PREA AUDIT REPORT ☐ Interim ☒ Final

COMMUNITY CONFINEMENT FACILITIES

Date of report: 1/20/17

Auditor Information			
Auditor name: Talia Huff			
Address: PO Box 31 McPherson, KS. 67460			
Email: talia360cc@gmail.com			
Telephone number: 785-766-2002			
Date of facility visit: October 16-17, 2016			
Facility Information			
Facility name: Mirror, Inc. Residential Reentry Center			
Facility physical address: 2201 SE 25th Topeka, KS 66605			
Facility mailing address: *(if different from above)* Click here to enter text.			
Facility telephone number: 785-783-3274			
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: Mary Handley			
Number of staff assigned to the facility in the last 12 months: 23			
Designed facility capacity: 46			
Current population of facility: 35			
Facility security levels/inmate custody levels: minimum to high			
Age range of the population: 18+			
Name of PREA Compliance Manager: Melissa Goodman		**Title:** Social Services Coordinator	
Email address: mgoodman@mirrorinc.org		**Telephone number:** 785-783-3274	
Agency Information			
Name of agency: Mirror, Inc.			
Governing authority or parent agency: *(if applicable)* Bureau of Prisons			
Physical address: 2201 SE 25th Topeka, KS 66605			
Mailing address: *(if different from above)* Click here to enter text.			
Telephone number: 785-783-3274			
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	

AUDIT FINDINGS

NARRATIVE

On October 16-17, 2016, a PREA audit was conducted of the Residential Reentry Center in Topeka, KS., operated by Mirror, Inc. The audit was conducted by 360 Correctional Consulting, LLC; led by certified PREA auditor Talia Huff. The Residential Reentry Center (RRC) is a community confinement facility that is contracted for the confinement of most their residents through the Bureau of Prisons (BOP).

At least six weeks prior to the audit, the RRC posted Auditor Notices provided by the Talia Huff. In addition, documentation was provided to the auditor prior to the audit; to include the Pre-Audit Questionnaire and other supporting documentation, which was provided via a flash drive. Correspondence between the auditor and the PREA Coordinator (PC) and PREA Compliance Manager (PCM) occurred throughout the pre-audit phase, and the auditor submitted a tentative audit schedule to the facility prior to arrival for the onsite portion of the audit.

The auditor reported to the RRC on October 16, 2016, to initiate the audit. The auditor was accompanied by the PREA Coordinator (PC) and PREA Compliance Manager (PCM) through a site review of the facility and facility grounds. PREA signage as well as the Auditor Notices were observed in places throughout the facility, ensuring that reporting information was adequately visible for all residents. The remainder of the first day entailed interviews with the PC, PCM, staff, and random residents. The following morning, October 17, when the Facility Director was available, a in-brief was held to introduce the auditor and discuss the audit process and methodology. In attendance for this meeting was Mary Handley (Facility Director), Ken McGill (VP of Correctional Services/PREA Coordinator), Melissa Goodman (Social Services Coordinator/PREA Compliance Manager), and 3 case managers. For the remainder of the second day, the auditor conducted interviews of specialized staff, as well as random staff. 10 random residents and 10 random staff (from varying shifts and positions, including "non-uniform") were interviewed. The resident interviews included transgender, but there were no inter-sex offenders, disabled/LEP offenders, or youthful residents identified by staff nor observed by the auditor.

The RRC is required to be PREA compliant, pursuant to the contract with BOP for the confinement of offenders. The RRC has made great strides in becoming PREA compliant and appears to have leadership that is invested in the sexual safety of the facility. Residents overwhelmingly reported that they felt sexually safe at the RRC. By virtue of the type of facility and program, most residents regularly leave the facility for program-related reasons (i.e. employment, job search) and residents are allowed to be in the possession of approved cell phones (an unmonitored and unlimited means of external reporting). Staff also reported that they felt the RRC is a sexually safe environment. During the 12-month review period prior to the audit, there were zero (0) reported allegations of sexual abuse and sexual harassment.

In addition to pre-audit documentation review and on-site interviews, the auditor reviewed resident education, staff training, and criminal records checks while onsite, which was found to be substantially congruent to what was outlined in policy and the PREA standards. Just Detention International was contacted prior to arrival, to which no allegations from the RRC were reported.

DESCRIPTION OF FACILITY CHARACTERISTICS

Mirror, Inc's Residential Reentry Center in Topeka, Kansas, is a minimum security community confinement facility that has a capacity of 46 residents. Population at the time of audit was 35. The physical plant consists of two (2) buildings; Building 3 and Building 4. Both buildings have two (2) wings/hallways. One hall of building 3 is designated for female residents while the other hallway is designated for male residents that are potentially vulnerable. At the time of the audit, the population of this building was 11. When the population allows it (i.e. when it is low enough), residents will room alone. All female residents were housed one per room. Most male residents in Building 3 were housed one per room except for 2 rooms which housed 2 residents.

Building 4, both hallways, house all other male residents. The population of this building at the time of the audit was 24. Building 4 has 10 rooms; 4 of which were 4-man rooms and 6 were 2-man rooms.

Part of the RRC campus consisted of a third building, which contains offices and the cafeteria. RRC residents come to the cafeteria for meals and are granted access by key card only during meal times. They do not access the rest of the building. The cafeteria consists of one large open room.

Both buildings have the same layout, with a tech (program technician) office at the entrance, case managers/administrator offices, bathroom on each hall, laundry room, and supply and mechanical closets (which were locked). Building 3 also has a handicap shower, which is utilized by transgender residents and is locked except for when in use. Both buildings had a locked bulletin board which contained reporting information; internal to the agency and external.

Cameras were located in all hallways, dayrooms, the kitchen, entrances to bathrooms, and externally at the entrances and in parking lots. There were no cameras in rooms or bathrooms.

It was noted and discussed that Mirror has 2 additional buildings on this campus, though, they are operated by a different division and referred to as the "treatment side." The two appeared to be distinct from one another with little association between the two. The auditor understood that residents on the treatment side are generally contracted by KDADS (Kansas Department of Aging and Disability) and that clients are not necessarily placed there for confinement as a result of a criminal offense. It was expressed that the agency was not inclined to think that the treatment side fell under the scope of PREA. Complete and adequate information was not available for the auditor to make the determination.

SUMMARY OF AUDIT FINDINGS

It was clear that sexual safety is importance at Mirror's RRC. Leadership appears to be invested in sexual safety and to achieving PREA compliance. With that said, the PREA standards require intricate compliance efforts in some areas and the require a facility to demonstrate institutionalization of those efforts. Therefore, with the issuance of an Interim Report, several of the standards required minor corrective action in order to meet each provision of each standard. Five (5) standards were exceeded. Twenty (20) standards were met, twelve (12) were not met, and 2 were not applicable.

By January 4, 2017, Mirror's Topeka Residential Reentry Center satisfied all required corrective action to achieve full PREA compliance. Five (5) standards have been exceeded, two (2) are not applicable, and the remaining (32) have been met.

Number of standards exceeded: 5

Number of standards met: 32

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 other documentation:

- PREA Policy
- Organizational Chart

Interviews, Document and Site Review:

The RRC has a zero tolerance policy toward all forms of resident sexual abuse and sexual harassment, which is outlined in their PREA Policy. The PREA Policy outlines the agency's approach to preventing, detecting, and responding to sexual abuse and sexual harassment and includes such definitions that are congruent with the PREA standards and includes a description of agency strategies and responses to reduce and prevent sexual abuse and sexual harassment of residents. The RRC also appears to have a culture that also exudes this zero tolerance.

All interviews with staff, residents, and specialized staff affirm the zero tolerance policy and measures of prevention, detection, and response strategies.

The RRC 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 Melissa Goodman as the PREA Compliance Manager (PCM). Though, the community confinement standards do not mandate the appointment of a PCM, Melissa Goodman has played the key role in PREA implementation at the RCC and it is the auditor's recommendation to have someone designated onsite to handle PREA-related matters. 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.

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)
- ☒ Not Applicable

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.

This standard is not applicable since the RRC does not contract for the confinement of residents. This was reported by the agency and also affirmed through questioning by the auditor.

Standard 115.213 Supervision and monitoring

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

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

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

- PREA Policy
- Staffing Plan Meeting 7/12/16
- Staffing Plan

Interviews, Document and Site Review:

The RRC's PREA Policy, beginning on page 4, cites the prison/jail PREA standards (115.13) as opposed to the community confinement standards (115.213), which are more stringent and have more requirements. Policy, therefore, currently exceeds this standard. The auditor was also provided with documentation of a Staffing Plan Meeting held on 7/12/16. Topics discussed on this documentation included the camera system and camera coverage and staffing, as such: "The On-Site PREA Staff have been actively training staff to be "PREA AWARE" and have reviewed the staffing patterns to ensure that staffing issues DO NOT present PREA CONCERNS i.e. pat searches, hourly counts, staff availability for client concerns etc."

Provision (a) requires that facility's staffing plans consider 1) the physical layout of each facility, 2) composition of the resident population, 3) the prevalence of substantiated and unsubstantiated incidents of sexual abuse, and 4) Any other relevant factors. The auditor was not provided with sufficient documentation of how the agency has considered these elements.

The RRC is only required by BOP to have a 24:1 resident/staff ratio, though, interviews with the Agency and Facility Head revealed that they generally exceed those ratios. As reported in interviews and observed by the auditor, generally there is one tech (program technician) per building and one "floater." During business hours, case managers and administrators are present and available in the buildings as well. There were no deviations from the staffing plan during the review period. It was reported by the PREA Coordinator that they can operate with just one staff per building and no floater, but that if necessary an administrator would come in to fill a post to ensure adequate staffing.

The Staffing Plan Meeting on 7/12/16 does account for the annual staffing plan review required by provision (c). Prevailing staffing patterns and deployment of monitoring technologies were documented.

Corrective Action:
1. Demonstrate how the agency has considered the following elements in terms of assessing adequate staffing levels: 1) the physical layout of each facility, 2) composition of the resident population, 3) the prevalence of substantiated and unsubstantiated incidents of sexual abuse, and 4) Any other relevant factors.

Update 1/4/17:
1. Several discussions were had with the PREA Compliance Manager regarding the expectations of this corrective action. Staff meeting minutes were provided for review which documented staffing and supervision expectations on a daily basis. A Staffing Plan was then provided on 1/4/17, which outlined the facility's staff coverage and typical daily schedule, supervisory position and daily scheduling. It includes the consideration of staffing as it pertains to the physical plant and resident composition as well as PREA screening designations. The staffing plan lists the camera locations and video monitoring.

Standard 115.215 Limits to cross-gender viewing and searches

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

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

- PREA Policy

Interviews, Document and Site Review:
The PREA Policy, on page 5, prohibits cross-gender strip searches, body cavity searches, and pat searches "except in exigent circumstances or when performed by medical practitioners."

Policy addresses and cites most of provisions (a)-(e). The RCC reported zero (0) cross-gender strip searches, visual body cavity searches, or pat searches during the review period and, in practice, RRC does not permit strip searches or body cavity searches or cross-gender pat searches at all. This was overwhelmingly reported by all parties that were interviewed; staff and residents. Therefore, training for cross-gender pat searches is not done. The auditor noted, and discussed with the PC and PCM, that policy does in fact allow it "in exigent circumstances or when performed by a medical practitioner." Furthermore, they should either remove the exception for exigent circumstances or train staff in the event of exigent circumstances. The PCM advised they would likely remove the policy language. It seems to be the practice that it is altogether prohibited.

Through auditor observations and consistent report during interviews, it was gleaned that the facility does ensure that residents can shower, change clothing, and use the toilet without being viewed by staff of the opposite gender. Generally, residents are not viewed by any staff when engaging in those activities. In addition, interviews corroborated that staff announce themselves prior to entering rooms. In fact, it appeared to be the practice that all staff announce themselves prior to entering rooms, regardless of resident gender.

Corrective Action:
1. RCC shall either remove the exception for exigent circumstances in policy or provide training for staff on how to conduct cross-gender pat searches, for use in the event of exigent circumstances.

Update 12/29/16:
1. Policy language now reflects Mirror's actual practice; that Mirror does not conduct cross-gender pat searches, even in exigent circumstances.

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 other documentation:
- PREA Policy
- Resident Handbook

Interviews, Document and Site Review:

The RRC's PREA Policy addresses this standard on page 6 by stating that they partner with the local YWCA (Young Women's Christian Association), which is a sexual assault and domestic violence prevention center. The policy also names two current staff members that are available for interpretive services; both fluent in Spanish. The auditor learned that one of the case managers is also versed in sign language and is available in the instance that a hearing-impaired resident was admitted. The policy additionally outlines the facility's practice by stating that case managers individually go over the Resident Handbook with each resident during the Initial Program Plan. Case managers ensure residents are aware of their "PREA rights" and then document this interaction in section II of the Initial Program Plan.

The practice that is outlined in policy was corroborated by staff onsite; PREA Compliance Manager and case managers. The auditor reviewed the Resident Handbook, which contains comprehensive information about PREA; zero tolerance, sexual abuse and harassment definitions, methods and avenues of reporting. The Resident Handbook is first gone over upon arrival by the tech staff and then again by the case managers. Written materials were not available in formats other than English, though, the practice of individually going over materials by the case managers and the availability of 2 staff members for interpretation provides the appropriate resources for LEP and disabled residents.

Random staff reported that the use of resident interpreters was not permitted and the RCC reported there to be 0 instances of using a resident interpreter during the review period.

The comprehensive information in the Resident Handbook along with both the technician staff and case managers individually reviewing the handbook as well as the availability of 3 staff interpreters exceeds this standard.

Corrective Action:
None.

Standard 115.217 Hiring and promotion decisions

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

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

- PREA Policy
- BOP background check records
- Employment Application
- Employee files

Interviews, Document and Site Review:

The RRC does not hire or promote anyone nor enlist the services of a contractor that has engaged in the activity described in 115.217(a). The PREA Policy, on page 8, addresses each provision of this standard. The Director of Human Resources, located in the central office in Newton, KS., was interviewed via phone and explained that the Bureau of Prisons (BOP) vets every applicant through an extensive background check entailing state and federal. This is completed and approval is obtained through BOP prior to proceeding in the hiring process. The Facility Director facilitates the records checks and approvals therefore and also completes Child and Adult Abuse Registry checks prior to hiring. The auditor was provided with all employee files and conducted a review of them, which revealed that backgrounds checks and registry checks were completed and documentation thereof was retained. Files were selected at random and included new hire staff, veteran staff, and administrative staff. The RRC reported on the Pre-Audit Questionnaire that 9 applicants were received and thus 9 background checks were completed during the review period. Provision (a) requires that criminal records checks are also done prior to promoting and at this time it does not appear that Mirror is doing that, which was also reported by the Facility Director.

The Director of Personnel explained that incidents of sexual harassment are considered when determining whether to hire or promote someone and that criminal records checks are also performed on contractors who may have contact with residents. There were 2 contractors in which these records checks were completed during the review period. These were performed on the off-site medical contractors with Sunflower Prompt Care.

In regard to conducting background checks at least every 5 years, pursuant to provision (e), the RRC must re-run every employee if the BOP contract is renewed, though, there is no set timeframe for how often that will happen. RRC PREA Policy states that they will be run upon renewal of the contract and states that they will conduct criminal records checks at least every 5 years, however, through interviews with the Facility Director PCM, and HR Director it does not appear that this practice is institutionalized.

The auditor gleaned that, before hiring new employees, the agency is not currently making its best effort to contact prior institutional employers to inquire about involvement in sexual abuse or resignation during a sexual abuse investigation, as required by provision (c). Discussion about this requirement and the agency's current practice was had with the Facility Director and HR Director, who agreed that this needs to be implemented. It is recommended that the agency perhaps have a form letter, or the like, with which to send these requests. The auditor noted, during review of employee files that some employees did have prior institutional employers and no documentation was provided to demonstrate that contact was attempted.

The Employment Application used by the agency does not specifically ask applicants about previous misconduct described in provision (a). Provision (f) mandates that those questions are included in written applications or interviews for hiring or promoting. Also part of provision (f), the agency does incorporate a continuing affirmative duty to disclose such misconduct, which is cited in the Standard of Conduct.

Page 8 of the PREA Policy mandates that material omissions regarding misconduct related to sexual abuse and sexual harassment is grounds for termination. There were no such instances for the auditor to review.

Policy requires the agency provide information on substantiated allegations of sexual abuse or sexual harassment involving former employees, upon receiving a request from another institutional employer. The auditor was not provided with information or documentation to verify whether this was a consistent and formalized practice, though, there had been no such requests received during the review period. The Facility Director asserted that such a request would be deferred to the HR Director. It is recommended that the agency establish a procedure and perhaps have a form letter, or the like, with which to respond to such requests.

Corrective Action:

1. The agency shall ensure that criminal records checks are conducted prior to promoting employees as well as prior to hiring applicants.
2. The agency shall ensure that either criminal records checks are conducted at least every 5 years on current

employee and contractors or have a system in place for otherwise capturing such information for current employees.
3. Amend the Employment Application, or otherwise include in the interview process, the requirements of provision (f).
4. The agency shall make its best effort to contact applicants' prior institutional employers to inquire about involvement in sexual abuse or resignation during a sexual abuse investigation, as required by provision (c).

Update 12/13/16:
1. Policy language was enhanced to state, "Prior to promoting any current employee, a new criminal records check will be completed before that promotion is granted." There have been no promotions during the corrective action period with which to verify practice.
2. Policy language was enhanced in order to solidify practice. It states, "Mirror shall either conduct criminal background records checks through, State, Federal, and local agencies. For employees working with Federal residents, the Bureau of Prisons performs background screenings prior to that employee working with residents. For employees working with Federal offenders, background checks are performed with the award of each contract as well. Mirror shall conduct criminal background and record checks at least once every five years on current employees and contractors who may have contact with residents." The auditor was informed that it is typically done at least every four years.
3. Auditor was provided with documentation that the Employment Application was amended to reflect provision (f); the 3 required questions. Applications are completed online and these modifications were verified.
4. The PREA Compliance Manager provided a Personal Inquiry Waiver form, which will now be sent to prior institutional employers. The form was sent 12/13/16 and implemented the same day. The Personal Inquiry Waiver form requests the required information from prior institutional employers. It is a release of information authorization signed by the applicant with a small area on the bottom of the form for the employer's response. There were no applicants with prior institutional employers during the corrective action period.

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 other documentation:

- PREA Policy

Interviews, Document and Site Review:
The RRC reported on the Pre-Audit Questionnaire there had been no expansions or modifications to the facility since August 20, 2012. Interviews with the Agency Head designee affirmed there had been no expansions or modifications to the facility and discussed the typical usage of video monitoring which occurs primarily through the Tech Office.

Corrective Action:
None.

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
- YWCA MOU
- TPD MOU
- TPD revised MOU

Interviews, Document and Site Review:
RRC's PREA Policy addresses only provisions (d), (e), and (h) specifically. The policy addresses aspects of the investigation of sexual abuse incidents. It does not specifically allude to uniform evidence protocol. The Pre-Audit questionnaire indicated that the RRC conducts administrative investigations. Local law enforcement conducts investigations of reports involving potential criminal conduct. Through interviews with the PC, PCM, and Facility Director, the auditor learned that even the administrative investigations conducted by the agency are limited. The facility is overseen by a Residential Reentry Manager from BOP who is in close contact and kept abreast of incidents that occur. In the instance of any staff-involved sexual abuse incident, the BOP would be immediately notified and they would initiate an investigation. The auditor gleaned that the BOP is very quick and thorough in their response and investigation of incidents in general. Any staff member involved would immediately leave the campus and the agency would remain informed of the status and outcome of the investigation. For incidents or reports that are not taken over by BOP, the PREA Policy states that it will be investigated by the Facility Director and PREA Coordinator. The auditor was directed to the Coordinated Response verbiage in the PREA Policy for a uniform evidence protocol. Though, it is not referred to as their "uniform evidence protocol," it does provide sufficient detail to maximize the potential for obtaining physical evidence. This is found on page 12 of the PREA Policy. The collection of physical evidence would not be done by staff at the facility, therefore those details are not in the protocol. Rather, the protocol asserts that evidence will be preserved and protected and instructions to the alleged perpetrator and abuser not to destroy evidence.

Forensic medical exams are obtained through Stormont Vail Hospital who has Sexual Assault Nurse Examiners (SANEs) available. If an exam is warranted, it is offered at no cost to the victim. No residents were taken for forensic exams during the review period. Furthermore, the PREA Policy outlines that a victim advocate is made available to the victim from YWCA (Young Women's Christian Association); a local community-based organization. Once an alleged victim is received at the hospital, part of their automatic protocol is to offer a victim advocate to accompany the victim through the exam process. In addition, the RRC has established an MOU with YWCA, which was

provided for auditor review. The MOU is signed by both parties and denotes that the YWCA will designate one staff person to provide resources and services to individuals who have been sexually victimized.

Regarding provision (f), the agency shall request that Topeka Police Department (TPD), the entity responsible for investigating criminal allegations of sexual abuse, follow the requirements of (a)-(e) of this standard referencing the use of a uniform evidence protocol. The auditor was provided with an MOU signed by the RRC and TPD, though, it largely cites the same information as the MOU with the YWCA, which speaks more to victim services. It is recommended that the MOU cite provisions (a)-(e).

Corrective Action:
1. The facility shall provide documentation requesting the TPD follow the requirements of (a)-(e). This can be done through the MOU or through other means.

Update 11/22/16:
1. The facility and auditor collaborated to include appropriate language in to the MOU. Mirror's Facility Director then submitted the revised MOU to the Topeka Police Department, who has not yet responded. It was reported that it took a long time to finalize the original MOU. Mirror has demonstrated their best effort and do have the original MOU in place. They should continue to strive to have the revised MOU finalized.

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
- Agency website

Interviews, Document and Site Review:
The agency does ensure an administrative or criminal investigation is completed for all allegations of sexual abuse and sexual harassment. That was clear and evident to the auditor. Through interviews with the Agency Head designee, PC and PCM, random staff, residents, and informal discussion it was evident that allegations of sexual abuse and sexual harassment are taken seriously and are acted upon right away. There was no indication that reports had been made or that underlying sexual abuse and sexual harassment was occurring. In the past 12 months, there were zero (0) allegations or investigations of sexual abuse or sexual harassment, as indicated on the Pre-Audit Questionnaire.

The RRC ensures allegations of sexual abuse are referred to the Topeka Police Department and/or to BOP for

criminal investigations, unless it involves no potential criminal activity. RRC's PREA Policy mandates this and outlines investigative procedures beginning on page 14. Pursuant to provision (b) of this standard, this policy is published on the agency's website, which can be found at this link: https://mirrorinc.org/news/prison-rape-elimination-act-prea-2/

The PREA information on the agency website is comprehensive and describes the responsibilities of both the agency and external investigating entities, pursuant to provision (c).

Provision (d) is not applicable in determining PREA compliance of this facility.

Provision (e) is not applicable in determining PREA compliance of this facility.

Corrective Action:
None.

Standard 115.231 Employee training

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

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

- PREA Policy
- Training Acknowledgement form
- Training curriculum

Interviews, Document and Site Review:
RRC's PREA Policy cites all provisions are except for (d) and states, "Mirror is committed to communicating to the residents, to its employees, and to contractors and volunteers, the following information through the training, education and orientation. The PREA Resource Center will be utilized for training curricula."

The policy then lists the 11 required training elements. The auditor conducted interviews of random staff including program technicians and ancillary staff as well leadership. Largely, training elements were articulated well. It was obvious that the PC and PCM have discussed PREA with staff a great deal and have made them "PREA aware." The auditor learned that PREA training was delivered to staff in person by the PC and PCM, but also through Educorr. Curriculum was provided for auditor review and all training elements were accounted for. Training records were provided from every staff. Training is provided annually via the agency's intranet. The first PREA training was held in January 2016 and were held sporadically since then and will be held annually moving forward.

Provision (d), and further interpretive guidance through the Department of Justice, requires an agency to document, through employee signature or electronic verification, they have "received and understood" their PREA training. While the auditor was provided with electronic records of training, interpretive guidance mandates that employees sign acknowledging they have "received and understand" the PREA training.

Corrective Action:
1. Provide documentation that employees sign and acknowledge they have received and understand their PREA training.

Update 12/29/16:
1. The PREA Compliance Manager provided a new form for auditor review. It was implemented for employees to sign and acknowledge they have received and understand their PREA training. It states, "By signing below, I acknowledge that I have received and understand the agency's PREA Policy, as well as the PREA training provided to me through Educorr." The auditor was provided with signed forms for all employees. The PREA Compliance Manager also explained that there is now a spot in their TIER system that acknowledges staff understand the PREA Educorr training and PREA Policy. Staff receive annual PREA refresher training.

Standard 115.232 Volunteer and contractor training

☒ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

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

Interviews, Document and Site Review:
Page 19 of RRC's PREA Policy cites this standard and states, "The Facility Director or Social Service Coordinator shall ensure that all volunteers and contractors who have contact with residents have been trained on their responsibilities under Mirror's sexual abuse and sexual harassment prevention, detection, and response policies and procedures."

The RRC currently has no volunteers and has had none for almost 3 years. At that time, a volunteer came to provide a resident with reading lessons, but volunteers are generally not utilized at this facility. As discussed in 115.231 Employee Training, the agency uses Educorr as their training system. Contractor/volunteer training is available through Educorr. There have been no volunteers, though, the two off-site medical contractors of Sunflower Prompt Care have completed the Educorr training. Documentation was provided to the auditor. As discussed with the PCM,

since the medical providers are off-site and do not come onto the RRC campus, this standard does not actually require them to complete this training. Thus, this exceeds the standard.

Corrective Action:
None.

Standard 115.233 Resident education

☒ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

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

- PREA Policy
- Resident Handbook
- Resident Handbook Acknowledgements
- "No Means No" poster
- YWCA flyer
- Reporting information posted

Interviews, Document and Site Review:
RRC's PREA Policy states the following on page 19:

(1) During the intake process, residents shall receive information explaining Mirror's zero-tolerance policy regarding sexual abuse and sexual harassment and how to report incidents or suspicions of sexual abuse or sexual harassment.

(2) Within 72 hours of intake, Mirror staff shall provide and document comprehensive education to residents regarding their rights to be free from sexual abuse and sexual harassment and to be free from retaliation for reporting such incidents, and Mirror's policies and procedures for responding to such incidents. This information shall be available in alternate formats for those who are limited English proficient, deaf, visually impaired, or otherwise disabled, as well as to residents who have limited reading skills.

(3) Additionally, key information is continuously and readily available to residents in the participant rule book and the PREA bulletin board.

Policy cites provisions (a), (c), and (e). As illustrated above, it also requires comprehensive education within 72 hours of intake. That requirement is an element of the Prison/Jail PREA standards and is not required of community confinement facilities specifically. Additional policy language that speaks to the process of resident education is found on page 6 and also addresses procedures for providing education in formats that are accessible to LEP, hearing

or visually-impaired, or otherwise disabled residents. Thus, related auditor comments can be found in standard 115.216 of this report.

Policy language appeared to be congruent with practice as evidenced by auditor observation and interviews with the PCM, case managers, staff, and residents. The auditor reviewed the Resident Handbook, which contains comprehensive information about PREA; zero tolerance, sexual abuse and harassment definitions, methods and avenues of reporting. The Resident Handbook is first gone over upon arrival by the program technician staff and then again by the case managers. Case managers ensure residents are aware of their "PREA rights" and then document this interaction in section II of the Initial Program Plan. The facility reported that 51 residents were provided this information at intake during the review period.

Written materials were not available in formats other than English, though, the practice of individually going over materials by the case managers and the availability of 2 staff members for interpretation provides the appropriate resources for LEP and disabled residents.

After going over the PREA information, the resident and staff sign the last page of the Resident Handbook, which is an acknowledgement form. Review of random resident files revealed that all residents had signed this form. Note: the auditor suggests that the facility add a date to this form in addition to the signatures.

Key information regarding PREA was observed throughout the site review and included a zero tolerance poster, YWCA information, and internal and external methods of report. These posters were contained in a locked bulletin board.

Due to the reiteration of PREA education by case managers, in addition to tech staff upon intake as well as the comprehensive information contained in the Resident Handbook and in the bulletin board, the RRC exceeds this standard.

Corrective Action:
None.

Standard 115.234 Specialized training: Investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

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

- Certificates of Completion

Interviews, Document and Site Review:
The auditor did not find policy language pertinent to this standard.

The RRC conducts administrative investigations of sexual abuse and sexual harassment and this standard mandates specialized training to include: 1) techniques for interviewing sexual abuse victims, use of Miranda and Garrity, sexual abuse evidence collection in confinement, and the criteria required to substantiate a case for administrative action or prosecution.

At the RRC, the PC and PCM are charged with conducting sexual abuse investigations. The auditor interviewed the PCM regarding specialized training to conduct these investigations and learned that both the PC and PCM had completed the specialized training offered through NIC (National Institute of Corrections). The PCM articulated the elements of the specialized training such as using soft interviewing techniques and open-ended questions. We also discussed that the RRC would not use Miranda or Garrity. If warranted, that would be utilized by law enforcement. Garrity would likely not be used at all.

Provision (d) is not applicable in determining PREA compliance of this facility.

Corrective Action:
None.

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:

- Certificates of Training for Sunflower Prompt Care
- NIC Certificates of Completion

Interviews, Document and Site Review:
The auditor did not find policy language pertinent to this standard.

The RRC employs one medical staff (nurse) and one mental health staff (LMSW). Generally, the nurse administers medication and may help determine the need for medical services, though, medical services are obtained off site if needed. Mirror has a contract in place for medical services that are obtained off-site, which is with Sunflower Prompt Care. The auditor was provided documentation of contractor training for the 2 off-site medical practitioners through Sunflower Prompt Care. The documentation provided was not sufficient in addressing the requirements of this specialized training. However, since these medical providers do not come onsite, it is not required that they receive

this specialized training. It is required, however, that the RRC's nurse receive specialized training per this standard, which was obtained through NIC (National Institute of Corrections) and the auditor was provided with the certificate of completion.

Some residents receive mental health services from an LMSW (Licensed Master's Social Worker) employed by the agency. If the RRC deems that it would be beneficial for the resident, approval is sought from BOP. If BOP gives approval, mental health services are provided. At the time of the onsite audit, there were approximately 7 residents receiving mental health services. Through interviews with the mental health staff, it was learned that she had received the general PREA training obtained by all staff as well as the NIC course for behavioral health in confinement. The auditor was provided with documentation of this specialized training.

Corrective Action:
None.

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
- Completed PREA Screenings/resident file review

Interviews, Document and Site Review:
The RRC's PREA Policy nearly cites all provisions of this standard verbatim, beginning on page 6.

At the RRC, the Social Services Coordinator, who is also the PCM, administers the PREA Screening. As explained by the PCM, this is completed within 72 hours and generally the first day. This is done with the PREA Screening form, which consists of two pages. The first page is completed with the resident in which the questions are asked and then verified through review by the PCM of documents received from BOP such as the Pre-Sentence Investigation report. The PCM articulated very well the use of and purpose of the PREA Screening and explained the second page of the document in which a resident's determination of sexual risk is documented based on the information received from the first page. The screening is scored and it culminates in a determination of one of the following: potential victim, potential abuser, mix/both, or neither/not scored. Objectivity if obtained by the scoring of the instrument. Auditor review of the instrument confirmed that all required elements of provision (d) were present, with one minor exception. Element (d)(7) should reflect both whether the resident identifies as LGBTI *and* whether they are *perceived* as LGBTI or gender nonconforming.

While onsite, the auditor verified the completion of the PREA screenings of residents and that they were completed within the first 72 hours. Reportedly, 117 residents had been screened using the PREA Screening during the review period.

Policy states, "Residents will receive a second screening at 30 days, which will be conducted again by the Mirror staff." The Pre-Audit Questionnaire indicated that zero (0) residents had be reassessed within 30 days during the review period. Though, the one transgender resident had been reassessed, it was not clear that this was an institutionalized practice. The PREA Screening does have indicators at the top of the form that discern the screening as initial, 30 day, special referral, or Identified Victim. This is helpful in quickly determining the purpose of the screening. There were no sexual abuse incidents during the review period that warranted a reassessment, though, if that were to occur, the screening would indicate at the top as "special referral."

Residents are not disciplined for not answering the screening questions and appropriate controls are implemented in order to protect the screening information from exploitation. Once the PREA Screening is completed, it goes to the respective case manager's office where it is kept in a locked filing cabinet.

Corrective Action:
1. Demonstrate that residents risk levels are reassessed within 30 days of arrival based upon additional, relevant information received since intake.

Update 12/5/16:
1. The auditor was provided with completed reassessments. The PCM explained the method in which she intends to track the completion of these reassessments, part of which includes adding this as a "task" in their recommendations for the program plan, so the case manager is aware that a re-screen will need to be done in that timeframe.

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 Screenings

Interviews, Document and Site Review:
The RRC's PREA Policy addresses this standard beginning on page 7 and asserts that "the agency the Social Service Coordinator will administer the risk screening tool, which will then be passed directly to the Facility Director. These

tools will be utilized throughout a resident's placement at the RRC to ensure the safety and security of all residents. The Facility Director will pass on all pertinent information to security staff once risk is determined through the use of the screening tool."

Furthermore, the PREA Policy states, "Mirror will make all effort to house high risk abusers and high risk victims in separate rooms. Should a resident need to be housed in the same room as high risk victims, the resident will be housed closest to the entrance of the door for high visualization by staff when doing rounds."

In interviews with the PCM and others, it was articulated that the RRC utilizes a resident's risk, as established with the PREA Screening, to determine which building and room a resident is placed. Building 3 houses male residents who are potentially more vulnerable. Efforts are made to house residents individually (alone in a room) if the population allows. Otherwise, rooms and roommates are examined to ensure the best and safest placement.

Policy cites provisions (c)-(f) verbatim and also imposes a provision (115.42(d)) from the Adult Prisons/Jails standards (which exceeds the requirement of the Community Confinement standards). These provisions address the housing and management of transgender/intersex residents. The RRC did have a transgender resident at the time of the onsite audit. The auditor gathered that the RRC made individual determinations about this resident's safety, taking her views into consideration. This transgender female resident was housed in Building 3 in a room alone on the female wing, was provided the handicap shower room to shower separately and to use the toilet separately. The leadership shared with the auditor the information and decision-making process, which was congruent with the expectations in this standard. It was additionally corroborated by the resident also. As mentioned, the policy language includes a provision that "Placement and programming assignments for each transgender or intersex resident shall be reassessed at least twice each year to review any threats to safety experienced by the resident." Technically, this provision is part of the Prisons/Jails standards, though, currently it is also part of the agency policy. The auditor was provided documentation that the transgender resident has been reassessed according to this provision and thus, it exceeds this standard.

Corrective Action:
None.

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
- Reporting posters

Interviews, Document and Site Review:
RRC's PREA Policy outlines resident reporting as such:

> *(a) Ways for Residents to Report Incidents [DOJ §115.51 (a), (b), and (c)]:*
> *(a1) Mirror shall provide multiple internal ways for residents to privately report sexual abuse and sexual harassment, retaliation by other or staff for reporting sexual abuse or sexual harassment, and staff neglect that may have contributed to such incidents. Mirror does not house residents who are detained solely for immigration issues. Residents may report concerns by:*
>
> *i. Reporting the incident to a staff member*
>
> *ii. Reporting the incident to the Facility Director of PREA Coordinator*
>
> *iii. In the locked grievance box*
>
> *iv. Anonymously through a third party (i.e. counselor, family member, etc.)*
>
> *(a2) Mirror shall also provide at least one way for residents to report abuse, harassment, retaliation, and staff neglect to a public or private entity that is not part of Mirror, and that is able to receive and immediately forward resident reports of sexual abuse and sexual harassment to agency officials, allowing the resident to remain anonymous upon request. Residents may report concerns by:*
>
> *i. The use of the telephone*
> *ii. The use of their cell phones*
>
> *(a3) Staff shall accept reports made verbally, in writing, and anonymously. Staff shall immediately document any verbal reports.*

The RRC provides multiple internal ways for residents to privately report sexual abuse or sexual harassment or retaliation for reporting such incidents. Policy language for this standard is found in the PREA Policy on page 10. Methods of report are emphasized during intake and when establishing the resident's Initial Program Plan with the case manager. Interviews with residents indicated that they felt sexually safe and that none of them had needed to report nor had heard of anyone who had.

Residents can report to any staff member, can call the RRM (BOP contact), write a grievance or note, tell a case manager or administrator, etc. Residents generally knew how to report sexual abuse or sexual harassment. Staff, too, were able to articulate the ways in which residents are able to report.

The facility provides at least one way for residents or staff to report externally to a public or private entity. That entity is the Residential Reentry Manager from BOP. The contact information for the RRM is posted in the locked bulletin board. Upon receipt of a report by the RRM, this typically results in immediate response and investigation. Residents also have contact with their probations officers and can report to family as well.

Corrective Action:
None.

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
- Quality Care Policy (Grievance Procedure) form
- Resident Grievance Report
- Instructions for Filing a Grievance

Interviews, Document and Site Review:
The RRC's PREA Policy addresses grievances and emergency grievances on pages 10 & 11. It cites the standard verbatim, with the exception of provision (e). Provision (e) is cited on page 12.

Upon intake, residents sign the Mirror Quality Care Policy (Grievance Procedure) form. This form states that residents can file grievances "without alteration, interference, or delay to the party responsible for receiving and investigating them." This form also says that a resident "who wishes to register a grievance with the Federal Bureau of Prisons utilizing the FBOP grievance procedure may request the appropriate FBOP grievance form." It then provides the mailing address and contact person to direct those grievances to. Both the staff and the resident sign the form.

There does seem to be some contradiction to the Mirror PREA Policy and the grievance procedures outlined by the Quality Care Policy. The PREA Policy, in line with the PREA standards, do not permit the use of an informal grievance process for sexual abuse grievances while the Quality Care Policy states that residents are expected to make "a reasonable, civil effort to resolve differences and conflicts prior to filing a grievance." Ideally, this form and policy should clearly make an exception to that for sexual abuse or sexual harassment grievances.

The Quality Care Policy does provide a means of submitting a grievance privately by allowing residents to place it in a sealed envelope and be mailed externally to the Director of Federal Programs. It exceeds response time frames by stating a response is generally returned within 24 hours, exclusive of holidays and weekends. This standard requires procedures for the filing of an emergency grievance and an initial response thereof within 48 hours of receipt and a final agency decision within 5 calendar days (if the grievance alleges imminent risk of sexual abuse). The PREA Policy addresses emergency grievances per this standard, but the Quality Care Policy does not. Considering the time it takes for mailing a response, the time frame for responding to an emergency grievance would not likely be met. The Quality Care Policy does, however, inform the resident that a timelier response could be obtained by submitting the grievance to the Facility Coordinator. This process could be strengthened by marrying these two policies better and/or ensuring there are no discrepancies between the two.

The RRC reported zero (0) sexual abuse grievances during the review period and zero (0) emergency grievances during the review period. During resident interviews, it was generally reported that the grievance process was not used. Some residents were not aware of it. Therefore, while the agency does have administrative procedures to address grievances, it does not seem to be a process that is widely known or used.

Corrective Action:
1. The agency shall ensure that an informal process is not required for sexual abuse or sexual harassment grievances and shall ensure that residents receive such information.
2. Regarding emergency grievances, ensure there are no discrepancies between the PREA Policy and the Quality

Care Policy.

Update 12/29/16:
1. Through discussions with the PCM, the auditor learned additional information about the grievance process and the way it intersects with the formal grievance process through Bureau of Prisons as outlined in the BOP Quality Care Policy. Mirror also responds to grievances in-house and offers locked grievance boxes. Mirror does not have authority to alter the BOP grievance process or policies which residents review and sign, although, the PCM provided documentation of the Instructions For Filing a Grievance form, which now reflects an adjustment of the response time frames that are congruent with this standard. Essentially, Mirror will adhere to this standard and time frames required therein and the BOP grievance process is separate. The Instructions For Filing a Grievance are contained in every resident binder (containing all RRC rules and regulations as well as the Resident PREA Handbook).
2. Instructions For Filing a Grievance include emergency grievances, so that residents are informed of that process. This is in addition to the policy language that already exists regarding emergency grievances.

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
- YWCA posting
- YWCA MOU

Interviews, Document and Site Review:
The RRC's PREA Policy addresses emotional support services on page 14. The policy outlines the way the facility provides emotional support services in the following way:

(a) Mirror residents can access outside victim advocates for emotional support services related to sexual abuse by contacting the agencies on the PREA bulletin board outside the kitchen door in the main dayroom. The information contains the mailing addresses and telephone numbers, of local, State, or national victim advocacy or rape crisis organizations, and for persons detained solely for civil immigration purposes, immigrant services agencies. Reasonable communication between residents/inmates and these organizations and agencies, will be available in as confidential a manner as possible.

(b) Communication between the resident and outside agencies will be monitored and forwarded to authorities in accordance with mandatory reporting laws.

(c) YWCA is the community service provider that will be used to provide inmates with confidential emotional support services related to sexual abuse.

The auditor noted the information posted in the bulletin board in both Building 3 and Building 4, which consisted of mailing addresses and phone numbers. By virtue of the type of facility, residents can make contact privately and confidentially by using their cell phones, the facility phone, or by mail.

The RRC has also established an MOU with the YWCA for emotional support services and this was provided for auditor review. Most residents were aware there was some information posted, though, they did not it was needed at the RRC.

Corrective Action:
None.

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
- Agency website

Interviews, Document and Site Review:
The RRC's PREA Policy cites this standard on page 11.

It was clear the RRC has an established practice to receive third-party reports of sexual abuse and sexual harassment, as they would any reports and they would be investigated and handled no differently. Third party reporting information is made publicly available via postings in the facility and on the agency website (www.mirrorinc.org).

Interviews with staff indicated were required to report third party allegations just as any other allegation.

Corrective Action:
None.

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

Interviews, Document and Site Review:

The RRC's PREA Policy mandates staff to report immediately any knowledge or suspicion of sexual abuse or sexual harassment as well as retaliation and staff neglect of duties. Staff are required to report immediately to their supervisor or Facility Director. It then gets immediately reported to the Residential Reentry Manager from BOP and to local law enforcement if warranted. Interviews of all staff – random, specialized, and administrative – indicated this to be an institutionalized practice. Staff acknowledged the sensitive nature of such information and that they would not divulge such information to anyone other than to the extent necessary.

All employees, including the medical and the mental health staff, are required to follow the same policy. The interview with the mental health staff indicated that residents are informed, at the initiation of services, of her duty to report and the limitations of confidentiality.

Mirror admits no residents under the age of 18, therefore, provision (d) is not applicable.

Corrective Action:

None.

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:
Page 11 of RRC's PREA Policy cites this standard and it was clearly indicated in interviews with staff, case managers, and leadership that immediate action is taken to protect a resident that is in imminent danger of sexual abuse. Moving residents to another part of the facility and/or transferring to another facility would likely be used.

Since there were no reports sexual abuse reported at the RRC, there was no event during the review period for the auditor to verify. The RRC reported there to be no instances of residents being in imminent danger of sexual abuse.

Corrective Action:
None.

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
- Report documentation
- Email correspondence

Interviews, Document and Site Review:
The RRC's PREA Policy states, "(1) Upon receiving an allegation that a resident was sexually abused while confined at another facility, the Facility Director shall notify the head of the facility or agency where the alleged abuse occurred. Such notification shall be documented and provided as soon as possible, but no later than 72 hours after receiving the allegation." It does not address provisions (c) or (d), which mandate the agency document such notification and that if Mirror receives such a notification from another agency that it will ensure the allegation is investigated in accordance with PREA.

The RRC reported that one such allegation was received from a resident upon admission to the RRC. The allegation was provided for auditor review, which was an allegation of sexual abuse at a prison. The auditor was not provided with documentation that the prison was notified according to this standard and the Mirror PREA Policy.

Corrective Action:
1. Provide documentation to the auditor of the notification to the head of the facility (or appropriate office of the

agency) where the alleged abuse occurred. It is also recommended that provisions (c) and (d) be added to the policy language.

Update 11/28/16:
1. Documentation of the notification that was made to the Oakdale facility was provided for auditor review. This documentation consisted of several email chains that occurred in April 2016 regarding the allegation that was made by the resident.

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 RRC's PREA Policy cites staff first responder duties on page 12/13.

Anyone at the RRC can be a first responder and therefore should know duties related thereto. Staff articulated their first responder duties well, except for requesting the alleged victim-and ensuring the alleged abuser-does nothing to destroy physical evidence such as washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating. Even with prompting, staff generally did not offer this information, so this is an aspect of first responder duties that could be strengthened.

During the review period, there were no allegations of sexual abuse, therefore, the auditor has no records to review to verify this practice. As dictated by this standard, non-security first responders are required to request that the victim not take any actions to destroy physical evidence.

Corrective Action:
None.

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 RRC's PREA Policy outlines the facility's written institutional plan for coordinating actions in response to a report of sexual abuse on page 12. The plan includes first responders, medical and mental health, law enforcement, and facility leadership. The language is as follows:

Coordinated Response [DOJ § 115.65]
In an effort to ensure that the victim receives the best possible care and that investigators have the best chance of apprehending the perpetrator, Mirror will coordinate the following:
(1) Assess the victim's acute medical needs.
(a) This shall be done by the first responder
(2) Inform the victim of his/her rights under relevant Federal and State law.
(a)This shall be done by the responding Local Law Enforcement
(3) Explain the need for a forensic medical exam and offering the victim the option of undergoing one, within 92 hours.
(a)This shall be done by the responding Local Law Enforcement
(b)This shall be done at no cost to the victim
(4) Offer the presence of victim advocate or qualified staff member during the exam.
(a)This shall be done by the PREA Coordinator
(5) Provide crisis intervention counseling through the YWCA.
(a)This shall be done by the PREA Coordinator
(6) Interview the victim and any witnesses.
(a) This shall be done by the PREA Coordinator
(7) Collect evidence.
(a)First responders' duties are to protect the evidence until Local Law Enforcement respond.
(b)First Responder and staff on duty will secure the area, making sure no evidence is removed, tampered with or destroyed.
(8) Provide for any special needs the victim may have.
(a)This shall be done by the PREA Coordinator
During this process, first responder will have delegated to other staff to contact 911, Facility Director and PREA Coordinator.

The PCM articulated the coordinated response well and all other staff articulated their duties in relation to it.

Corrective Action:
None.

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)

☒ Not Applicable

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:
This standard is not applicable. There is no collective bargaining in this facility. Furthermore, policy language asserts, "Mirror is not involved with collective bargaining."

Corrective Action:
None.

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's PREA Policy, page 16, addresses provisions (a), (b), and (c) of this standard, but not (d), (e), or (f). The policy does not designate the staff member charged with the responsibility of monitoring for retaliation.

The auditor gathered that the Social Services Coordinator is the designee for monitoring retaliation. At the RRC, the Social Service Coordinator is also the PCM. Conversations with the PCM and others indicated that there is currently no formal process for monitoring retaliation and though there have been no allegations of sexual abuse during the review period, the agency shall have a procedure in place nonetheless. This was discussed with the PC, PCM, and Facility Director, who were receptive to ideas of formalizing this. The facility currently has a weekly PRT (Peer Review Team) meeting which involves the Facility Director, PCM, case managers, the counselor, and the lead program technician. During this meeting, issues with residents are discussed and are documented. This was discussed as an existing process to possibly use for monitoring retaliation.

Congruent with this standard, the policy nicely outlines the items to monitor, as such:

> *(3) For at least 90 days following a report of sexual abuse, Mirror shall monitor the conduct and treatment of residents or staff who reported sexual abuse, and of resident who were reported to have suffered sexual abuse, to see if there are changes that may suggest possible retaliation by residents or staff, and shall act promptly to remedy any such retaliation.*
> *Monitoring past 90 days shall continue if the initial monitoring indicates an ongoing need and shall include:*
> *(a) Periodic in-person conversations with residents and/or staff;*
> *(b) Review of disciplinary incidents involving residents;*
> *(c) Review of housing or program changes; and*
> *(d) Review of negative performance reviews or reassignments of staff.*

Corrective Action:
1. The RRC shall formalize the process for monitoring retaliation, in accordance with this standard, by demonstrating the way the process is tracked and/or documented. The agency's obligation to monitor shall cease if the allegation is determined to be unfounded.

Update 12/29/16:
1. The PCM created a form with which to formalize the monitoring of retaliation. There have been no reports of sexual abuse or sexual harassment or retaliation since the audit and, therefore, no monitoring of retaliation has been warranted.

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:
The "Investigation of Incidents" policy language in the PREA Policy, addresses several standards including this one, beginning on page 14.

The RRC and Mirror investigates administrative allegations of sexual abuse and sexual harassment and does so promptly, thoroughly, and objectively for all allegations including third party and anonymous reports. Internal administrative investigations, if not conducted by the BOP, are conducted by the PC or PCM. There were no investigations of sexual abuse during the review period. As one of the two designated investigators, the auditor interviewed the PCM and confirmed that she and the PC had received specialized training as also indicated in the auditor comments of 115.234. The PCM articulated the steps of a sexual abuse investigation, though, there had not been one. Interviews of leadership, supervisors, and staff supported that third party and anonymous reports are handled in the same manner as all other allegations. The auditor did not interview criminal investigators as they are external to the facility. However, the auditor learned that the facility has a healthy relationship with the Topeka Police Department.

The auditor did not review investigative files since there were no sexual abuse reports. Throughout all staff and resident interviews, there were no indication of reports made that hadn't been investigated.

Interviews and document reviews indicated that the role of administrative investigators may include the gathering of direct and circumstantial evidence, generally in the form of electronic evidence and/or other pertinent information the facility may have. Investigators at the RRC do not conduct compelled interviews. In the event there is support for criminal prosecution, the investigation would be in the hands of local law enforcement. It would be their responsibility to consult prosecution prior to conducting compelled interviews. Interviews and discussion with the PC and PCM and other staff indicated that persons involved in an investigation are not judged or treated with any bias. The established environment exuded one of respect for all residents void of unjustly assessing one's credibility. The facility uses no polygraph examinations with residents under any circumstances.

All investigations are documented in a written report, which would include the documentary evidence used in determining the case findings. Detecting staff neglect or violation of duties was a practice conveyed by the leadership. Substantiated allegations that appear to be criminal are referred by TPD for prosecution. It was also conveyed that the departure of an alleged victim or abuser does not serve as basis for terminating an investigation.

Provision (k) is not applicable to determining this facility's PREA compliance.

When an allegation is investigated externally, the facility leadership would endeavor to remain informed of the progress of the investigation by contacting either the TPD or the BOP.

Corrective Action:
None.

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:
Through interviews with the PCM, it was evident that the facility uses the standard "preponderance of evidence" to determine whether allegations of sexual abuse are substantiated. The PREA Policy cites this on page 15. The RRC shall ensure, for any sexual abuse investigations in the future, to clearly document their determination of substantiated, unsubstantiated, or unfounded.

Corrective Action:
None.

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
- Resident-on-Resident Notification of Investigative Finding

Interviews, Document and Site Review:
RRC's PREA Policy cites each provision of this standard on page 15. It does not state who is charged with providing this notification to residents. The policy language would be strengthened by also including this information. There were no investigations during the review period and, therefore, no residents were notified of case dispositions. The auditor was provided with a Resident-on-Resident Notification of Investigative Finding form that documents the case disposition and whether the 1) Resident* no longer resides at Mirror, 2) Resident* was indicted on a charge related to sexual abuse within the facility, or 3) Resident* was convicted on a charge related to sexual abuse within the facility. The resident and staff then sign the form. This is great tool to document this process. *One recommendation is to change the verbiage from "resident" to "alleged abuser."

The auditor was also provided with a form to document when a staff abuser is no longer employed at Mirror, is no longer posted within the resident's unit, was indicted on a charge related to sexual abuse within the facility, or convicted on a charge related to sexual abuse within the facility. This form that was provided was also titled Resident-on-Resident Notification of Investigative Finding, which is likely inadvertent. This form is intended to be used for staff-on-resident allegations.

These forms have not yet been used as there have not yet been any reports of sexual abuse since its implementation (or during the review period).

Corrective Action:
1. Amend the notification form intended for staff-on-resident use.

Update 11/25/16:
1. This amendment was completed and provided to the auditor for verification.

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:
There was no applicable staff discipline during the review period for the auditor to review, though, the RRC's PREA Policy, cites this standard verbatim on page 17. It was articulated that disciplinary actions against staff are commensurate with the nature and circumstances surrounding the violation and that termination was presumptive for a staff member that engaged in sexual abuse with a resident. There were no such instances to review.

Corrective Action:
None.

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 RRC's PREA Policy cites this standard, although it is largely not applicable at this time. The RRC currently has no volunteers and as had none during the review period and there are no also no applicable service contractors that have contact with residents on campus. Technically, Mirror does contract with Sunflower Prompt Care for some off-site medical services. However, those providers do not come to the facility. There were no allegations of sexual abuse by contractors or volunteers, none reported to licensing bodies, and none reported to law enforcement.

Corrective Action:
None.

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
- Chapter 11: Discipline

Interviews, Document and Site Review:
RRC's PREA Policy, page 17, addresses each provision of this standard.

The PCM explains the disciplinary process in the following way:

I am the CDC [Center Disciplinary Committee] here at Mirror in Topeka. If staff writes an NOV [Notice of

Violation], the resident signs that and there is an immediate sanction (loss of a pass, extra chores, etc.). If there is an IR [Incident Report], the staff writes that IR, but a different staff member that is not involved will serve and investigate that IR. After they have been given a hearing time and copies of all paperwork for that IR packet, they will meet with me for their formal hearing. For all 200 and 100 level IRs, I send those to the DHO [Disciplinary Hearing Officer] with the BOP. If it is a 300 level IR, I usually handle those with extra chores or maybe loss of gym pass. The DHO is with the BOP, so after I have detailed my findings in a report, they will sanction the IR. Oftentimes they take Good Conduct Time for 100 and 200 level IRs.

Chapter 11: Discipline outlines the formal disciplinary process. The following is an excerpt thereof:

b. Formal Hearings Before the CDC. Mirror conducts formal CDC hearings concerning all High (200) Level violations. Mirror convenes CDC hearings on all Greatest (100) Level Prohibited Act violations and refers them to the DHO. Mirror also refers disciplinary actions in the High (200) Level, Moderate (300) Level and Low Moderate (400) Level concerning offenders who are VCCLEA (rated violent) and PLRA offenders. Mirror's CDC makes a disposition on all other violations not informally resolved unless they are otherwise required to make referral to the DHO, (100 Level, VCCLEA, PLRA status, multiple separate offenses). Mirror CDC does not impose sanctions A through F as articulated in the BOP Prohibited Acts.

When a referral is made to the DHO, the CDC recommends one or more sanctions commensurate to the Prohibited Acts outlined in the BOP Prohibited Acts. No other sanctions are recommended.

At the RRC sexual activity with another resident is considered a major rule infraction. A resident will be subjected to disciplinary sanctions only pursuant to the formal disciplinary process outlined above, following an administrative finding that the resident engaged in resident-on-resident sexual abuse or following a criminal finding of guilt for resident-on-resident sexual abuse. There were no findings of resident-on-resident sexual abuse during the review period.

By staff report and review of the process, it was learned that disciplinary sanctions are 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.

Interviews with the PCM and mental health staff indicated that the disciplinary process considers whether a resident's mental disabilities or mental illness contributed to his or her behavior, although, it was relayed that a resident with this type of mental health condition would not likely be fit for placement at the RRC.

As set forth in policy, a resident may be disciplined for sexual contact with staff only upon finding that the staff member did not consent to such contact. There have been no such instances at this facility. Policy also sets forth that a report of sexual abuse made in good faith based upon a reasonable belief that the alleged conduct occurred shall not constitute falsely reporting an incident or lying, even if an investigation does not establish evidence sufficient to substantiate the allegation.

All sexual activity between residents is strictly prohibited at the RRC and will result in discipline action against residents for such activity. However, such activity between residents does not constitute sexual abuse if it is determined that the activity is not coerced.

Corrective Action:
None.

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
- YWCA MOU

Interviews, Document and Site Review:

The RRC does ensure that residents receive timely access to emergency medical treatment and crisis intervention. Emergency medical services are obtained from Stormont Vail Hospital where crisis intervention is offered from a victim advocate, the facility employs one mental health staff for continued emotional support, and/or emotional support and crisis intervention is also available through the YWCA. The auditor was provided with an MOU that outlines services for sexual abuse reports and interviewed the mental health staff.

As noted in the RRC's PREA Policy as well as auditor comments of 115.264, staff first responders would take preliminary steps to protect the victim and immediately notify the appropriate medical and/or mental health staff.

Policy language and interviews indicated that these services would be provided without cost to the victim, whether the victim names the abuser or not.

Corrective Action:

None.

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
- YWCA MOU

Interviews, Document and Site Review:
By virtue of the YWCA MOU for emotional support services, the RRC provides appropriate medical and mental health care to resident victims of sexual abuse. This is in addition to the mental health care offered at the facility.

The mental health staff that was interviewed reported that the level of care is above what is offered in the community, which concurs with auditor observations.

Pregnancy tests (if applicable), treatment and prophylaxis for STI's as appropriate are obtained through the forensic exam process via Stormont Vail Hospital. All these services are offered without cost to the victim, which is mandated by policy and was also reported by staff. There were no instances that warranted this during the review period.

Corrective Action:
None.

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

Interviews, Document and Site Review:
The RRC's PREA Policy cites each provision of this standard, on page 16. There were no reports of sexual abuse during the review period and no sexual abuse incident reviews warranted. The PREA Policy does state that the review team consists of "the Facility Director, PREA Coordinator, Vice President of Corrections, upper-level management and the Security Shift Manager."

Though, there were no reviews warranted, it is strongly recommended that there be a method of documenting and demonstrating compliance for when a sexual abuse incident review is needed, such as a form that accounts for all the required elements of this standard. The auditor provided examples of such forms upon request by the PCM. A form

will be developed and implemented.

Corrective Action:
None.

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
- Survey of Sexual Victimization 2015

Interviews, Document and Site Review:
Page 19/20 of the RRC's PREA Policy cites this standard verbatim and charges the PC with this responsibility.

Since there were no reports of sexual abuse or sexual harassment during the review period, there was no data to provide to the auditor for review. The agency does complete the Survey of Sexual Victimization (SSV) annually. The auditor was provided the completed SSV from 2015, which was completed by the PC and revealed there to be no reports of sexual abuse or sexual harassment.

It is recommended that the RRC collect sexual abuse and sexual harassment data per the definitions of sexual abuse and sexual harassment found in their PREA policy, which are congruent with the PREA standards.

Provision (e) is not applicable as the RRC does not contract with private facilities for confinement.

Corrective Action:
None.

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
- Agency website

Interviews, Document and Site Review:
Pursuant to the RRC's PREA Policy, page 20, data that is collected shall be submitted to the PCM for review. The policy addresses each provision of this standard including that an annual report will be prepared and published on the agency website. The PCM is charged with presenting the annual report to the Board of Directors for approval.

An annual report was not available on the agency website and through interviews with the PC and PCM, they were aware of this deficiency and had plans to rectify it.

Corrective Action:
1. The agency shall prepare an annual PREA report of findings and corrective actions for each facility and the agency as a whole. The report shall identify problem areas, ongoing corrective actions, and a comparison of data from previous years.
2. The annual report shall be approved by the Agency Head and published on the agency website.

Update 12/29/16:
1. Sexual abuse data was posted on the website, though, an annual report outlined by this standard was still needed. By 1/4/17, the PCM provided an annual report and the auditor verified that it was posted on the website as well.
2. The Annual Report was approved by the Agency Head and in fact also the agency's Board and then published on the website.

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

- Agency website

Interviews, Document and Site Review:
The RRC has placed language pertaining to this standard in the PREA Policy which can be found on page 20.

Sexual abuse data has not been made readily available to the public through its website. The RRC does not contract with private facilities for the confinement of residents, so that part of provision (b) is not applicable.

When making data available to the public, the agency shall ensure that no personal identifiers are made available publicly.

Corrective Action:
1. Make sexual abuse data publicly available through the agency website.

Update 12/29/16:
1. Sexual abuse and sexual harassment data was posted on the website in the form of the Survey of Sexual Victimization for all three Mirror residential facilities.

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.

Talia Huff _____ 1/20/17

Auditor Signature Date