PREA AUDIT REPORT ☐ Interim ☒ Final

COMMUNITY CONFINEMENT FACILITIES

Date of report: 01/23/2017

Auditor Information			
Auditor name: Maren Arbach			
Address: PO Box 7203 Bismarck ND 58506			
Email: fcc@midco.net			
Telephone number: 701-214-8660			
Date of facility visit: October 30-November 1, 2016			
Facility Information			
Facility name: Mirror Inc			
Facility physical address: 236 S Pattie Wichita KS 67211			
Facility mailing address: *(if different from above)* Click here to enter text.			
Facility telephone number: 316-264-5999			
The facility is:	☐ Federal	☐ State	☐ County
	☐ Military	☐ Municipal	☐ Private for profit
	☒ Private not for profit		
Facility type:	☐ Community treatment center ☒ Halfway house ☐ Alcohol or drug rehabilitation center	☐ Community-based confinement facility ☐ Mental health facility ☐ Other	
Name of facility's Chief Executive Officer: Barth Hague			
Number of staff assigned to the facility in the last 12 months: 10			
Designed facility capacity: 56			
Current population of facility: 5			
Facility security levels/inmate custody levels: Minimum to Maximum			
Age range of the population: 21-53			
Name of PREA Compliance Manager: Rhendi Leiker	**Title:** Case Manager		
Email address: rleiker@mirrorinc.gov	**Telephone number:** 316-416-5451		
Agency Information			
Name of agency: Mirror Inc			
Governing authority or parent agency: *(if applicable)* Bureau of Prisons			
Physical address: Residential Re-Entry Management Office Central Sector, Kansas City Office Gateway Tower II Complex 400 State Ave Sixth Floor Kansas City KS 66001			
Mailing address: *(if different from above)* Click here to enter text.			
Telephone number: 913-551-1117			
Agency Chief Executive Officer			
Name: Barth Hague	**Title:** President and CEO		
Email address: bhague@mirrorinc.org	**Telephone number:** 316-283-6743		
Agency-Wide PREA Coordinator			
Name: Ken McGill	**Title:** Vice President of Correctional Services		
Email address: kmcgill@mirrorinc.org	**Telephone number:** 316-208-9362		

AUDITFINDINGS

NARRATIVE

A PREA audit was conducted of the Pattie Residential Re-Entry facility on October 31 to November 1, 2016; one of two facilities in Wichita, KS, operated by Mirror, Inc. The audit was led by certified PREA auditor Maren Arbach and was subcontracted by 360 Correctional Consulting, LLC. The audit notices for 360 Correctional Consulting were posted at least six weeks prior to the audit but, after the change of auditors, new signage was posted on 09/24/2016.

The completed PREA pre-audit questionnaire (PAQ) was received by the auditor on 10/09/2016 allowing for sufficient time for pre-audit review. The PAQ was arranged on a thumb drive in a very organized manner. Correspondence occurred between the PREA auditor, PREA Coordinator, and PREA Compliance Manager throughout the pre-audit phase and a tentative audit schedule was provided to the facility on 10/22/2016. The auditor reported to Mirror Inc. Pattie on 10/31/2016 at approximately 9 am to initiate the audit. Those in attendance included: Rhendi Leiker, PREA Compliance Manager.

The PREA Compliance Manager accompanied the auditor through the facility and pointed out the camera coverage as well as the gaps in the camera coverage they have encountered. Due to the fact the audit was being conducted jointly with the Mirror Inc Toben facility, the auditor began with random resident interviews. On 10/31 and 11/01, five resident and all technicians were interviewed. One of these residents was limited English proficient. Staff reported they had no transgender or intersex inmates at the facility at the time and the auditor did not observe any residents who appeared to be transgender or intersex.

On 10/31, while at Mirror Inc Toben, specialized interview were conducted with the following: Ken McGill, who operates as the PREA Coordinator, the Bureau of Prisons contract administrator, and a PREA Investigator; the Human Resources director; Stacy White, Executive Director; Mark Mitchell, PREA Compliance Manager for Toben facility, PREA Investigator, and staff who performs resident screening; and Rhendi Leiker, PREA Compliance Manager for Pattie facility and PREA Investigator. The staff and residents of the facility indicated a knowledge of what PREA is, how to report and respond to allegations, and the right of the resident's to be free from sexual abuse and sexual harassment. The facility did not have any sexual abuse or sexual harassment allegations during the time frame reviewed. This information was corroborated by both residents and staff which tends to show there were not incidents that were not accounted for. Mirror Inc Pattie has trained staff to investigate allegations on the administrative level. Criminal investigations will be performed by the Wichita Police Department. Documentation reviewed indicates a positive relationship with the police department.

DESCRIPTION OF FACILITY CHARACTERISTICS

Mirror Inc. Pattie facility is a private not for profit halfway house operated in Wichita KS. The facility was built in 1978 and opened in its current capacity in 1999. This facility has the capability to house up to 56 female residents with security classifications ranging from minimum to maximum. At the time of the onsite audit, the resident population was 5 female residents. The Mirror Inc. Pattie facility is one multi-level building made up of a large dorm room on the lower floor. Adjacent to the dorm area are a bathroom and a recreation area. In addition, there is a large dayroom/dining area, a kitchen, a single person room/bathroom, and several offices located on the main floor.

Mirror Inc. Pattie provides residents with access to finding treatment and employment options in the community of Wichita.

The agency mission statement is: Mirror's mission is that through broad-based partnerships, we will provide substance abuse prevention and treatment, correctional, and other community health and human services to people in need.

SUMMARY OF AUDIT FINDINGS

After a short corrective action period, RRC Pattie is in compliance with the PREA standards. They have exceeded standards 115.211 and 115.215.

There are two standards that are not applicable to the facility.

There are a total of 35 standards RRC Pattie meets.

Of the deficiencies found, the facility staff made substantial efforts to come into compliance with the standards expediently. Overall, the auditor was very impressed with their obvious belief in the spirit of the act. Repeatedly, the auditor heard how the facility is committed to the safety of their residents and this was evident in reviewing the efforts and practices.

On January 23, 2017, Mirror Inc's Wichita Residential Reentry Center Pattie satisfied all required corrective action to achieve full PREA compliance.

Number of standards exceeded: 2

Number of standards met: 35

Number of standards not met: 0

Number of standards not applicable: 2

Standard 115.211 Zero tolerance of sexual abuse and sexual harassment; PREA Coordinator

☒ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

In order to make my determination, I reviewed the following policies and documentation:
- PREA Policy
- Organizational Chart

Interviews, document, and site review:
In terms of policy, Mirror Inc has developed a policy which meets all the requirements of the PREA standards. Kenneth McGill is the PREA Coordinator for the facilities but they have elected to have a PREA Compliance Manager on site at each facility so there is someone on site who can ensure continuing compliance with PREA.

All interviews with staff, residents, and specialized staff affirm the zero tolerance policy and the measures used for prevention, detection, and responding to allegations of sexual abuse and sexual harassment.

The residential re-entry center has appointed an upper-level PREA Coordinator who also serves in the position of Vice President of Correctional Services; Ken McGill. The auditor reviewed the agency organizational chart, which listed the PREA Coordinator (PC) position. Ken, as the PC, reported that he has sufficient time and has authority to develop and oversee agency PREA compliance efforts. The PREA Coordinator reports directly to President/CEO, Barth Hague. Ken McGill was interviewed as the Agency Head designee. Interviews with PC revealed that PREA compliance efforts are a priority. The RCC has also designated Rhendi Leiker as the PREA Compliance Manager (PCM). Though, the community confinement standards do not mandate the appointment of a PCM, Rhendi Leiker has played the key role in PREA implementation at the RCC and it is the auditor's opinion that having someone designated onsite to handle PREA-related matters, will ensure the longevity of the sites efforts in compliance. This exceeds this standard.

One minor revision in the policy is recommended, which is to revise the definition of LGBTI. As of now, the inference is that all LGBTI residents are gender non-conforming when in fact the two are distinct. The acronym stands for Lesbian, Gay, Bisexual, Transgender, or Intersex. The standards account in various ways for vulnerabilities of residents who are LGBTI or are gender non-conforming; those whose appearance or manner does not conform to traditional gender expectations.

Corrective Action:
None needed.

Standard 115.212 Contracting with other entities for the confinement of residents

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

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

Not applicable. The agency does not contract with anyone for the confinement of residents.

Standard 115.213 Supervision and monitoring

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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In order to make my determination, I reviewed the following policies and documentation:

- PREA Policy
- Staff Schedule

Interviews, document, and site review:
The Pattie RRC has implemented a staffing ratio of one technician for each 24 residents. During the busiest times of the day, they staff with three technicians to ensure adequate coverage and response capability.

During the interview with the PC, Ken McGill, it was indicated there is a monthly review of the staff schedule which they referred to as a quality control review. As each schedule is created, it is reviewed by upper level staff to ensure minimum staffing levels are achieved. If there are any holes in the schedule, these posts are either filled voluntarily by staff or assigned by administration.

The auditor was provided with a breakdown of the facility staffing plan. RRC Pattie technicians are required to conduct rounds at least every 30 minutes. In the staffing plan, it is noted the technician posts will not be covered by another position. It is documented in the staffing plan that the position of Program Technician will devote its time to supervising residents.

The PAQ indicates the facility has not had any instances of non-compliance with the staffing plan.

Corrective Action:
None needed.

Standard 115.215 Limits to cross-gender viewing and searches

☒ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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In order to make my determination, I reviewed the following policies and documentation:

- PREA Policy

Interviews, document, and site review:
Mirror Inc. Pattie is an all-female facility that does employee some male staff. When male staff are on site, they are generally there to conduct urinalysis testing on external probationers but they may assist with duties within the facility. Mirror Inc has a ban on staff conducting any unclothed body searches of the residents.

The facility has two measures in place to limit cross gender viewing. The first method is they require all male staff to announce when entering into the dorm areas. Staff and residents all indicated that male staff do not enter the lower level of the facility. While on site, the auditor did not witness any male staff working in the facility.

Pattie RRC staff indicated they have not had any recent transgender or intersex residents in either of their Wichita locations. Policy review and staff interviews showed a consistent understanding they are not allowed to search an inmate to determine their genital status.

Pattie RRC has a ban on all cross gender pat searches. The male staff at this site are not allowed to pat search any of the residents.

Based on all of this information together, Pattie RRC exceeds the expectations of this standard.

Corrective Action:
None needed.

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

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

In order to make my determination, I reviewed the following policies and documentation:

- PREA Policy

Interviews, document, and site review:
RRC Pattie policy indicates usage of the Wichita Family Crisis Center, formerly known as YWCA: Sexual Assault & Domestic Violence Prevention Center, as a resource to assist residents with disabilities or with limited English proficiency. The facility employs staff who are fluent in Spanish and they also have a staff member who knows sign language.

During interviews, the staff was unable to articulate any other options for translation services if they were unable to translate using an internal person. Speaking with PC Ken McGill, the facility just completed entering into a MOU with a new interpreter service. At the time of the onsite audit, the facility had not yet trained staff on using this service.

New Information from Corrective Action:
During the corrective action period, the facility added the information pertaining to the new interpreter contract into the PREA policy. In addition, instructions and the pin number have been added to the facility drive that can be accessed by all staff.

Corrective Action:

None Needed.

Standard 115.217 Hiring and promotion decisions

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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In order to make my determination, I reviewed the following policies and documentation:
- PREA Policy
- Employment application forms

Interviews, document, and site review:
The current application form does not ask the three elements required in standard 115.217 (a) and 115.217 (f).
(1) 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);
(2) 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
(3) Has been civilly or administratively adjudicated to have engaged in the activity described in paragraph (a)(2) of this section.

In addition, the facility is not consistently contacting prior institutional employers for information on substantiated allegations of sexual abuse or any resignations during a pending investigation of an allegation of sexual abuse which is required under standard 115.217 (c). In addition, the facility does not have a process in place for responding to requests for information from other institution regarding this same information.

Background checks of all employees are run according to the Bureau of Prisons contract. These checks are run upon hiring a new employee and every five years after hire.

New Information from Corrective Action:
The facility provided the auditor with information regarding the changes that they made to the application process. The agency application has been updated to include the information in 115.217 (a)(f). On 01/01/2017, the auditor went onto the agency website and completed an application. The auditor found all necessary elements are now contained in the application. The facility has also implemented a Personal Inquiry Waiver form as a method to ensure other institutional employers are contacted as part of the hiring process.

The auditor requested information asking for the records of any staff that have been hired since the implementation of this new process. At this time, there have not been any new hires so documentation review was not able to be done.

Corrective Action:
None Needed.

Standard 115.218 Upgrades to facilities and technologies

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

In order to make my determination, I reviewed the following policies and documentation:
- PREA Policy

Interviews, document, and site review:
The facility has not undergone any expansions since August 20, 2012.

The facility's camera system is well designed and keeps in mind the safety of the residents, not only sexual safety.

Corrective Action:
None Needed.

Standard 115.221 Evidence protocol and forensic medical examinations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

In order to make my determination, I reviewed the following policies and other documentation:
- PREA Policy
- Proposed MOU with Via Christi St Joseph
- Proposed MOU with Wichita Police Department Sexual Assault Division and supporting communication between the facility and the police department
- MOU with Wichita Area Sexual Assault Center
- Resources provided to the residents by the Wichita Are Sexual Assault Center

Interviews, Document, and Site Review:
RRC Pattie is responsible for conducting the administrative investigations which occur at the facility. At this time, the PREA Coordinator and the PREA Compliance Manager are trained in conducted the administrative investigations.

If an allegation is made alleging sexual abuse, the Wichita Police Department would be contacted to complete the investigation, including any evidence collection. The facility is currently working on a memorandum of understanding with the Wichita Police Department to conduct the criminal investigations into sexual abuse allegations. The Wichita Police Department has a Sexual Assault division that would respond to the allegations at the facility. At the time of the onsite audit, the MOU was being reviewed by the legal department of the Wichita Police Department.

While the facility staff are not responsible for evidence collection, during interviews, they were able to consistently articulate the methods the facility will utilize to ensure the alleged victim and alleged abuser do not take any actions to destroy evidence

The facility is currently working on a memorandum of understanding with Via Christi St. Joseph (Wichita), a local hospital. I spoke with Tina Peck, the Via Christi contact, on the phone regarding the MOU. She indicated they are in the final stages of

completing the MOU. When asked what the protocol would be for the residents without the MOU in place, she stated there would be no difference in care. The residents of Pattie RRC will be offered the same level of services as dictated by their sexual assault protocol. She indicated all sexual assault examinations are conducted by a SANE.

The facility has an active memorandum of understanding with the Wichita Area Sexual Assault Center to provide services to any sexual abuse victims in the facility. In addition, the agency employees a Licensed Master Social Worker at the facility who will be providing advocacy services. The facility plans to utilize their staff member or a staff from the Wichita Area Sexual Assault Center to provide the residents with support through the forensic exam and investigative process as requested by the resident.

Corrective Action:
None Needed

Standard 115.222 Policies to ensure referrals of allegations for investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

In order to make my determination, I reviewed the following policies and other documentation:

- PREA Policy

Interviews, Document, and Site Review:
In the past twelve months, the facility indicated they have had no allegations of sexual harassment or sexual abuse.

The facility has one primary administrative investigator but there is another administrative investigator who works at the other facility in town. In addition, the PREA Coordinator is also a trained administrative investigator. If deemed there may have been a criminal element to the allegation, the investigator will contact the Wichita Police Department to ensure investigation of the incident.

Corrective Action:
None needed.

Standard 115.231 Employee training

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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In order to make my determination, I reviewed the following policies and other documentation:

- PREA Policy

- Staff training forms
- Training Curriculum

Interviews, Document, and Site Review:
The facility is currently utilizing the training curriculum developed by The Moss Group for the PREA Resource Center for their staff training. While PREA is still new to this facility, during interviews, all staff was able to articulate the elements that are included in the standard. Most importantly, they were able to consistently articulate what their responsibilities were following an allegation.

Staff in the facility have obviously received training on PREA and their responsibilities. Each staff person interviewed was able to articulate all of the required elements of the training they had received. However, at the time of the onsite audit, staff had not been required to sign off acknowledgement of the training they have received.

In addition to in house training, the facility utilizes EduCorr for additional PREA training.

New Information from the Corrective Action Period:
In the time since the onsite audit, all staff has completed additional training covering the requirements of the standard and have signed off on an acknowledgement.

Corrective Action:
The facility needs to develop an action plan for the documentation of the acknowledgement of training.

Standard 115.232 Volunteer and contractor training

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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In order to make my determination, I reviewed the following policies and other documentation:
- PREA Policy
- Outside Contractor training forms
- Training Curriculum

Interviews, Document, and Site Review:
The facility has one United States Probation Office employee who works within the facility meeting with outpatient people and occasionally meets with residents for counseling services. She does not have a contract with RRC Pattie but is contracted by USPO. She has been trained using the same classes as the facility staff. As above, the facility needs to provide documentation of staff acknowledgement of the training.

New Information from Corrective Action:
The facility provided the auditor with proof the United States Probation Officer contractor completed both facility PREA training as well as specialized training for behavioral health staff.

Corrective Action:
None Needed.

Standard 115.233 Resident education

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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In order to make my determination, I reviewed the following policies and other documentation:

- PREA Policy
- Resident Handbook

Interviews, Document, and Site Review:
RRC Pattie issues a handbook to the residents who are brought into the facility. The residents are required to sign off that they received the handbook. In addition, the facility case manager covers the information with them normally within 24 hours of intake. The PREA reporting information is posted in the dayroom by the facility phones. The majority of residents have cell phones and have access to the reporting phone numbers in their individual handbooks as well.

During interviews with the residents, they indicated awareness of multiple reporting methods for incidents of sexual abuse or sexual harassment. While a majority indicated they would talk to staff about the allegation, they also listed the Bureau of Prisons, their probation officer, and the PREA hotline as options. The interviews showed a strong indication the residents are well informed of their right to be free from sexual abuse, sexual harassment, and retaliation for reporting allegations.

Corrective Action:
None needed.

Standard 115.234 Specialized training: Investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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In order to make my determination, I reviewed the following policies and other documentation:

- PREA Policy
- Training Documentation

Interviews, Documents, and Site Review:
The two facility PREA Compliance Managers who are located in Wichita and the PREA Coordinator have completed the National Institute of Corrections training PREA: Investigating Sexual Abuse in a Confinement Setting. Copies of the training certificates were provided to the auditor. The facility compliance managers and the coordinator will be conducting administrative investigations only. During interviews with the trained investigators, they consistently were able to articulate the process of conducting an administrative investigation including the criteria or evidence needed to substantiate an allegation.

Wichita Police Department will be conducting the criminal investigations. The facility investigator will act as a liaison between

the officer and the facility to ensure a timely completion of the investigation.

Corrective Action:
None Needed.

Standard 115.235 Specialized training: Medical and mental health care

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

In order to make my determination, I reviewed the following policies and other documentation:
- PREA Policy
- Training Documentation

Interviews, Documents, and Site Reviews:
RRC Pattie has a Licensed Master in Social Work who has completed the same training as the rest of the staff. At the time of the onsite audit, she has not completed any specialized training pertaining to PREA and behavioral health care.

All medical care is offsite.

Corrective Action:
The social worker will need to complete a specialized training course for behavioral health staff such as the one provided on the National Institute of Corrections learn center. Upon completion, proof should be provided to the auditor.

New Information from Corrective Action:
RRC Pattie's social worker completed the NIC specialized training course for behavioral health staff on 01/09/2017 and provided the auditor with proof of training completion.

Corrective Action:
None Needed

Standard 115.241 Screening for risk of victimization and abusiveness

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

In order to make my determination, I reviewed the following policies and other documentation:
- PREA Policy

- PREA Screening form

Interviews, Document, and Site Review:
The technicians conducting the intakes of residents are not using a screening instrument that would assess their risk of being an abuser or victim. Rather, file review is completed by the facility director prior to the resident arriving onsite and determination as to appropriate housing is made using the information received prior to arrival. Primarily, they are reviewing for issues which would indicate a need for a bottom bunk or for increased observation but it does not generally include anything pertaining to their status as a victim or perpetrator.

The PREA Screening currently used by the facility social services coordinator/PREA Compliance Manager is conducted within 72 hours but is normally conducted on the date of their arrival at the facility. This screening does not include all the elements listed in 115.241 (d).

(1) Whether the resident has a mental, physical, or developmental disability;
(2) The age of the resident;
(3) The physical build of the resident;
(4) Whether the resident has previously been incarcerated;
(5) Whether the resident's criminal history is exclusively nonviolent;
(6) Whether the resident has prior convictions for sex offenses against an adult or child;
(7) Whether the resident is or is perceived to be gay, lesbian, bisexual, transgender, intersex, or gender nonconforming;
(8) Whether the resident has previously experienced sexual victimization; and
(9) The resident's own perception of vulnerability.

RRC Pattie is only conducting an initial assessment with the social services coordinator rather than an intake assessment followed by a more in depth assessment.

The facility policy states:

(g) A resident's risk level shall be reassessed when warranted due to a referral, request, incident of sexual abuse, or receipt of additional information that bears on the resident's risk of sexual victimization or abusiveness.

(h) Resident's may not be disciplined for refusing to answer, or for not disclosing complete information related to, (d1), (d7), (d8) and (d9) above.

For the period reviewed, RRC Pattie did not have any incidents where a reassessment was warranted.

New Information from Corrective Action:
The facility provided the auditor with completed assessments for residents who have entered the facility since the time of the onsite audit. Documentation review shows that they are now using a screening tool which includes all the elements under 115.24 (d). In addition, information pertaining the housing locations of the residents is noted on the assessment forms indicating the facility is using the screening to make housing assignments. All assessments were completed within the 72 hour time period as required by the standard.

Corrective Action:
None Needed.

Standard 115.242 Use of screening information

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

In order to make my determination, I reviewed the following policies and other documentation:

- PREA Policy
- PREA Screening form

Interviews, Document, and Site Review:
RRC Pattie residents are being assigned to housing without an intake screening being conducted. The facility director does review the files prior to the resident arriving and notes any medical or physical disabilities the staff will need to consider when assigning a bed.

In regards to transgender and intersex inmates, the facility has not had any instances at this point. The policy and interviews indicated the decision regarding these residents would be made on a case by case basis and allow for the resident to provide information about their view of their safety. The Pattie facility has a single bed room with a bathroom on the main floor that could be utilized for a transgender or intersex resident and would allow the resident the ability to shower and change clothing without staff viewing. Finally, the agency has another facility in Topeka which could be considered for housing.

New Information from Corrective Action:
The facility has begun using a two part screening process since the onsite portion of the audit. The facility provided the auditor with proof of the 30 day review of screenings. These secondary screenings review the initial housing placement and document the future plans in term of housing.

Corrective Action:
None Needed.

Standard 115.251 Resident reporting

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

In order to make my determination, I reviewed the following policies and other documentation:
- PREA Policy
- Resident Handbook

Interviews, Document, and Site Review:
The facility offers multiple way for the residents to report allegations of sexual abuse or sexual harassment. The residents may speak to any staff member, submit a written report (either signed or anonymously), submit a grievance, contact the probation officer (if applicable), contact the Bureau of Prisons, contact the sexual abuse hotline, or contact the Wichita Police Department.

The facility offers a few different ways for staff to report as well. They can report to the PREA Compliance Manager, the facility director, the PREA Coordinator, administration at central office, the Bureau of Prisons, or the Wichita Police Department.

All staff and residents who were interviewed were able to provide a list of different options for reporting.

All staff interviewed where able to articulate the options available to the residents for reporting allegations.

Corrective Action:
None needed.

Standard 115.252 Exhaustion of administrative remedies

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

In order to make my determination, I reviewed the following policies and other documentation:
- PREA Policy
- Resident Handbook

Interviews, Document, and Site Review:
RRC Pattie does have a formalized grievance procedure. The residents are informed in their handbook of their ability to file an allegation utilizing the grievance form by filling out the form and placing it in the locked grievance box. They are also informed the locked grievance box is only checked once daily.

RRC Pattie does not require the use of the grievance process or incorporate a timeline for allegations of sexual abuse or sexual harassment. The facility does not require the resident who is making the allegation to confront the staff member who the grievance is against and the grievance is not referred to the staff member who is the subject of the allegation.

At this time, they have not received any grievances, standard or emergency, alleging sexual abuse or sexual harassment. The policy does follow the requirements of 115.252 (d).

Corrective Action:
None needed.

Standard 115.253 Resident access to outside confidential support services

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

In order to make my determination, I reviewed the following policies and other documentation:
- PREA Policy
- MOU with Wichita Area Sexual Assault Center
- Information provided to residents by Wichita Area Sexual Assault Center
- Resident Handbook

Interviews, Document, and Site Review:
The facility has an active memorandum of understanding with the Wichita Area Sexual Assault Center (WASAC) in addition to

having one mental health staff person. The residents are given information about the WASAC in the resident handbooks. In addition, WASAC provides information to the facility that they have available for distribution to the residents. The residents who have cell phones can use these for making contact with WASAC. If they choose to use the payphone in the dayroom, this phone is not monitored or recorded.

During interviews, the residents were able to articulate the different resources for support services.

Corrective Action:
None needed.

Standard 115.254 Third-party reporting

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

In order to make my determination, I reviewed the following policies and other documentation:
- PREA Policy
- MOU with Wichita Area Sexual Assault Center
- Agency Website

Interviews, Document, and Site Review:
The facility has a few different outside reporting options available. Their website provides contact information for Melissa Goodman who is stationed at the RRC in Topeka. In the cases of use of these, the agency will contact the facility with the information to provide the allegation information. The facility will follow up on these reports in the same manner as in a verbal report to staff.

Corrective Action:
None Needed

Standard 115.261 Staff and agency reporting duties

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

In order to make my determination, I reviewed the following policies and other documentation:
- PREA Policy
- Training Curriculum

Interviews, Document, and Site Review:
RRC Pattie staff are required by policy to refer on any suspicions, information, or allegations of sexual abuse or sexual harassment they become aware of.

During staff interviews, they all indicated a knowledge of the appropriate response process in line with the facilities coordinated response. Staff was also able to articulate an understanding of the confidential nature of the information and stated they would not share the information except with those who needed to know. Staff was able to articulate who the investigators are within the facility.

Corrective Action:
None needed.

Standard 115.262 Agency protection duties

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

In order to make my determination, I reviewed the following policies and other documentation:

- PREA Policy

Interviews, Document, and Site Review:
RRC Pattie policy indicates a coordinated response which is in compliance with the PREA standards.

The facility has not had any allegations or information that was received during the past twelve months indicating someone was at substantial risk of being abused.

During interviews, there were no indications that there were events that were not investigated and/or documented. Each staff person indicated the potential victim would be separated from the potential perpetrator and an investigation would be launched if such as allegation was brought forward.

Corrective Action:
None needed.

Standard 115.263 Reporting to other confinement facilities

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

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

In order to make my determination, I reviewed the following policies and other documentation:
- PREA Policy

Interviews, Document, and Site Review:
RRC Pattie has had one allegation of sexual abuse which occurred in an outside facility. The resident declined to provide any information regarding the allegation. While the auditor was provided with information regarding the allegation in the form of a memo regarding the interview with the alleged victim, the auditor was not provided with any documentation showing the referral had taken place to the county jail where the incident allegedly occurred.

New Information from Corrective Action:
The facility provided the auditor with the PREA Checklist they will be utilizing to track the notification of outside facilities. On the bottom of the checklist, there is a notifications section which will be utilized. The PREA Coordinator and facility PREA Compliance Manager will be responsible for making the notifications.

Corrective Action:
None Needed.

Standard 115.264 Staff first responder duties

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

In order to make my determination, I reviewed the following policies and other documentation:
- PREA Policy

Interviews, Document, and Site Review:
The facility staff has a very good understanding of the coordinated response in the facility and on what they need to do as first responders. All staff interviewed onsite, technicians and non-security staff, could provide the information covered in standard 115.264 (a). In addition, staff were able to articulate the steps which need to be taken so the alleged victim and alleged perpetrator do not destroy physical evidence.

At the time of the onsite audit, they had not had any sexual abuse allegations which would require the response.

Corrective Action:
None needed.

Standard 115.265 Coordinated response

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

In order to make my determination, I reviewed the following policies and other documentation:

- PREA Policy

Interviews, Document, and Site Review:
The facility has a laid out coordinated response plan within their PREA policy. They have made an effort to make sure all staff is aware of the steps that must be taken following an allegation. The only area noted where there was confusion was regarding who was going to contact the Wichita Police Department. Some technician's indicated this would be their responsibility and others indicated the PREA Compliance Manager or PREA Investigator would do this.

It is recommended the facility clear this part of the coordinated response up and train all staff on that level or response.

Corrective Action:
None needed.

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

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Not Applicable. The agency does not enter into collective bargaining.

Standard 115.267 Agency protection against retaliation

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

In order to make my determination, I reviewed the following policies and other documentation:

- PREA Policy

Interviews, Document, and Site Review:
The RRC Pattie policy indicates a policy which is compliance with the standard. However, at the time of the interviews, the

facility director, the technicians, and non-security staff indicated everyone would be responsible for monitoring but there was no indication of who would be responsible for documenting the monitoring or what elements would be reviewed.
At this time, there were no allegations which required retaliation monitoring to occur.

New Information from Corrective Action:
The facility has implemented a formalized retaliation monitoring process. Retaliation Monitoring is documented on the Retaliation Monitoring Form. The site PREA Compliance Manager, Director, and PREA Coordinator will meet on a weekly basis to monitor retaliation and complete the form. The form is set up for twelve weeks of monitoring and includes reviewing disciplinary reports, reviewing housing changes, face-to-face contact, reviewing programming changes, reviewing performance evaluations, and reviewing staff assignments.

Corrective Action:
None Needed.

Standard 115.271 Criminal and administrative agency investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

In order to make my determination, I reviewed the following policies and other documentation:
- PREA Policy

Interviews, Document, and Site Review:
RRC Pattie's PREA policy is in compliance with the elements of this standard. The facility PREA Investigator/PREA Compliance Manager and the PREA Coordinator have completed specialized training through the NIC site. In addition, the PREA Investigator/PREA Compliance from the other site in Wichita has also completed this training and could be utilized to conduct investigations if needed. Documentation of the completed training was provided to the auditor.

The facility only conducts the administrative investigations into allegations. All criminal investigations will be conducted by the Wichita Police Department. Any evidence collection in criminal allegations will be performed by the Wichita Police Department. The facility investigator will be the liaison between the Wichita Police Department and the facility. The auditor did not speak with any of the investigators at the Wichita Police Department because they are an outside entity but, through email communications that were provided, a positive relationship between the facility and the police department is evident.

The facility investigator will collect and maintain any evidence needed in an administrative investigation such as video or interview notes.

The facility will make determinations about the allegations only after investigation, not based on the status or credibility of the alleged victim. During an investigation, the investigator will review all information available to see if staff actions or inactions played a part in the incident.

All investigations, whether administrative or criminal, would be documented in a written report. If an outside agency is conducting the investigation, the facility will make best efforts to keep advised as to the status of the investigation by contacting the agency conducting the investigation.

At this time, there were no investigative files to review for this facility.

Corrective Action:

None needed.

Standard 115.272 Evidentiary standard for administrative investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

In order to make my determination, I reviewed the following policies and other documentation:

- PREA Policy

Interviews, Document, and Site Review:
The facility investigators were able to articulate the need for no more than a preponderance of evidence to substantiate an allegation of sexual abuse or sexual harassment. They went on to define preponderance of evidence as 51% of the credible evidence.

For the timeframe covered by this audit, there were no investigative files to be reviewed.

Corrective Action:
None needed.

Standard 115.273 Reporting to residents

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

In order to make my determination, I reviewed the following policies and other documentation:

- PREA Policy
- Notification of Investigative Findings forms

Interviews, Document, and Site Review:
The facility has prepared forms to meet the needs of this standard. At this time, they have not had any allegations where notifications were needed. The policy and information are in place once they have an allegation.

During the interviews with the PREA Investigators, they articulated knowledge of the need to provide the notices of investigative status to the alleged victims in the investigations.

For the timeframe covered by this audit, there were no investigative files to be reviewed.

Corrective Action:
None needed.

Standard 115.276 Disciplinary sanctions for staff

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

In order to make my determination, I reviewed the following policies and other documentation:

- PREA Policy

Interviews, Document, and Site Review:
The facility outlines in their policy that staff is subject to discipline up to and including termination for violating the agency's sexual abuse and sexual harassment policies. At the time of the audit, the facility had not had any allegations against staff. The policy the facility has in place and the information received from administrative staff indicate compliance with this standard.

For the timeframe covered by this audit, there were no investigative files to be reviewed.

Corrective Action:
None needed.

Standard 115.277 Corrective action for contractors and volunteers

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

In order to make my determination, I reviewed the following policies and other documentation:

- PREA Policy

Interviews, Document, and Site Review:
The facility has policy in place regarding contractors and volunteers who engage in sexual abuse. This policy indicated they will be prohibited from contact and reported to law enforcement. At this time, the facility does not have any volunteers who come in to the facility. They have one person who has a contract with the United States Probation Office who works in their facility. They do not carry that contract but she is treated as facility staff in terms of training and expectations.

Corrective Action:

None needed.

Standard 115.278 Disciplinary sanctions for residents

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

In order to make my determination, I reviewed the following policies and other documentation:

- PREA Policy
- 7-3 BOP Revised Prohibited Acts
- 7-4 Mirror Prohibited Acts Revised

Interviews, Document, and Site Review:
RRC Pattie utilizes the BOP Revised Prohibited Acts and Mirror Prohibited Acts policies as the guideline for disciplinary sanctions. The sanctions indicated in these policy appear to be appropriate for the alleged acts committed. If a resident is found to be a perpetrator of sexual abuse, interviews indicated the resident would be transferred out of the RRC facility.

Corrective Action:
None needed.

Standard 115.282 Access to emergency medical and mental health services

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

In order to make my determination, I reviewed the following policies and other documentation:

- PREA Policy

Interviews, Document, and Site Review:
The facility is in the process of entering into a memorandum of understanding with Via Christi St. Joseph, a local hospital. Even without the MOU in place, the facility residents who report to the hospital as sexual assault victims will receive the same care as any other person who would come to the facility. Via Christi has Sexual Assault Nurse Examiners who would take care of the victim and would also conduct an examination and evidence collection. The victim would be provided with information on treatment for sexually transmitted diseases and other necessary testing. In addition, Via Christi would contact the Wichita Area Sexual Assault Center to have an advocate respond to the hospital to support the victim. Agency policy indicates these treatments and any follow up care are offered at no cost to the victim.

Corrective Action:
None needed

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

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

In order to make my determination, I reviewed the following policies and other documentation:

- PREA Policy
- MOU with Wichita Area Sexual Assault Center
- MOU with YWCA: Sexual Assault and Domestic Violence Prevention Center

Interviews, Document, and Site Review:
RRC Pattie does not have medical care available onsite. They will ensure any confirmed victims in need of continued medical care will be receive the necessary care in the community.

The facility has a licensed addiction counselor who is utilized for behavioral health services. The MOU's with the WASAC and YWCA indicate a strong plan for emotional support services, both during the investigative process and during the post investigation phase.

The interview with the mental health staff employed by the agency indicated the care received by the residents is at the same level as what is available in the community, which is supported by auditor observation.

There have been no instances in this review period that warranted the use of these services.

Corrective Action:
None needed.

Standard 115.286 Sexual abuse incident reviews

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

In order to make my determination, I reviewed the following policies and other documentation:

- PREA Policy
- Sexual Abuse Incident Review Form

Interviews, Document, and Site Review:

The facility has a policy and procedure in place to conduct a sexual abuse incident review on all substantiated and unsubstantiated allegations of sexual abuse. The form they have created would gather all of the information required by standard 115.286 (d).

Interviews conducted with staff who would be members of the incident review team indicated a knowledge of the elements required under standard 115.286 (d).

As of this time, the facility has not had to conduct a review but has a process in place.

Corrective Action:
None needed.

Standard 115.287 Data collection

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

In order to make my determination, I reviewed the following policies and other documentation:
- PREA Policy
- 2015 Survey of Sexual Violence

Interviews, Document, and Site Review:
The facility provided a copy of the 2015 Survey of Sexual Violence by the Department of Justice. This form is completed for each facility by the PC.

For the time period reviewed, the facility did not have any allegations that apply to this standard.

The facility does not contract with any other facilities so standard 115.287 (e) does not apply.

The 2015 SSV is currently posted to the facility website for public access.

Corrective Action:
None needed.

Standard 115.288 Data review for corrective action

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

In order to make my determination, I reviewed the following policies and other documentation:

- PREA Policy
- 2015 Survey of Sexual Violence

Interviews, Document, and Site Review:
The facility has not completed an annual report based on the information from the 2015 SSV.

New Information from Corrective Action:
The facility compiled all information into a comprehensive Annual PREA report. The report is available on the agency website.

Corrective Action:
None needed.

Standard 115.289 Data storage, publication, and destruction

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

In order to make my determination, I reviewed the following policies and other documentation:

- PREA Policy
- 2015 Survey of Sexual Violence

Interviews, Document, and Site Review:
RRC Pattie has the 2015 SSV posted to their agency website for public review. There is no personal identifying information included on the report that is posted on the agency website.

Corrective Action:
None needed.

AUDITOR CERTIFICATION
I certify that:

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

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

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

Maren Arbach ______________________ 01/23/2017 ______________

Auditor Signature Date