTH SERVICES FOR WORK RELEASE OFFENDERS provides for these tests. Because all services are provided in the community, the need for these test and completion of said tests would be decided between the medical practitioner and the resident.

A final analysis of the evidence indicates the facility is in substantial compliance with this provision.

115.283 (g):

DOC 610.300 HEALTH SERVICES FOR WORK RELEASE OFFENDERS that the a victim of sexual misconduct will not have debt added to his/her account for any medical or mental health treatment received as a result of reported sexual misconduct.

Although ECHWR reports no instances or need of this level of medical and mental health services. The facility head stated in their interview that these service are provided at no cost to the victim of reported sexual misconduct.

A final analysis of the evidence indicates the facility is in substantial compliance with this provision.

115.283 (h):

DOC 610.300 HEALTH SERVICES FOR WORK RELEASE OFFENDERS in section F subsection 1. States that abusers who refuse to participate in a community mental health evaluation will be transferred to a facility which provides mental health services for evaluation and treatment.

A final analysis of the evidence indicates the facility is in substantial compliance with this provision.

Findings:

A final analysis of the evidence indicates the facility is substantially compliant with this standard.

Corrective Action:

There is no corrective action to take

DATA COLLECTION AND REVIEW

Standard 115.286: Sexual abuse incident reviews

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.286 (a)

- Does the facility 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? Yes No

115.286 (b)

- Does such review ordinarily occur within 30 days of the conclusion of the investigation? Yes No

115.286 (c)

- Does the review team include upper-level management officials, with input from line supervisors, investigators, and medical or mental health practitioners? Yes No

115.286 (d)

- Does the review team: Consider whether the allegation or investigation indicates a need to change policy or practice to better prevent, detect, or respond to sexual abuse? Yes No
- Does the review team: Consider whether the incident or allegation was motivated by race; ethnicity; gender identity; lesbian, gay, bisexual, transgender, or intersex identification, status, or perceived status; gang affiliation; or other group dynamics at the facility? Yes No
- Does the review team: Examine the area in the facility where the incident allegedly occurred to assess whether physical barriers in the area may enable abuse? Yes No
- Does the review team: Assess the adequacy of staffing levels in that area during different shifts? Yes No
- Does the review team: Assess whether monitoring technology should be deployed or augmented to supplement supervision by staff? Yes No
- Does the review team: Prepare a report of its findings, including but not necessarily limited to determinations made pursuant to §§ 115.286(d) (1) - (d)(5), and any recommendations for improvement and submit such report to the facility head and PREA compliance manager? Yes No

115.286 (e)

- Does the facility implement the recommendations for improvement, or document its reasons for not doing so? Yes No

Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Evidence analyzed in making the compliance determination:

1. **Documents:** (*Policies, directives, forms, files, records, etc.*)
 - a. DOC 02-383 PREA Investigation Review Checklist
 - b. DOC 490.860 PRISON RAPE ELIMINATION ACT (PREA) INVESTIGATION
2. **Interviews:**
 - a. Facility Head
3. **Site Review Observations:**

115.286 (a):

ECHWR reports one incident requiring a sexual abuse incident review during this audit period. ECHWR submitted the incident review. The auditor found that the incident review encompassed all major areas of sexual abuse detection, response and investigation

A final analysis of the evidence indicates the facility is in substantial compliance with this provision.

115.286 (b)

The auditor had only one incident review to evaluate for this audit period. The review was completed within 30 days of the findings by the appointing authority.

A final analysis of the evidence indicates the facility is in substantial compliance with this provision.

115.286 (c):

The review evaluated by the auditor included upper level management staff, line supervisors, investigators and mental health practitioners on the review team

A final analysis of the evidence indicates the facility is in substantial compliance with this provision.

115.286 (d):

The incident review examined by the auditor included all six areas outlined in the provision. The facility head stated in her interview that community confinement/work release has a review team that is not facility specific. She further elaborated that recommendations for policy changes are forwarded to a specific agency committee that evaluates and updates all policies and recommendations for changes in facility structure, electronic monitoring or staffing would be forwarded to the appointing authority.

115.286 (e):

The auditor reviewed the incident review report form utilized to document sexual abuse allegations. The report includes an action plan section for recommendations from the review team. This section includes a review by the appointing authority as well as the date forwarded to the agency PREA Coordinator. The incident available for the auditor's review did not make any recommendations as the final determination was unsubstantiated. The review was signed off on by the appointing authority and forwarded to the PREA Coordinator.

A final analysis of the evidence indicates the facility is in substantial compliance with this provision.

Findings:

A final analysis of the evidence indicates the facility is substantially compliant with this standard.

Corrective Action:

There is no corrective action to take.

Standard 115.287: Data collection

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.287 (a)

- Does the agency collect accurate, uniform data for every allegation of sexual abuse at facilities under its direct control using a standardized instrument and set of definitions? Yes No

115.287 (b)

- Does the agency aggregate the incident-based sexual abuse data at least annually? Yes No

115.287 (c)

- Does the incident-based data 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? Yes No

115.287 (d)

- Does the agency maintain, review, and collect data as needed from all available incident-based documents, including reports, investigation files, and sexual abuse incident reviews?
 Yes No

115.287 (e)

- Does the agency also obtain incident-based and aggregated data from every private facility with which it contracts for the confinement of its residents? (N/A if agency does not contract for the confinement of its residents.) Yes No NA

115.287 (f)

- Does the agency, upon request, provide all such data from the previous calendar year to the Department of Justice no later than June 30? (N/A if DOJ has not requested agency data.)
 Yes No NA

Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Evidence analyzed in making the compliance determination:

- 1. Documents:**
 - a. Three previous year's Survey of Sexual Violence submitted to the Department of Justice
- 2. Interviews:**
 - a. PREA Coordinator
 - b. Agency Head
- 3. Site Review Observations:**
 - a. Review of the agency public website

115.287 (a):

The agency maintains a PREA allegation and case database within the Offender Management Network Information (OMNI) system. This system allows for the standardized collection of uniform data for every allegation of sexual abuse at facilities under its direct control using a standardized instrument and set of definitions.

A final analysis of the evidence indicates the facility is in substantial compliance with this provision.

115.287 (b):

The agency retrieves data from the previous year in February. This data is then compared to previous year's data. The process was discussed during the interview with the PREA Coordinator and then verified by the auditor in reviewing annual reports on the agency's public website.

A final analysis of the evidence indicates the facility is in substantial compliance with this provision.

115.287 (c):

The agency provided the auditor the Survey of Sexual Violence for the three previous years which the agency submitted to the Department of Justice

A final analysis of the evidence indicates the facility is in substantial compliance with this provision.

115.287 (d):

Review by the auditor, of the reporting completed by the agency, shows that the agency does maintain, review, and collect data as needed from all available incident-based documents, including reports, investigation files, and sexual abuse incident reviews. The PREA coordinator stated that they are responsible for the collection of the data which comes from OMNI and IMRS.

A final analysis of the evidence indicates the facility is in substantial compliance with this provision.

115.287 (e):

The auditor reviewed the reports provided by the agency on the public website. The reports outline contracted facilities and the data collected from the facilities.

A final analysis of the evidence indicates the facility is in substantial compliance with this provision.

115.287 (f):

The auditor found that for the previous three years that the agency filed all requested information with the DOJ in a timely fashion.

A final analysis of the evidence indicates the facility is in substantial compliance with this provision.

Findings:

A final analysis of the evidence indicates the facility is substantially compliant with this standard.

Corrective Action:

There is no corrective action to take.

Standard 115.288: Data review for corrective action

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.288 (a)

- Does the agency 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 by: Identifying problem areas? Yes No
- Does the agency 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 by: Taking corrective action on an ongoing basis? Yes No
- Does the agency 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 by: Preparing an annual report of its findings and corrective actions for each facility, as well as the agency as a whole? Yes No

115.288 (b)

- Does the agency's annual report include a comparison of the current year's data and corrective actions with those from prior years and provide an assessment of the agency's progress in addressing sexual abuse? Yes No

115.288 (c)

- Is the agency's annual report approved by the agency head and made readily available to the public through its website or, if it does not have one, through other means? Yes No

115.288 (d)

- Does the agency indicate the nature of the material redacted where it redacts specific material from the reports when publication would present a clear and specific threat to the safety and security of a facility? Yes No

Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Evidence analyzed in making the compliance determination:

- 1. Documents:**
 - a. Screenshots from agency website
- 2. Interviews:**
 - a. PREA Coordinator
 - b. Agency Head
- 3. On-site Observations:**
 - a. Agency public website

115.288 (a):

The auditor reviewed the reports and documents supplied by the agency on the public website. The agency has supplied reports on collected data concerning PREA starting in 2013.

In her interview, the PREA Coordinator stated that all data from the previous year is compiled in February. At this time the agency and individual facilities are required to review the data against data collected from previous years to identify trends and issues not previously identified and to create corrective action plans.

A final analysis of the evidence indicates the facility is in substantial compliance with this provision.

115.288 (b):

The auditor verified that the yearly report does compare data from previous years and provides a summary of the agency's efforts towards sexual safety in its facilities.

A final analysis of the evidence indicates the facility is in substantial compliance with this provision.

115.288 (c):

The auditor verified that the agency's yearly reports are located and readily accessible by the public on the website

A final analysis of the evidence indicates the facility is in substantial compliance with this provision.

115.288 (d):

The auditor could not find where any reports on the website had been redacted. When asked during her interview, The PREA Coordinator said that the report is written without personal identifying information and without information that would jeopardize the security of any facility and therefore redaction is not necessary

A final analysis of the evidence indicates the facility is in substantial compliance with this provision.

Findings:

A final analysis of the evidence indicates the facility is substantially compliant with this standard.

Corrective Action:

There is no corrective action to take.

Standard 115.289: Data storage, publication, and destruction

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.289 (a)

- Does the agency ensure that data collected pursuant to § 115.287 are securely retained?
 Yes No

115.289 (b)

- Does the agency make all aggregated sexual abuse data, from facilities under its direct control and private facilities with which it contracts, readily available to the public at least annually through its website or, if it does not have one, through other means? Yes No

115.289 (c)

- Does the agency remove all personal identifiers before making aggregated sexual abuse data publicly available? Yes No

115.289 (d)

- Does the agency 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? Yes No

Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Evidence analyzed in making the compliance determination:

- Documents:** (*Policies, directives, forms, files, records, etc.*)
 - Table outlining access approval for PREA Database
 - Screen Shots from State DOC Website
(<http://www.wa.gov/corrections/prea/resources.htm#reports>)
 - Washington State Record Retention schedule

2. Interviews:

- a. Agency Head

3. Site Review Observations:

115.289 (a):

The agency has a database which is solely for reporting, investigating and maintaining information which relates to PREA. The facility provided the auditor with a table which shows which positions within state government has what access as it pertains to this information. While on-site at ECHWR, the auditor was shown how the data is stored, how it is accessed and who may access the information

A final analysis of the evidence indicates the facility is in substantial compliance with this provision.

115.289 (b):

The auditor was able to locate all aggregated sexual abuse data, from facilities under its direct control and private facilities with which it contracts on its website.

A final analysis of the evidence indicates the facility is in substantial compliance with this provision.

115.289 (c):

The data reviewed by the auditor on the agency's public website did not include any personal identifiers

A final analysis of the evidence indicates the facility is in substantial compliance with this provision.

115.289 (d):

The auditor was provided the record retention schedule for the State of Washington. The finalized report comprised of the sexual abuse data collected is classified as archival and therefore is never scheduled to be destroyed

A final analysis of the evidence indicates the facility is in substantial compliance with this provision.

Findings:

A final analysis of the evidence indicates the facility is substantially compliant with this standard.

Corrective Action:

There is no corrective action to take.

AUDITING AND CORRECTIVE ACTION

Standard 115.401: Frequency and scope of audits

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.401 (a)

- During the prior three-year audit period, did the agency ensure that each facility operated by the agency, or by a private organization on behalf of the agency, was audited at least once? (*Note: The response here is purely informational. A "no" response does not impact overall compliance with this standard.*) Yes No

115.401 (b)

- Is this the first year of the current audit cycle? (*Note: a "no" response does not impact overall compliance with this standard.*) Yes No
- If this is the second year of the current audit cycle, did the agency ensure that at least one-third of each facility type operated by the agency, or by a private organization on behalf of the agency, was audited during the first year of the current audit cycle? (N/A if this is **not** the *second* year of the current audit cycle.) Yes No NA
- If this is the third year of the current audit cycle, did the agency ensure that at least two-thirds of each facility type operated by the agency, or by a private organization on behalf of the agency, were audited during the first two years of the current audit cycle? (N/A if this is **not** the *third* year of the current audit cycle.) Yes No NA

115.401 (h)

- Did the auditor have access to, and the ability to observe, all areas of the audited facility? Yes No

115.401 (i)

- Was the auditor permitted to request and receive copies of any relevant documents (including electronically stored information)? Yes No

115.401 (m)

- Was the auditor permitted to conduct private interviews with residents? Yes No

115.401 (n)

- Were residents permitted to send confidential information or correspondence to the auditor in the same manner as if they were communicating with legal counsel? Yes No

Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

Evidence analyzed in making the compliance determination:

1. Documents:

- a. Completed Audits
- b. Audit Notice

2. Interviews:

- a. PREA Coordinator

3. Site Review Observations:

- a. Audit Notice postings
- b. ECHWR staff were polite, professional and helpful

115.401 (a):

The auditor confirmed by review of WADOC's public website that beginning in Audit Cycle II, and during each three-year period thereafter, the agency ensured each facility operated by the agency, or by a private organization on behalf of the agency, was and is audited at least once. The public website lists the facility and respective audit year, in addition to a hyperlink to access the final report.

A final analysis of the evidence indicates the facility is in substantial compliance with this provision.

115.401 (b):

Although this audit was conducted in 2021, it was originally scheduled for 2020 the first year of the new audit cycle. Due to the Covid-19 pandemic, which caused unforeseen auditing and travel complications, WADOC did not achieve the one third requirement in year I of audit cycle III. WADOC's response to these circumstances was to schedule the missed audits from year I in year II.

A final analysis of the evidence indicates the facility is in substantial compliance with this provision.

115.401 (h):

The auditor received a complete site review of the facility and was not denied access to any portion of the facility

A final analysis of the evidence indicates the facility is in substantial compliance with this provision.

115.401 (i):

The auditor requested and received documents from the facility point of contact throughout the audit.

A final analysis of the evidence indicates the facility is in substantial compliance with this provision.

115.401 (m):

The auditor interviewed 11 residents while on-site. The facility head assisted in making as many residents as possible available for interview.

A final analysis of the evidence indicates the facility is in substantial compliance with this provision.

115.401 (n):

The correspondence information for the auditor was posted in a significant amount of areas prior to the on-site audit and during the audit. The auditor did not receive any correspondence prior to or after the site audit.

A final analysis of the evidence indicates the facility is in substantial compliance with this provision.

Findings:

A final analysis of the evidence indicates the facility is substantially compliant with this standard.

Corrective Action:

There is no corrective action to take.

Standard 115.403: Audit contents and findings

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.403 (f)

- The agency has published on its agency website, if it has one, or has otherwise made publicly available. The review period is for prior audits completed during the past three years PRECEDING THIS AGENCY AUDIT. The pendency of any agency appeal pursuant to 28 C.F.R. § 115.405 does not excuse noncompliance with this provision. (N/A if there have been no Final Audit Reports issued in the past three years, or in the case of single facility agencies that there has never been a Final Audit Report issued.) Yes No NA

Auditor Overall Compliance Determination

- Exceeds Standard** (*Substantially exceeds requirement of standards*)
- Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- Does Not Meet Standard** (*Requires Corrective Action*)

Evidence analyzed in making the compliance determination:

1. **Documents:** (*Policies, directives, forms, files, records, etc.*)
2. **Interviews:**
3. **Site Review Observations**

115.403 (f):

The auditor has reviewed the agency website and found that all completed audits for the last three years have been published.

A final analysis of the evidence indicates the facility is in substantial compliance with this provision.

Findings:

A final analysis of the evidence indicates the facility is substantially compliant with this standard.

Corrective Action:

There is no corrective action to take.

AUDITOR CERTIFICATION

I certify that:

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

Auditor Instructions:

Type your full name in the text box below for Auditor Signature. This will function as your official electronic signature. Auditors must deliver their final report to the PREA Resource Center as a searchable PDF format to ensure accessibility to people with disabilities. Save this report document into a PDF format prior to submission.¹ Auditors are not permitted to submit audit reports that have been scanned.² See the PREA Auditor Handbook for a full discussion of audit report formatting requirements.

Wallace Gordon Bump

January 20, 2022

Auditor Signature

Date

¹ See additional instructions here: <https://support.office.com/en-us/article/Save-or-convert-to-PDF-d85416c5-7d77-4fd6-a216-6f4bf7c7c110>.

² See *PREA Auditor Handbook*, Version 1.0, August 2017; Pages 68-69.