

**PREA AUDIT REPORT    Interim    Final  
COMMUNITY CONFINEMENT FACILITIES**

**Date of report:** 8-06-2017

<b>Auditor Information</b>			
<b>Auditor name:</b> David "Will" Weir			
<b>Address:</b>			
<b>Email:</b>			
<b>Telephone number:</b>			
<b>Date of facility visit:</b> July 11, 2017			
<b>Facility Information</b>			
<b>Facility name:</b> Maricopa Reentry Center			
<b>Facility physical address:</b> 24601 N. 29th Ave.; Phoenix, Arizona 85027			
<b>Facility mailing address:</b> <i>(if different from above)</i> <a href="#">Click here to enter text.</a>			
<b>Facility telephone number:</b> 623-474-1500			
<b>The facility is:</b>	<input type="checkbox"/> Federal	<input checked="" type="checkbox"/> State	<input type="checkbox"/> County
	<input type="checkbox"/> Military	<input type="checkbox"/> Municipal	<input type="checkbox"/> Private for profit
	<input type="checkbox"/> Private not for profit		
<b>Facility type:</b>	<input type="checkbox"/> Community treatment center	<input type="checkbox"/> Community-based confinement facility	
	<input type="checkbox"/> Halfway house	<input type="checkbox"/> Mental health facility	
	<input type="checkbox"/> Alcohol or drug rehabilitation center	<input checked="" type="checkbox"/> Other	
<b>Name of facility's Chief Executive Officer:</b> Deputy Warden Patricia Barnhart			
<b>Number of staff assigned to the facility in the last 12 months:</b> 42			
<b>Designed facility capacity:</b> 100			
<b>Current population of facility:</b> 67			
<b>Facility security levels/inmate custody levels:</b> minimum			
<b>Age range of the population:</b> 18 and up			
<b>Name of PREA Compliance Manager:</b> Michael McCarville		<b>Title:</b> PREA Coordinator	
<b>Email address:</b> mmccarvi@azcorrections.gov		<b>Telephone number:</b> 602-771-5798	
<b>Agency Information</b>			
<b>Name of agency:</b> Arizona Department of Corrections			
<b>Governing authority or parent agency:</b> <i>(if applicable)</i> <a href="#">Click here to enter text.</a>			
<b>Physical address:</b> 1601 W. Jefferson; Phoenix, Arizona 85007			
<b>Mailing address:</b> <i>(if different from above)</i> <a href="#">Click here to enter text.</a>			
<b>Telephone number:</b> 602-542-5497			
<b>Agency Chief Executive Officer</b>			
<b>Name:</b> Charles L. Ryan		<b>Title:</b> Director	
<b>Email address:</b> cryan@azcorrections.gov		<b>Telephone number:</b> 602-542-5225	
<b>Agency-Wide PREA Coordinator</b>			
<b>Name:</b> Michael McCarville		<b>Title:</b> PREA Coordinator	
<b>Email address:</b> mmccarvi@azcorrections.gov		<b>Telephone number:</b> 602-771-5798	

## AUDIT FINDINGS

### NARRATIVE

PREA America LLC was retained by the Arizona Department of Corrections on February 21, 2017 to conduct the PREA Audit for the Maricopa Reentry Center in Phoenix, Arizona. The process was initiated and dates were agreed upon. Notices went up at the facility by May 26, 2017. The Pre-Audit Questionnaire, completed digitally, and accompanied with documents on a flash drive, completed and collected by PREA Coordinator Michael McCarville and Deputy Warden Patricia Barnhart were received by the auditor by June 28, 2017. In the weeks leading up to the onsite audit, Auditor Weir and Mr. McCarville exchanged emails and phone calls to clarify and better understand the materials provided. Materials included policies, logs, memos, reports, reviews, directives, postings, curriculum, and other guidance, evidence, and verification, as needed, addressing each specific standard. The auditor also reviewed information available through on-line sources, and contacted community providers directly.

The on-site audit was conducted as scheduled with Auditor Will Weir and PREAmerica Project Manager Thomas Kovach arriving at the facility at 8AM Tuesday, July 11th. There was an introductory meeting in the Deputy Warden's office attended by the audit team, Deputy Warden Patricia Barnhart, ADC PREA Coordinator Michael McCarville and Substance Abuse Program Manager . The audit team was then taken on a tour of the facility. The audit team utilized rosters of residents and staff to randomly select residents and staff for private interviews. 16 residents were selected and interviewed, including residents from each housing area. A total of 15 specialized and line staff were interviewed on site. Other interviews had been completed prior to the onsite audit. These included interviews with , Deputy Inspector General, HR Administrator , BIU Supervisor , Agency Contractor Administrator , Deputy Bureau Administrator (and Interim Deputy Director and Director's Designee) .

At the conclusion of the onsite audit, an exit conference was held, attended by the audit team, PREA Coordinator McCarville and DW Barnhart who were congratulated on their effective work getting the facility ready for the audit and thanked for making the audit process proceed smoothly and professionally. The team reviewed the highlights of the audit so far and impressions gleaned from the interviews. Mr. McCarville and Ms. Barnhart provided the required information in an easy reference format allowing for a very smooth and orderly pre-audit process well in advance of the on-site audit. Also, the activities of the onsite audit were managed well and flowed smoothly. Facility strengths include well worded PREA policies and the provision of consistent and quality PREA training for both staff and residents. Staff and residents interviewed indicate an adequate understanding of PREA and also indicate that all the standards they were questioned about are being followed. Residents say they can tell the facility is still new, but the staff are reliable and professional. When the staff do not know the answer to a question, they go find the answer and get back to them. The residents interviewed, as a whole, indicated the staff are available and sincere about doing their jobs right. The residents are benefiting from programming they would not otherwise have and are typically trying to utilize the opportunities provided by the facility to improve their ability to be successful and crime free upon release.

Documentation reviewed includes: Pre-Audit Questionnaire; Rosters of staff and residents; ADC Chapter 100 Agency Administration Department Order 106 Contract Beds, and Order 108 Americans with Disabilities Act Compliance, and Order 125 Sexual Offense Reporting Policy (with Attachments A & B); Sexual Assault Procedures List; Organizational Charts; Contracts; ADC Chapter 600 Inspector General Department Order 601 Administrative Investigations and Employee Discipline, Order 602 Background Investigations, Order 603 Polygraph Services, Order 606 regarding Internal Inspections Program, and Order 608 Criminal Investigations; ADC Director's Office Memorandum dated August 22, 2014: Employee Assignments and Staffing – Revised; MRC Post Charts; MRC Staff Posting Projections; Weekly Staffing Reports; ADC Chapter 500 Administrative/Human Services Department Order 501 Employee Professionalism, Ethics and Conduct, and Order 504 Recruitment and Hiring, Order 508 Criminal Investigations, Order 509 Employee Training and Education, Order 517 Employee Grievances, Order 521 Employee Assistance Program, Order 524 Employee Assignments, Order 526 Victim Services, and Staffing Policy and Order 527 Employment Discrimination and Harassment; Staffing Plan Review Meeting Minutes; ADC Chapter 700 Operational Security: Security/Facility Inspections Policy; Inspections/Tour Report Form; Searches and Contraband Training Lesson Plan; ADC Chapter 700 Operational Security Department Order 708: Searches Policy, and Order 704: Inmate Regulations, Dress and Clothing Requirements; Arizona State Law 13-1419 regarding unlawful sexual conduct, correctional facilities, classification, and definitions; ADC Chapter 800 Inmate Programs Department Order 801 Classification and Order 802 Inmate Grievance Procedure (English and Spanish), Order 804 Inmate Behavior Control, Order 805 Protective Custody, Order 810 Management of LGBTI Inmates, and Order 811 Individual Inmate Assessments and Reviews; ADC Chapter 1100 Inmate Health Services Department Order 1101: Inmate Access to Health Care; ADC Staff Development Bureau Curriculum and Training Plans; Training and Acknowledgment documentation of staff training; MRC Resident House Rules and Regulations; ADC Chapter 900 Inmate Programs and Services Department Order 906: Inmate Recreation/Arts & Crafts, and Order 910 Inmate Education and Resource Center Services, Order 914 Inmate Mail, Order 915 Inmate Phone Calls, Order 916 Staff-Inmate Communications; PREA Reporting and Advocacy Posters in English and Spanish; examples of background investigations; ADC Director's Office Memorandum Instruction #315: Preliminary Background Checks for Contractors; Verification of 5 year background checks being conducted on all staff; ADC Background Questionnaire for Applicants; Order 601 Attachment C; Arizona Administrative Code Title 2, Chapter 5; ADC Chapter 1000 Order 1003 regarding Community Corrections and Order 1006 regarding Reentry Centers; Community Corrections Technical Manual; ADC Conditions of Supervision and Release; Sample of Background Information Requests; documented efforts to establish MOU's with sexual victim's advocacy organization; established MOU with Southern Arizona Center Against Sexual Assaults; Intervention Checklist; PREA Compliance Training FY2016 and FY2017; 2017 Annual Training Plan; Training Excel Spreadsheets tracking training with employee

acknowledgment and verification; PREA Training for Volunteers with curriculum and signature documentation and electronic acknowledgment; Resident PREA training record documentation and acknowledgment; Resident Weekly Training Report; Resident Pamphlet in English and Spanish; other notices; Investigator Training with Certificates of Completion; Medical Staff Training Report and sign in sheets; SANE Procedures; Risk Assessment Screening Report and Training with samples of completed screenings and codes to understand them; Statewide Screening and Retaliation Training; examples of screenings being used to protect residents; PREA Hotline Agreement; Significant Incident and Criminal Investigation Reports; Employee Handbook; ADC website; Sexual and Domestic Violence Services lists; Coordinated Response Plan; Retaliation Monitoring policy and examples; General Records Retention Schedule for all Public Bodies Law Enforcement Records; Daily Count Sheets; PREA Risk Screening and Retaliation Review (Training PowerPoint); AIMS sample PREA Screening Instruments with Status Codes for Classification; Sample Transgender Actions Detail Screen; Inmate Education and Resource Center Services; Contract with Kathy Hansen Interpreting Services; Intensive Substance Abuse Treatment With Housing Program Contracts for 30 day and 90 day programs; Mission Statement; Annual Report; Mental Health Assessment Form; sample of Shared Medical Information; Consent Forms; 06-21-2017 Maricopa Reentry Center Deputy Warden PREA Meeting Minutes; and DOJ Survey of Sexual Violence.

## DESCRIPTION OF FACILITY CHARACTERISTICS

Maricopa Reentry Center is located on the former grounds of the Adobe Mountain Juvenile School. On the day of the audit, preparations were underway for the celebration of the first year for the Center; planning and decorations were helping to mark the successes achieved here with this format.

The main building consists of an intake area and administration wing with a central Control Room bisecting the building with a breeze way. The Lobby and Visitation Area are adjacent to the Control Room and beyond them are Parole offices.

The large grounds have Three Housing Units keeping their names from the former Juvenile school with uplifting titles such as Dignity. Each Housing unit has a control room, which serves as offices for the staff, Housing two housing wings and day rooms. The rooms are usually double occupancy and have toilets but the showers are separate along with laundry rooms. This is set up to help offender's transition back to conditions they will find in the community, namely less supervision more personal responsibility.

Outside there is a lawn and large open areas. Many of the landscaping projects were completed by offenders. Several buildings are used only for training staff and these are located in the back. There is a gym with a court dividing staff and offender facilities. This is next to their vegetable garden.

Mid-way on the grounds there is a mixed use building with a library, class rooms and some staff training rooms. Close to the administration building is another multi-use building which has a kitchen, dining room, chapel, and warehouse and maintenance area. All areas with offenders have cameras appropriately placed for supervision.

The DOC Website explains: The fundamental purpose of the Maricopa Reentry Center (MRC) is to facilitate the successful re-integration of offenders into the community following incarceration.

The Pima Reentry Center (PRC) and MRC were established to assist individuals who have been recently released from prison to successfully complete their period of community supervision by providing critical programs and services. Services include outpatient substance abuse treatment; residential substance abuse treatment; cognitive restructuring classes; assistance in finding employment; life skills classes; sanctions; day reporting; and temporary housing – not to exceed 90 days – for released individuals who have not yet secured permanent housing and would otherwise be living on the streets.

State and community-based organizations/partners also offer on-site programming for those on community supervision. For instance, the Arizona Department of Economic Security has staff at the facility to assist released individuals with employment searches.

The centers provide structure, supervision, and surveillance of offenders who are in technical violation of their conditions of supervised release and/or who are in need of additional structured support in order to successfully complete community supervision, rather than automatically returning them to prison.

The ITH program is a cognitive based, 90-day substance abuse treatment program. Offenders participating in this program work with licensed counselors and paraprofessionals to address their substance abuse problems and successfully reintegrate back into society. Offenders remain on-site for services and do not leave the facility during the first 45 days of treatment. After 45 days, based on the individual's program progress and behavior, they may earn limited passes to visit family and engage in pro-social activities (such as outside 12-Step meetings, job interviews, etc.).

The Sanctions program serves as an intervention technique with offenders who are violating the technical terms of their supervision status, but who are not committing new crimes or presenting a danger to the public.

Instead of returning to prison to await a revocation hearing, these offenders are sent to MRC for brief stays (typically 2-3 days) during which they remain on-site at the facility. They are only allowed to leave the premises to attend pre-existing employment. While in the sanctions program, offenders attend classes and complete assignments designed to help them rethink their decision making processes.

**SUMMARY OF AUDIT FINDINGS**

On July 11, 2017, PREA America Auditor Will Weir completed the onsite PREA Audit of Maricopa Reentry Center. Audit results indicate Maricopa Release Center complies with all 37 applicable standards. Two standards are not applicable.

Number of standards exceeded: 0

Number of standards met: 37

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)
- X Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- Does Not Meet Standard (requires corrective action)

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

The Pre-Audit Questionnaire and accompanying documentation indicate the agency has zero tolerance toward all forms of sexual abuse and sexual harassment in the facility. The policy outlines how it will implement the agency's approach to preventing, detecting, and responding to sexual abuse and sexual harassment. The policy includes definitions of prohibited behaviors regarding sexual abuse and sexual harassment. The policy includes sanctions for those found to have participated in prohibited behaviors. The policy includes a description of agency strategies and responses to reduce and prevent sexual abuse and sexual harassment of residents. The agency designates an upper-level PREA coordinator. The PREA coordinator has sufficient time and authority to develop, implement, and oversee agency efforts to comply with the PREA standards. PREA Coordinator Michael McCarville answers directly to \_\_\_\_\_, Deputy Inspector General. All residents and staff interviewed indicate a clear understanding of the zero tolerance policy.

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

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

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

N/A for Maricopa Reentry Center. The agency (not the facility) contracts with other entities for the confinement of residents and all these contractors are required to be PREA compliant.

### Standard 115.213 Supervision and monitoring

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

**Auditor 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.**

During the audit it was found that the facility and agency have worked together to develop, document, and comply on a regular basis with a staffing plan that provides for adequate levels of staffing and video monitoring to protect residents against abuse, taking into account all parts of this standard, including an annual review to see if adjustments are needed. Each time the staffing plan is not complied with, the facility documents and justifies all deviations from the staffing plan. According to documentation as well as staff and administrative interviews, there have been no deviations from staffing plan. The average number of residents has been 44, the same number upon which the staffing plan is based. In calculating adequate staffing levels and determining the need for video monitoring, the agency takes the following into consideration: (1) Generally accepted detention and correctional practices; (2) Any judicial findings of inadequacy; (3) Any findings of inadequacy from Federal investigative agencies; (4) Any findings of inadequacy from internal or external oversight bodies; (5) All components of the facility's physical plant (including "blind-spots" or areas where staff or residents may be isolated); (6) The composition of the resident population; (7) The number and placement of supervisory staff; (8) Institution programs occurring on a particular shift; (9) Any applicable State or local laws, regulations, or standards; (10) The prevalence of substantiated and unsubstantiated incidents of sexual abuse; and (11) Any other relevant factors. Verification of compliance with this standard was based on a review of documentation regarding staffing plans and reviews, such as meeting minutes.

### **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.**

During the onsite audit it was verified that the facility does not conduct cross-gender strip or cross-gender visual body cavity searches of residents and there have been no exceptions known in the past year. If exceptions do occur, documentation is required. This facility does not house female offenders so portions of this standard relating to female offenders do not apply. Procedures had been implemented that enable residents to shower, perform bodily functions, and change clothing without non-medical staff of the opposite gender viewing their breasts, buttocks, or genitalia, except in exigent circumstances or when such viewing is incidental to routine cell checks (this includes viewing via video camera). Also, this Standard requires staff of the opposite gender to announce themselves when entering a resident housing unit. The agency has a policy prohibiting staff from searching or physically examining a transgender or intersex resident for the sole purpose of determining the resident's genital status. None of these searches have occurred and all staff have been trained on this policy. All interviews conducted during the audit, including resident interviews, verify that no cross gender searches are being performed. Staff agree that if a cross gender search had to occur due to exigent circumstances, they would document. Interviews and observations during the tour also verify that residents can perform bodily functions without genitals being viewed by staff of the opposite gender.

### **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.**

The agency has established procedures to provide disabled residents and residents with limited English proficiency equal opportunity to

participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment. Agency policy prohibits use of resident interpreters, resident readers, or other types of resident assistants except in limited circumstances where an extended delay in obtaining an effective interpreter could compromise the resident's safety, the performance of first-response duties under §115.264, or the investigation of the resident's allegations. There have been no exceptions, but if there are, they must be documented. Staff and administrators interviewed indicated an understanding of the importance this standard, and procedures in place so residents with disabilities and with limited English proficiency can have equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment. Resident interpreters are not being used. Residents with disabilities who were interviewed indicated that staff help them understand what they need to understand.

### **Standard 115.217 Hiring and promotion decisions**

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

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During the audit process, policy was verified which prohibits hiring or promoting anyone who may have contact with residents and prohibits enlisting the services of any contractor who may have contact with residents who: Has engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility, or other institution (as defined in 42 U.S.C. 1997); Has been convicted of engaging or attempting to engage in sexual activity in the community facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse; or Has been civilly or administratively adjudicated to have engaged in the activity described in paragraph (a)(2) of this section. Agency policy requires the consideration of any incidents of sexual harassment in determining whether to hire or promote anyone, or to enlist the services of any contractor, who may have contact with residents. Agency policy requires that before it hires any new employees who may have contact with residents, it (a) conducts criminal background record checks, and (b) consistent with federal, state, and local law, makes its best efforts to contact all prior institutional employers for information on substantiated allegations of sexual abuse or any resignation during a pending investigation of an allegation of sexual abuse. Agency policy requires that a criminal background record check be completed before enlisting the services of any contractor who may have contact with residents. Agency policy requires that either criminal background record checks be conducted at least every five years for current employees and contractors who may have contact with residents, or that a system is in place for otherwise capturing such information for current employees. Policy states that material omissions regarding such misconduct, or the provision of materially false information, shall be grounds for termination. Interviews with administrators indicated they will give information on substantiated sexual abuse to potential employers upon request, unless advised otherwise by the legal department.

### **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)

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video monitoring system. Interviews and documentation verify resident safety and PREA was considered during this process, and is being considered on an ongoing basis.

#### **Standard 115.221 Evidence protocol and forensic medical examinations**

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

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ADC is responsible for conducting administrative and criminal sexual abuse investigations (including resident-on-resident sexual abuse or staff sexual misconduct) and follows a uniform evidence protocol that maximizes the potential for obtaining usable physical evidence for administrative proceedings and criminal prosecutions. The facility offers all residents who experience sexual abuse access to forensic medical examinations without financial cost to the victim. When possible, SANEs and SAFEs conduct the exams, but when they are not available a qualified medical practitioner performs the forensic medical examinations. The facility documents efforts to provide SANEs and SAFEs. The facility attempts to make a victim advocate from a rape crisis center available to the victim, either in person or by other means, and documents these efforts. If and when a rape crisis center is not available to provide victim advocate services, the facility provides a qualified staff member from a community-based organization or a qualified agency staff member. If requested by the victim, a victim advocate, qualified agency staff member, or qualified community-based organization staff member accompanies and supports the victim through the forensic medical examination process and investigatory interviews and provides emotional support, crisis intervention, information, and referrals. Crisis service providers contracted, MOU's reviewed, and investigators interviewed, indicate evidence protocols are understood and followed. Maricopa Reentry Center Resident's forensic examinations are provided through regional emergency rooms with SANE nurse through Honor Health attending. An MOU with the Southern Arizona Center Against Sexual Assault (SACASA) is specifically applicable to MRC. Agreements with Honor Health and SACASA were verified by the audit team. Honor Health is to be contacted at 480-312-6340 is to be contacted and they will sent a nurse to the hospital the resident is taken to. SACASA will also respond with an advocate. ADC officials and Michael McCarville have completed advocacy training and are available should outside advocacy not be available.

#### **Standard 115.222 Policies to ensure referrals of allegations for investigations**

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

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

The agency ensures that an administrative or criminal investigation is completed for all allegations of sexual abuse and sexual harassment. The agency has a policy that requires that allegations of sexual abuse or sexual harassment be referred for investigation to the agency investigators and that these referrals be documented. This policy is published on the agency website. To verify compliance with this standard, the auditor reviewed investigators, staff and residents. The auditor also studied the notification, routing and referral processes taken when an allegation is made. Although MRC has not had allegations in the past 12 months, the same investigators are assigned to other facilities this audit team has audited this year. The audit team has been able to review investigations they have conducted and is assured all

of ADC follows the same basic policies, protocols and procedures that assures all allegations are properly investigated.

### Standard 115.231 Employee training

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

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The agency trains all employees who may have contact with residents on the following matters: (1) Its zero-tolerance policy for sexual abuse and sexual harassment; (2) How to fulfill their responsibilities under agency sexual abuse and sexual harassment prevention, detection, reporting, and response policies and procedures; (3) Residents' rights to be free from sexual abuse and sexual harassment; (4) The right of residents and employees to be free from retaliation for reporting sexual abuse and sexual harassment; (5) The dynamics of sexual abuse and sexual harassment in confinement; (6) The common reactions of sexual abuse and sexual harassment victims; (7) How to detect and respond to signs of threatened and actual sexual abuse; (8) How to avoid inappropriate relationships with residents; (9) How to communicate effectively and professionally with residents, including lesbian, gay, bisexual, transgender, intersex, or gender nonconforming residents; and (10) How to comply with relevant laws related to mandatory reporting of sexual abuse to outside authorities. All staff employed by the facility, who may have contact with residents, have been trained in PREA requirements. Between trainings, the agency provides employees who may have contact with residents with refresher information about current policies regarding sexual abuse and sexual harassment, at least annually and when there are changes. The agency documents that employees who may have contact with residents understand the training they have received through employee signature or electronic verification, verified by the auditor. Employees interviewed generally remembered receiving each portion of the training and indicated an understanding of the material, as well as a commitment to the well being and safety of residents.

### Standard 115.232 Volunteer and contractor training

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

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All 23 volunteers and contractors who have contact with residents have been trained on their responsibilities under the agency's policies and procedures regarding sexual abuse/harassment prevention, detection, and response. The level and type of training provided to volunteers and contractors is based on the services they provide and level of contact they have with residents. All volunteers and contractors who have contact with residents have been notified of the agency's zero-tolerance policy regarding sexual abuse and sexual harassment and informed how to report such incidents. The agency maintains documentation confirming that volunteers/contractors understand the training they have received, which was reviewed by the auditor.

### Standard 115.233 Resident education

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

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Residents of Maricopa Reentry Center receive information at time of intake about the zero-tolerance policy and how to report incidents or suspicions of sexual abuse or harassment. All residents have received this information at intakes and received comprehensive information within 30 days. Agency policy requires that residents who are transferred from one facility to another be educated regarding their rights to be free from both sexual abuse/harassment and retaliation for reporting such incidents and on agency policies and procedures for responding to such incidents to the extent that the policies and procedures of the new facility differ from those of the previous facility. Resident PREA education is available in accessible formats for all residents including those who are: limited English proficient, deaf, visually impaired, otherwise disabled, and limited in their reading skills. The agency maintains documentation of resident participation in PREA education sessions. The agency ensures that key information about the agency’s PREA policies is continuously and readily available or visible through posters, resident handbooks, or other written formats. These were reviewed during the on-site audit tour. Interviews with staff and residents clearly indicate residents have been trained and state they understand.

**Standard 115.234 Specialized training: Investigations**

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

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The agency performs its own administrative and criminal investigations and investigators have received training in conducting such investigations in confinement settings. Specialized training includes techniques for interviewing sexual abuse victims, proper use of Miranda and Garrity warnings, sexual abuse evidence collection in confinement settings, and the criteria and evidence required to substantiate a case for administrative action or prosecution referral. The agency has documented the training and it was reviewed by the audit team.

**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.**

The agency has a policy related to the training of medical and mental health practitioners who work regularly in its facility. All medical and mental health care practitioners who work regularly at this facility received the training required by agency policy, and it is documented, but they do not conduct forensic medical exams. Medically trained staff interviewed remember their training regarding how to detect and assess signs of sexual abuse and harassment, how to preserve physical evidence of sexual abuse, how to respond effectively and professionally to victims of sexual abuse, and how to report allegations or suspicions.

### **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.**

ADC has a policy that requires screening (upon admission to a facility or transfer to another facility) for risk of sexual abuse victimization or sexual abusiveness toward other residents. The policy requires that residents be screened for risk of sexual victimization or risk of sexually abusing other residents within 72 hours of their intake. Risk assessment is to be conducted using an objective screening instrument, which considers: (1) Whether the resident has a mental, physical, or developmental disability; (2) The age of the resident; (3) The physical build of the resident; (4) Whether the resident has previously been incarcerated; (5) Whether the resident's criminal history is exclusively nonviolent; (6) Whether the resident has prior convictions for sex offenses against an adult or child; (7) Whether the resident is or is perceived to be gay, lesbian, bisexual, transgender, intersex, or gender nonconforming; (8) Whether the resident has previously experienced sexual victimization; (9) The resident's own perception of vulnerability; and (10) Whether the resident is detained solely for civil immigration purposes. The policy requires that the facility reassess each resident's risk of victimization or abusiveness within a set time period, not to exceed 30 days after the resident's arrival at the facility, based upon any additional, relevant information received by the facility since the intake screening. The facility will reassess the resident's risk of victimization or abusiveness based upon any additional, relevant information received by the facility since the intake screening. Residents may not be disciplined for refusing to answer, or for not disclosing complete information in response to, questions asked pursuant to the screening questions related to this section. The agency has appropriate controls on the dissemination within the facility of responses to questions asked pursuant to this standard in order to ensure that sensitive information is not exploited to the resident's detriment by staff or other residents. Screenings and reassessments are recorded through computer entry by screeners. Random selections of these screenings were provided for the auditor's review. Screeners and residents interviewed provided additional verification that these screenings are completed appropriately. The screening process has been special attention at Maricopa as part of their commitment to get the new facility online safely with a minimum of disruption.

### **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.**

Maricopa Reentry Center uses information from the risk screening required by § 115.241 to inform housing, bed, work, education, and program assignments with the goal of keeping separate those residents at high risk of being sexually victimized from those at high risk of being sexually abusive. They make individualized determinations about how to ensure the safety of each resident. They makes housing and program assignments for transgender or intersex residents in the facility on a case-by-case basis. 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. A transgender or intersex resident's own views with respect to his or her own safety shall be given serious consideration. Transgender and intersex residents shall be given the opportunity to shower separately from other residents. Lesbian, gay, bisexual, transgender, or intersex residents will not be placed in dedicated facilities, units, or wings solely on the basis of such identification or status. Interviews indicate screening information has been used appropriately, and protections are in place with limited access to sensitive information.

### Standard 115.251 Resident reporting

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

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

The agency has established procedures allowing for multiple internal ways for residents to report privately to agency officials about: sexual abuse and sexual harassment, retaliation by other residents or staff for reporting sexual abuse and sexual harassment, and staff neglect or violation of responsibilities that may have contributed to such incidents. The agency provides at least one way for residents to report abuse or harassment to a public or private entity or office that is not part of the agency. The agency has a policy mandating that staff promptly accept reports of sexual abuse and sexual harassment made verbally, in writing, anonymously, and from third parties, and to give these reports promptly to their supervisor who will notify statewide PREA Investigators and to appropriate official(s) for investigation. Staff and residents are informed of these procedures in writing, in training, verbally, and through signs posted in the facility. Residents interviewed indicated they remember their options for reporting and that they can get help reporting. They can report to the ADC Inspector General Bureau (801 South 16th Street; Phoenix AZ 85034). Reports can also be made through the agency website. The resident handbook reminds residents to look for the postings on the windows of each housing unit giving information on how to report, and it also tells them about their ability to report to the Southern Arizona Center Against Sexual Assault (SACASA) at 520-327-7273 or 1600 N. Country Club Road; Tucson, AZ 85716.

### Standard 115.252 Exhaustion of administrative remedies

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

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

The facility is except from this standard since it does not have an administrative procedure for dealing with resident grievances regarding sexual abuse. Since residents are only at this facility for a relatively short period of time, all their allegations are handled through the other systems and procedures in place.

### Standard 115.253 Resident access to outside confidential support services

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

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

The facility provides residents with access to outside and facility staff victim advocates for emotional support services related to sexual abuse by: Giving residents mailing addresses and telephone numbers (including toll-free hotline numbers where available) for local, state, or national victim advocacy or rape crisis organizations. The resident handbook tells residents they may contact the Southern Arizona Center Against Sexual Abuse (SACASA) at (520)327-7273 or write to: 1600 N. Country Club Rd., Tucson, AZ 85716, to report sexual abuse or sexual harassment. No residents are detained solely for immigration purposes, so the portion of this standard dealing with these residents does not apply. Interviews at the facility indicate the facility is invested in enabling reasonable communication between residents and these organizations in as confidential a manner as possible. The facility informs residents, prior to giving them access to outside support services, the extent to which such communications will be monitored, and about the mandatory reporting rules governing privacy, confidentiality, and/or privilege that apply to disclosures of sexual abuse made to outside victim advocates, including any limits to confidentiality under relevant federal, state, or local law. To verify compliance with this standard the auditor reviewed and verified the Memorandum's of Understanding (MOU) with Southern Arizona Center Against Sexual Assault. Residents view MRC as a link to the community anyway, by the nature of the services it provides, so it appears they find their easy access to SACASA to be consistent with other aspects of MRC programming. Also, several residents indicated that the counseling and classes they receive via MRC serve to reinforce the idea that services must be utilized, as needed, in order for them to be successful and autonomous as they move forward and discharge home and into other placements.

### Standard 115.254 Third-party reporting

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

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

The agency provides a method to receive third-party reports of resident sexual abuse or sexual harassment. Information about reporting is publicly distributed in the lobbies and visitation areas, and on the agency website. Third parties can report directly to CIU Supervisor Juan Herrera. The auditor has verified that information is publicly available regarding how to report sexual abuse and sexual harassment on behalf of a resident.

### 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.**

The agency requires all staff to report immediately and according to agency policy: Any knowledge, suspicion, or information they receive regarding an incident of sexual abuse or sexual harassment that occurred in a facility, whether or not it is part of the agency; Any retaliation against residents or staff who reported such an incident; and, Any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation. Apart from reporting to designated supervisors or officials and designated state or local service agencies, agency policy prohibits staff from revealing any information related to a sexual abuse report to anyone other than to the extent necessary to make treatment, investigation, and other security and management decisions. Medical and mental health practitioners are required to report sexual abuse and to inform residents of the practitioner’s duty to report, and the limitations of confidentiality when they initiate services. If the alleged victim is under the age of 18 or considered a vulnerable adult under a State or local vulnerable persons statute, the agency will report the allegation to the designated State or local services agency under applicable mandatory reporting laws. The facility reports all allegations of sexual abuse and sexual harassment, including third-party and anonymous reports, to the facility’s designated investigators. Interviews indicate an understanding of this standard and related policies and procedures.

**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.**

When the agency or facility learns that an resident is subject to a substantial risk of imminent sexual abuse, it takes immediate action to protect the resident. In the 12 months prior to the onsite audit, the facility has not determined that a resident was subject to substantial risk of imminent sexual abuse. Interviews with staff indicate a commitment to take immediate action when there are indications of risk of imminent abuse. Residents interviewed indicated they feel staff would take steps to protect.

**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.**

The agency has a policy requiring that, upon receiving an allegation that a resident was sexually abused while confined at another facility, the head of the facility must notify the head of the facility or appropriate office of the agency or facility where sexual abuse is alleged to have occurred. Agency policy requires the facility head to provide such notification as soon as possible, but no later than 72 hours after receiving the allegation. The facility documents that it has provided such notification within 72 hours of receiving the allegation. The agency or facility policy requires that allegations received from other facilities/agencies are investigated in accordance with the PREA standards. Verification of compliance with this standard was supported by a review of policy, investigations, and other Pre-Audit documentation. Also, interviews indicated regular communication between wardens and agency officials to assure compliance with this standard. However, there have been no allegations received in the past 12 months regarding residents being abused at another facility, or of former MRC residents being abused while at MRC.

### **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.**

The agency has a first responder policy for allegations of sexual abuse. The agency policy requires that, upon learning of an allegation that a resident was sexually abused, the first security staff member to respond to the report is required to: (1) Separate the alleged victim and abuser; (2) Preserve and protect any crime scene until appropriate steps can be taken to collect any evidence; (3) If the abuse occurred within a time period that still allows for the collection of physical evidence, request that the alleged victim not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating; and (4) If the abuse occurred within a time period that still allows for the collection of physical evidence, ensure that the alleged abuser does not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating. Agency policy requires that if the first staff responder is not a security staff member, that responder shall be required to: request that the alleged victim not take any actions that could destroy physical evidence, and then notify security staff. Staff interviews indicated that staff have a basic understanding of the first responder protocol. Also, investigative forms used indicate staff and administrators have reminders of first responder duties built in to their processes. Also, first responder cards are issued as another way of reinforcing the policy and training.

### **Standard 115.265 Coordinated response**

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

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

The facility has developed a written institutional plan to coordinate actions taken in response to an incident of sexual abuse among staff first responders, medical and mental health practitioners, investigators, and facility leadership. This plan was reviewed and verified by the auditor.



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

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

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

The agency has not entered into or renewed any collective bargaining agreement since the previous audit. They retain the ability to protect residents from abuse.

### Standard 115.267 Agency protection against retaliation

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

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

The agency has a policy to protect all residents and staff who report sexual abuse or sexual harassment or cooperate with sexual abuse or sexual harassment investigations from retaliation by other residents or staff. Policy charges the facility administrator with this task. Deputy Warden Patricia Barnhart fully understands these duties and indicates a full endorsement of these policies and a resolve to carry out these duties effectively. Agency policy is very clear that she is to be supported and assisted in these efforts by other administrators, including every level up to and including the Director of the agency. For example, HR must assist with monitoring whether staff have been retaliated against and Victim Services, Employee Grievance Program, and Employee Assistance Programs provide outreach, training and services. The PREA Coordinator and Special Review Team help monitor residents for retaliation and agency professionals as well as SACASA provides services to residents. The agency monitors housing changes or transfers for resident victims or abusers, removal of alleged staff or resident abusers from contact with victims, and emotional support services for residents or staff who fear retaliation for reporting sexual abuse or sexual harassment or for cooperating with investigations for at least 90 days. In the case of residents, such monitoring also includes periodic status checks. If any other individual who cooperates with an investigation expresses a fear of retaliation, the agency takes appropriate measures to protect that individual against retaliation. The agency acts promptly to remedy retaliation and continues to monitor longer 90 days if needed. There have been no instances of retaliation reported in the 12 months prior to the onsite audit.

### Standard 115.271 Criminal and administrative agency investigations

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

**Auditor 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.**

ADC has a policy related to criminal and administrative agency investigations and these investigations are typically done by agency investigators. Substantiated allegations that appear to be criminal are referred for prosecution. Where sexual abuse is alleged, the agency uses investigators who have received special training in sexual abuse investigations. These investigations are conducted promptly, thoroughly, and objectively for all allegations, including third-party and anonymous reports. Investigators gather and preserve direct and circumstantial evidence, including any available physical and DNA evidence and any available electronic monitoring data; interview alleged victims, suspected perpetrators, and witnesses; and review prior complaints and reports of sexual abuse involving the suspected perpetrator. Where the evidence seems to support criminal prosecution, the agency conducts compelled interviews only after consulting with prosecutors as to whether compelled interviews may be an obstacle for subsequent criminal prosecution. The credibility of an alleged victim, suspect, or witness is assessed on an individual basis and is not determined by the person's status as a resident or staff. The agency does not require a resident who alleges sexual abuse to submit to a polygraph examination or other truth-telling device as a condition for proceeding with the investigation of such an allegation. Administrative investigations include efforts to determine whether staff actions or failures to act contributed to the abuse; and documents in written reports that include a description of the physical and testimonial evidence, the reasoning behind credibility assessments, and investigative facts and findings. Criminal investigations are documented in a written report that contains a thorough description of physical, testimonial, and documentary evidence and attaches copies of all documentary evidence. The agency retains all written reports pertaining to the administrative or criminal investigation of alleged sexual abuse or sexual harassment for as long as the alleged abuser is incarcerated or employed by the agency, plus five years. The departure of the alleged abuser or victim from the employment or control of the facility or agency is not a basis for terminating an investigation. These policies and procedures were verified through documentation review, review of investigative files (from other agency facilities) and interviews with investigators. There were no reports alleging/suspecting sexual abuse or harassment of MRC residents during the 12 months that were reviewed for this audit.

#### **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.**

As stated in policy and interviews with administration, as well as the agency investigators, the agency imposes a standard of a "preponderance of the evidence" when determining whether allegations of sexual abuse or sexual harassment are substantiated during administrative investigations.

#### **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.**

The agency has a policy requiring that any resident who makes an allegation that he or she suffered sexual abuse in an agency facility is informed, verbally or in writing, as to whether the allegation has been determined to be substantiated, unsubstantiated, or unfounded following an investigation by the agency. If an outside entity conducts such investigation, the agency requests the relevant information from the investigative entity in order to inform the resident of the outcome of the investigation. In the 12 months prior to the onsite audit, there has been no such notifications documented since there have been no allegations or investigations. Following an resident's allegation that a staff member has committed sexual abuse against the resident, the agency/facility subsequently informs the resident (unless the agency has determined that the allegation is unfounded) whenever: (1) The staff member is no longer posted within the resident's unit; (2) The staff member is no longer employed at the facility; (3) The agency learns that the staff member has been indicted on a charge related to sexual abuse within the facility; or (4) The agency learns that the staff member has been convicted on a charge related to sexual abuse within the facility. Following a resident's allegation that he or she has been sexually abused by another resident in an agency facility, the agency subsequently informs the alleged victim whenever: The agency learns that the alleged abuser has been indicted on a charge related to sexual abuse within the facility; or, The agency learns that the alleged abuser has been convicted on a charge related to sexual abuse within the facility. The agency has a policy that all notifications to residents described under this standard are documented.

**Standard 115.276 Disciplinary sanctions for staff**

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

**Auditor 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.**

As verified by policy review and interviews with the Deputy Warden, PREA Coordinator, and HR, staff is subject to disciplinary sanctions up to and including termination for violating agency sexual abuse or sexual harassment policies. Termination is the presumptive disciplinary sanction for staff who have engaged in sexual abuse. Disciplinary sanctions for violations of agency policies relating to sexual abuse or sexual harassment (other than actually engaging in sexual abuse) are commensurate with the nature and circumstances of the acts committed, the staff member's disciplinary history, and the sanctions imposed for comparable offenses by other staff with similar histories. All terminations for violations of agency sexual abuse or sexual harassment policies, or resignations by staff who would have been terminated if not for their resignation, are reported to law enforcement agencies, unless the activity was clearly not criminal, and to any relevant licensing bodies. During the past 12 months there have been no substantiated findings that staff engaged in sexual abuse or harassment, and therefore no terminations or discipline based on this standard, or notification of law enforcement.

**Standard 115.277 Corrective action for contractors and volunteers**

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

**Auditor 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.**

ADC agency policy requires that any contractor or volunteer who engages in sexual abuse be reported to law enforcement agencies, unless the activity was clearly not criminal, and to relevant licensing bodies. Agency policy requires that any contractor or volunteer who engages in sexual abuse be prohibited from contact with residents. Although there have been no allegations in the past 12 months, the Deputy Warden and PREA Coordinator verify that the facility follows these policies and takes appropriate remedial measures and considers whether to prohibit further contact with residents in the case of any other violation of agency sexual abuse or sexual harassment policies by a contractor or volunteer.

### Standard 115.278 Disciplinary sanctions for residents

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

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

Residents at MRC are subject to disciplinary sanctions only pursuant to a formal disciplinary process following an administrative finding, or criminal finding, the resident engaged in resident-on-resident sexual abuse. When there are substantiated allegations, sanctions are to be commensurate with the nature and circumstances of the abuse committed, the resident’s disciplinary history, and the sanctions imposed for comparable offenses by other residents with similar histories. The disciplinary process considers whether a resident’s mental disabilities or mental illness contributed to his or her behavior when determining what type of sanction, if any, should be imposed. The facility offers therapy, counseling, or other interventions designed to address and correct the underlying reasons or motivations for abuse and considers whether to require the offending resident to participate in such interventions as a condition of access to programming or other benefits. The agency would only discipline residents for sexual conduct with staff only upon finding that the staff member did not consent to such contact. The agency prohibits disciplinary action for a report of sexual abuse made in good faith based upon a reasonable belief that the alleged conduct occurred, even if an investigation does not establish evidence sufficient to substantiate the allegation. The agency prohibits all sexual activity between residents, but does not deem such activity to constitute sexual abuse unless it determines that the activity is coerced. Compliance with this standard was verified by a review of policy and in interviews with investigators, the Deputy Warden, and the PREA Coordinator, although there were no substantiated allegations of resident-on-resident sexual abuse during the past 12 months, and therefore no residents subjected to discipline for such activity.

### 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.**

MRC resident victims of sexual abuse receive timely, unimpeded access to emergency medical treatment and crisis intervention services at area hospitals. The nature and scope of such services are determined by medical and mental health practitioners according to their professional judgment. If no qualified medical or mental health practitioners are on duty at the time a report of recent abuse is made, security staff first responders take preliminary steps to protect the victim pursuant to § 115.62 and immediately notify the appropriate medical and mental health practitioners. Resident victims of sexual abuse while incarcerated are offered timely information about and timely access to

emergency contraception and sexually transmitted infections prophylaxis, in accordance with professionally accepted standards of care, where medically appropriate. Treatment services are provided to every victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident. MRC residents have access to services in the regional area. Documentation and interviews indicate a victim of sexual abuse will be treated at whatever hospital they are transported to by a Sexual Abuse Nurse Examiner (SANE) from Honor Health. Since there were no incidents of sexual abuse reported in the past 12 months indicating a need for treatment, the auditor did not review documentation specific to the practice of this standard. However, interviews with first responders and administrators indicated a readiness and ability to follow this policy. Also, a review of policy indicated policies and procedures are consistent with this standard.

### **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.**

From a review of agency policy and training, and interviews with administrators, the auditor has verified that the facility offers medical and mental health evaluation and, as appropriate, treatment to all residents who have been victimized by sexual abuse in any prison, jail, lockup, or juvenile facility as required by this PREA Standard. The evaluation and treatment of such victims includes, as appropriate, follow-up services, treatment plans, and, when necessary, referrals for continued care following their transfer to, or placement in, other facilities, or their release from custody. The facility provides such victims with medical and mental health services consistent with the community level of care. This is an all male facility, so the portions of this standard relating to female residents do not apply. Treatment services are provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident. The facility documents attempts to conduct mental health evaluations of all known resident-on-resident abusers within 60 days of learning of such abuse history and offers treatment when deemed appropriate by mental health practitioners.

### **Standard 115.286 Sexual abuse incident reviews**

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

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

The Deputy Warden and the PREA Coordinator verify that the facility, according to policy, conducts a sexual abuse incident review, at the conclusion of every criminal or administrative sexual abuse investigation, unless the allegation has been determined to be unfounded. According to policy, the facility ordinarily conducts a sexual abuse incident review within 30 days of the conclusion of the criminal or administrative sexual abuse investigation. The sexual abuse incident review team is to include upper-level management officials and allows for input from line supervisors, investigators, and medical or mental health practitioners. The review team will: (1) Consider whether the allegation or investigation indicates a need to change policy or practice to better prevent, detect, or respond to sexual abuse; (2) Consider whether the incident or allegation was motivated by race; ethnicity; gender identity; lesbian, gay, bisexual, transgender, or intersex identification, status, or perceived status; or gang affiliation; or was motivated or otherwise caused by other group dynamics at the facility;

(3) Examine the area in the facility where the incident allegedly occurred to assess whether physical barriers in the area may enable abuse; (4) Assess the adequacy of staffing levels in that area during different shifts; (5) Assess whether monitoring technology should be deployed or augmented to supplement supervision by staff. The facility prepares a report of its findings from sexual abuse incident reviews, including but not necessarily limited to determinations made pursuant to this section, and any recommendations for improvement, and submits such report to the facility head and PREA Coordinator. None of these reviews were indicated or performed during the 12 months reviewed for this audit.

### 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.**

ADC collects accurate, uniform data for every allegation of sexual abuse using a standardized instrument and set of definitions. The standardized instrument includes the data necessary to answer all questions from the most recent version of the Survey of Sexual Violence conducted by the Department of Justice. The agency aggregates the incident-based sexual abuse data at least annually. The agency maintains, reviews, and collects data in reports. The agency reports to the Department of Justice as requested. Interviews with investigators, the PREA Coordinator and other administrators indicate all information is available for compilation and review. Record keeping and statistical evaluation appears to be taken seriously by the agency and the various divisions within the agency who collect and provide the information to the PREA Coordinator.

### 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.**

ADC reviews data collected and aggregated pursuant to §115.287 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, and training, including: (1) Identifying problem areas; (2) Taking corrective action on an ongoing basis; and (3) Preparing an annual report of its findings and corrective actions for the facility. The annual report includes a comparison of the current year's data and corrective actions with those from prior years. The annual report provides an assessment of the agency's progress in addressing sexual abuse. The agency makes its annual report readily available to the public at least annually through the ADC website. The reports are approved by the agency head. When the agency redacts material from an annual report for publication the redactions are limited to specific materials where publication would present a clear and specific threat to the safety and security of the facility. The agency indicates the nature of material redacted. Compliance with this standard was verified through a review of annual reports and documentation provided during the audit process. Interviews with the state's PREA Coordinator also indicated ongoing efforts to collect accurate data and to use the data to improve the system through effective processes to protect residents.

**Standard 115.289 Data storage, publication, and destruction**

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

**Auditor 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.**

Arizona Department of Corrections policy and procedure ensure that incident-based and aggregate data are securely retained, requiring that aggregated sexual abuse data be made readily available to the public, at least annually, and this is done through the their website, which the audit team found to be user friendly. They have published their policies as well as a variety of reports and statistics readily available at azcorrections.gov. Before making aggregated sexual abuse data publicly available, the agency removes all personal identifiers. The agency maintains sexual abuse data collected pursuant to §115.287 for at least 10 years after the date of initial collection, unless federal, state, or local law requires otherwise. Compliance with this standard was established through a review of the website, materials provided with the Pre-Audit Questionnaire, and interviews with administrators conducted during the audit.

**AUDITOR CERTIFICATION**

I certify that:

- X The contents of this report are accurate to the best of my knowledge.
- X No conflict of interest exists with respect to my ability to conduct an audit of the agency under review, and
- X 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.

David Will Weir \_\_\_\_\_

8-06-2017 \_\_\_\_\_

Auditor Signature

Date