PREA AUDIT REPORT ☐ **Interim** ☒ **Final**

ADULT PRISONS & JAILS

Date of report: April 10, 2017

Auditor Information			
Auditor name: Michele Morgenroth			
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Email: mmorgenroth@mt.gov			
Telephone number: 406-444-2828			
Date of facility visit: January 23-25, 2017			
Facility Information			
Facility name: Warm Springs Correctional Center			
Facility physical address: 3301 E. 5th Street, Carson City, NV 89701			
Facility mailing address: *(if different from above)* P.O. Box 7007 Carson City, NV 89702			
Facility telephone number: 775-684-3000			
The facility is:	☐ Federal	☒ State	☐ County
	☐ Military	☐ Municipal	☐ Private for profit
	☐ Private not for profit		
Facility type:	☒ Prison	☐ Jail	
Name of facility's Chief Executive Officer: Harold Wickham			
Number of staff assigned to the facility in the last 12 months: 12			
Designed facility capacity: 575			
Current population of facility: 558			
Facility security levels/inmate custody levels: Medium and Minimum			
Age range of the population: 18-78			
Name of PREA Compliance Manager: Traves Roberts		**Title:** Lieutenant	
Email address: troberts@doc.nv.gov		**Telephone number:** 775-684-3011	
Agency Information			
Name of agency: Nevada Department of Corrections			
Governing authority or parent agency: *(if applicable)* State of Nevada			
Physical address: 5500 Snyder Ave., Carson City, NV 89701			
Mailing address: *(if different from above)* P.O. Box 7000, Carson City, NV 89701			
Telephone number: 775-887-3285			
Agency Chief Executive Officer			
Name: James Dzurenda		**Title:** Director	
Email address: jdzurenda@doc.nv.gov		**Telephone number:** 702-486-9912	
Agency-Wide PREA Coordinator			
Name: Pamela Del Porto		**Title:** Inspector General	
Email address: pdelporto@doc.nv.gov		**Telephone number:** 775-887-3395	

AUDIT FINDINGS

NARRATIVE

This report describes the process and findings of a PREA Audit of the Warm Springs Correctional Center (WSCC) in Carson City, NV. The audit was conducted by Michele Morgenroth and Andrew Jess, Department of Justice PREA certified auditors. The onsite portion of the audit occurred January 23-25, 2017. Six weeks prior to the onsite visit, notification of the dates of the audit and the auditor's contact information was posted in all housing units and common areas of the prison. The auditor did not receive any letters from inmates at WSCC. Pre-audit documents were submitted by the facility and were reviewed by the auditor prior to the onsite portion of the audit. These documents included policies, procedures, training lesson plans, training records, logs, tracking sheets, reports, etc. As part of the pre-audit process, Just Detention International was contacted to determine if they had received any reports regarding the facility. Just Detention International responded with limited information of PREA-related allegations. However, without more specific details, the auditor was unable to pursue this information and it is therefore not included in this audit.

The onsite portion of the audit included a thorough inspection of the facility, including inmate housing units, recreation areas, kitchen and dining areas, medical unit, intake unit, education, visiting areas, etc. Camera placement was also included in the onsite tour. Staff and inmates were observed as they went about their daily routine and the auditors asked questions regarding possible blind spots, privacy of inmates, opposite gender announcements, supervisory rounds, etc.

Random and targeted interviews with both staff and inmates were conducted in a private office. Ten staff were randomly selected for interviews by the auditor from the current staff duty roster. This included case managers, program staff, and correctional officers from both the day shift and night shift. Inmates were randomly selected for interviews by the auditor from the unit roster lists to ensure each housing unit was represented in the inmate interviews. A total of 17 random inmates were interviewed. Targeted interviews were conducted with disabled inmates, limited English proficient inmates, and inmates who identified as LGBTI. Targeted interviews were conducted with staff in specific positions or with specific duties. This included: Deputy Director (designated by the Director), Warden, human resources staff, an investigator, PREA Coordinator, PREA Compliance Manager, medical and mental health staff, supervisory staff, intake staff, volunteers, and first responders. While onsite, the auditors also reviewed additional staff training records, investigation reports, and incident reviews.

Upon completion of the onsite portion of the audit, the auditors met with facility administrators, including the Warden, PREA Coordinator and PREA Compliance Manager and discussed initial impressions and findings. Any areas of concern and corrective actions are noted herein.

All standards were assessed for compliance based on review of documentation (policy, procedure, reports, logs, etc.), visual observation during the facility inspection, and interviews with both staff and inmates. Where policy or procedure is directly quoted, this is to show evidence of compliance with the standard where the facility or agency has clearly adopted the standard in written documentation and instruction to staff members.

DESCRIPTION OF FACILITY CHARACTERISTICS

Warm Springs Correctional Center (WSCC) was constructed in 1961. It has seen many uses and updates in its history, but its current function as an adult male medium custody facility dates back to July 2008. WSCC has 126 employees, 97 of which are sworn staff, and a capacity of 575 inmates with a current population of 558. WSCC provides programming including high school and adult basic education, college courses, substance abuse program, dog training program, reentry program, and a prison industry program.

The facility has several buildings that contain a total of 7 multiple occupancy cell housing units but does not have administrative or disciplinary segregation housing. Additional buildings house culinary arts, education, reentry programs, medical, kitchen and dining hall, and a gym. Each housing unit varies in design and layout. Some units have common bathrooms with separate showers and toilet stalls. Others have a common shower area with separate stalls and toilets in each cell.

The Nevada Department of Corrections (NDOC) has a centralized human resources office. NDOC also has investigators in the Inspector General's office who are trained to investigate all PREA related allegations, whether administrative or criminal, for all facilities.

SUMMARY OF AUDIT FINDINGS

All staff who were interviewed demonstrated a good understanding of their obligations regarding prevention, detection, reporting and response to sexual abuse and sexual harassment. It was evident that training on this subject is a priority of the facility. Staff were very cooperative and forthcoming in answering the auditor's questions. All inmates interviewed indicated they had received information regarding reporting sexual abuse and harassment upon entering the facility. Three inmates randomly selected to be interviewed refused to participate. However, they informed the auditor this was not due to any fear of reprisal or fear for their safety; they simply did not want to participate.

The interim audit report contained four standards that were not met. A required corrective action began on February 27, 2017. The facility submitted documents and information to the auditor for each standard initially found non-compliant. After reviewing the information provided, the facility has met all standards as of the date of this final audit report.

Three standards were not applicable: 115.12, 115.14, 115.66
All other standards were met.

Number of standards exceeded: 0

Number of standards met: 40

Number of standards not met: 0

Number of standards not applicable: 3

Standard 115.11 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.

115.11 (a): Administrative Regulation (AR) 421 Custodial Sexual Misconduct, Inmate Sexual Offenses and Prison Rape Elimination Act section 421.01 states the agency has zero tolerance for any form of sexual abuse and sexual harassment. The AR goes on to outline the agency's approach to preventing, detecting, and responding to such conduct, including information on criminal records checks, reporting, employee/volunteer/contractor training, inmate education, inmate screening, investigations, protection against retaliation, disciplinary action, etc. Operational Procedure (OP) 421 outlines the facility specific efforts to comply with PREA.

115.11 (b): The NDOC has designated an upper-level, agency-wide PREA Coordinator. Pamela Del Porto, the Inspector General, is the NDOC PREA Coordinator. She oversees PREA compliance in all NDOC facilities. She has sufficient authority to fulfill her duties as she reports directly to the NDOC Director. AR 421 section 421.02 outlines the PREA Coordinator's responsibilities.

115.11 (c): The facility has designated Traves Roberts, Lieutenant, as the PREA Compliance Manager. The Compliance Manager reports to the Warden of the facility. AR 421 section 421.03 and OP 421.03 outline the Compliance Manager's responsibilities. Lt. Roberts has sufficient time and authority to coordinate the facility's PREA efforts.

Based on the facility and agency's overall efforts to comply with PREA, the facility is compliant with this standard. This was evident in the knowledge of PREA expressed in staff and inmate interviews, and the emphasis on standard specific language in policies and procedures.

Standard 115.12 Contracting with other entities for the confinement of inmates

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

N/A: This standard is not applicable as the agency does not contract with other entities for the confinement of inmates.

Standard 115.13 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.

115.13 (a): AR 326 Posting of Shifts/Overtime outlines standards for minimum staffing and what to do if minimum staffing is not met. Section 326.04 requires an annual staffing plan review in collaboration with the PREA Coordinator, as required by the standard. The facility submitted a staff schedule which shows pull positions, shut down positions and positions which must be filled. During the onsite inspection, the auditors noted staff posted at necessary positions throughout the facility. OP 325 addresses minimum staffing at WSCC. It states that minimum staffing levels are reviewed and recalculated each year. This evaluation includes reviewing staffing levels from other institutions of similar populations and custody levels; any findings of inadequacy from investigations, audits, or court findings; the physical layout of WSCC; custody designations; location and number of supervisory staff; and workload of each shift such as programs, facility schedules, etc. Previous incidents of sexual abuse and harassment are also considered. Interviews with the Warden and PREA Compliance Manager indicated that all subsections of this standard are taken into consideration in the staffing plan and that it is reviewed on an annual basis.

115.13 (b): The facility OP 325 specifically outlines shutdown, pull positions, and overtime requirements. WSCC has not gone below minimum staffing and therefore have not had any circumstances where they did not comply with the staffing plan. The facility reports no deviations from the plan. Deviations would be documented in Nevada Offender Tracking Information System (NOTIS).

115.13 (c): A staffing plan review was conducted in September 2016. Documentation of this review showing the signature of the NDOC Director and PREA Coordinator was provided to the auditors. All elements required in 115.13 (c) were included in the staffing plan review. The PREA Coordinator reported in her interview that these reviews are completed annually.

115.13 (d): As evidence to support compliance with this standard, OP 400 states "institutional/tours will be conducted regularly on all shifts by either a sergeant or lieutenant and proper documentation generated…These tours will be unannounced and no efforts will be made to alert staff to the presence of supervisors." Documentation was provided to the auditors showing unannounced rounds for 04/01/16 - 4/30/16, 05/17/16, and 09/01/16 - 09/30/16. Intermediate and supervisory staff interviewed verified they complete these rounds, that they are unannounced, and that staff are prohibited from alerting other staff that rounds are being conducted.

Standard 115.14 Youthful inmates

☐ 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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N/A: The facility does not house youthful inmates.

Standard 115.15 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.

115.15 (a): OP 422 section 422.01 states all unclothed body searches will be conducted by a staff member that is the same gender as the inmate. The procedure also states that, other than qualified medical staff members, personnel will not conduct unclothed body searches of an inmate of the opposite gender, except in emergency, i.e. riot, escapes, etc. These situations will be logged in Nevada Offender Tracking Information System (NOTIS). AR 422 states intrusive body cavity searches will only be performed by a licensed medical professional. All staff who were interviewed verified that cross-gender strip searches are not conducted except in exigent circumstances.

115.15 (b): Not applicable as this facility does not house female inmates.

115.15 (c): OP 422 states unclothed body searches will be conducted by a staff member of the same gender as the inmate and only conducted by someone of the opposite gender when it is an emergency situation, which will be logged in NOTIS. The facility reports that there have been no circumstances since the last audit where a cross-gender strip search was conducted.

115.15 (d): WSCC states they have not had any exigent circumstances relevant to this standard. OP 400 section 400.02.1 states that female staff will be announced and the announcement will be documented in the shift log. Section 400.02.3.E states staff will not loiter in areas where inmates are unclothed or partially unclothed or performing bodily functions other than what is necessary to complete their duties. Staff and inmates reported in interviews that female staff consistently announce their presence in the housing units. Inmates report that they are able to shower, change clothing, and use the toilet without being viewed by staff of the opposite gender. While onsite, the auditors observed female staff being announced when they entered housing units. The auditors witnessed onsite that all showers have privacy curtains which allow staff to see that an inmate is in the shower, while still allowing privacy.

Unit 1B has a common bathroom for inmates. While onsite, the auditors observed that this bathroom had no door or privacy curtain and that toilets were openly exposed to staff as they walked down the hallway. This was brought to the attention of Lt. Roberts who immediately corrected this exposure by adding a curtain to the bathroom entrance. Lt. Roberts also submitted pictures of the curtain to document corrective action. No further corrective action is needed.

115.15 (e): OP 422 section 422.01 1.C states "searches will never be used to harass or to determine the genital status of inmates," which supports compliance with this standard. Staff report searches are only used for security purposes and never to determine genital status. Transgender inmates who were interviewed reported that they have never been searched for the purpose of determining their genital status.

115.15 (f): All staff are trained on cross-gender pat searches and searches of transgender and intersex inmates. The auditors reviewed the NDOC Staff PREA Training presentation as well as training acknowledgement forms. All staff interviewed reported they were trained on how to conduct cross-gender pat searches in a professional and respectful manner.

Standard 115.16 Inmates with disabilities and inmates 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.

115.16 (a): AR 421 section 421.07.3 states all inmates will be afforded education in formats accessible to everyone, including limited English proficient, deaf, visually impaired, or otherwise disabled, as well as to inmates who have limited reading skills. The inmate training acknowledgement form, PREA Q&A section of the inmate handbook, and PREA risk assessment screening form are available in Spanish as Spanish is the second most predominant language at the facility. The PREA: What You Need to Know video transcript is available to inmates. Posters with information about PREA and reporting methods were displayed throughout the facility in both English and Spanish. WSCC provided the auditors with a list of staff who speak Spanish and are available to translate. The PREA Q&A in Spanish initially

provided to the auditors did not have the New Mexico outside reporting address but this was corrected while the auditors were onsite and a new copy with the NM address was provided to the auditors. Inmates who are limited English proficient and one inmate with limited hearing abilities were interviewed and all expressed an understanding of PREA, their rights to be free from sexual abuse and harassment, and the methods available for reporting.

115.16 (b): The State of Nevada has a contract with Corporate Translation Services (CTS) which provides immediate, 24/7 translation services in 100+ languages. Staff and limited English proficient inmates identified that staff are available to help interpret when needed.

115.16 (c): OP 121 section 121.01.6 states that inmate interpreters will not be used when collecting information about sexual abuse or sexual harassment and that only staff interpreters will be used. All staff interviewed stated that they would not use an inmate to interpret but that staff interpreters and the CTS is available.

Standard 115.17 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.

115.17 (a): AR 300 states the agency will not hire anyone who will have contact with inmates who meets the criteria listed in 115.17(a). It also states all applicants considered for promotion must pass the NCIC background check. AR 212 states that Department contracts will be processed in compliance with PREA federal mandates. Both the Inspector General and human resources staff verified that background checks are completed. The auditors reviewed 4 agency background checks for staff, including new hires and promotions. These were randomly selected by the auditors from a list of new hires, re-hires, and promotions from the last year.

115.17 (b): A human resources staff member was interviewed and he stated that the agency does consider prior incidents of sexual harassment in determining whether to hire or promote someone. This consideration includes the nature and circumstances of the incident, when and where it occurred, etc.

115.17 (c): AR 300 states employment is contingent upon successful completion of a background check, including but not limited to an NCIC check. The agency provided an example of a letter they send to previous institutional employers asking for information on substantiated allegations of sexual abuse or if the employee resigned pending an investigation.

115.17 (d): AR 212 states that Department contracts will be processed in compliance with PREA federal mandates and all contractors will be required to pass background checks. Both the Inspector General and human resources staff verified that background checks are completed.

115.17 (e): AR 300 states employees must pass periodic post-hire background checks. AR 212 states mandatory background checks will be conducted on contractors/vendors no less than every 3 years. The Contracts unit maintains documentation of these background checks. Human resources staff and the Inspector General verified that NDOC completes employee background checks every three years to coincide with the PREA 3 year audit schedule.

115.17 (f): DOC 1057 PREA Questionnaire is required in interview packets. The questionnaire asks the questions related to section (f) of this standard. However, these questions are not asked again during the employee performance review process. Human resources staff reported that the employee appraisal process must include a discussion between the employee and his/her supervisor (also noted on Employee Appraisal & Development Report form). Because an interview is part of this process, the agency must comply with this standard. See the FAQ for this standard dated Sept. 29, 2015 for further clarification from the PREA Resource Center. AR 339 Employee Code of Ethics and Conduct states "failure to report, failure to act, or failure to disclose is considered misconduct." The human resources staff member interviewed confirmed that the agency imposes a continuing affirmative duty to disclose misconduct.

The PREA Coordinator responded on 02/07/17 that as of 02/06/17, all current staff are given the DOC 1057 PREA Questionnaire to fill out during In Service Training, which occurs annually. This will ensure every employee answers these questions annually, regardless of if they

receive a yearly performance evaluation. The signed documents will be maintained within NOTIS in the IR record for their on going background checks and with the training file for the employee. The facility has begun this process with staff who are currently going through the In Service Training.

115.17 (g): AR 339 states falsification of application for employment or other personnel forms is a Class 5 offense which results in termination.

115.17 (h): See Nevada Administrative Rules 284.718 and 284.726 which governs the release of employee information.

Corrective Action Plan:
(f) The facility must provide the auditor with completed and signed DOC 1057 PREA Questionnaires from 12 staff randomly selected by the auditor. This must be provided to the auditor no later than 5 months from the facility's receipt of this interim report to allow the auditor sufficient time to review the provided documents. The facility will be determined compliant when these forms are complete and submitted per the auditor's recommendation.

Corrective Action:
As confirmed by the PREA Compliance Manager, all staff at WSCC have completed and signed DOC 1057 PREA Questionnaires. The form will now be completed annually by all staff when they attend their mandatory annual training. The auditor randomly selected 12 staff from the shift rosters and reviewed the completed and signed forms for all 12 staff. The PREA Coordinator also submitted completed and signed DOC 1057 PREA Questionnaires from five agency staff members to show this is being completed across the agency.

Standard 115.18 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.

115.18 (a): A new building was acquired by WSCC which is owned and staffed by the Carson City School District to provide a culinary arts program for the general population. All functions of the building fall under the ARs of NDOC and OPs of WSCC. When this building was brought in, the facility assessed their staffing plan and made necessary adjustments. They also ensured the new building was equipped with phones, radios and other necessary equipment. This new building was included in the onsite inspection and no deficiencies or concerns were noted by the auditors.

115.18 (b): The facility has not installed or updated monitoring or surveillance systems since their last audit.

Standard 115.21 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.

115.21 (a): The evidence protocol used by the facility is "A National Protocol for Sexual Assault Medical Forensic Examinations Adults/Adolescents, Second Edition" from the DOJ Office on Violence Against Women. The facility also utilizes "Recommendations for Administrators of Prisons, Jails, and Community Confinement Facilities for Adapting the U.S. Department of Justice's A National Protocol for Sexual Assault Medical Forensic Examinations Adults/Adolescents."

115.21 (b): See (a) above.

115.21 (c): OP 421 section 421.10.3 states medical services and treatment will be provided to victims of sexual abuse at no cost regardless of whether the victim names abusers or cooperates with any investigation. OP 458 states that victims will be offered forensic medical examination and transported to the Sexual Assault Support Services in Reno, NV and that it will be performed by a certified SANE. This process was verified during staff interviews, including the medical and mental health staff interviews. The facility reports that no forensic medical exams were required or performed in the last 12 months.

115.21 (d): NDOC has a Memorandum of Understanding (MOU) with the Crisis Call Center, Inc. to provide a victim advocate to accompany and support a victim through a forensic medical exam.

115.21 (e): OP 458 states the victim advocate will accompany the inmate through the medical examination and investigation process and will offer support as needed. The MOU with the Crisis Call Center, Inc. outlines these responsibilities as well.

115.21 (f): n/a – the agency conducts all investigations

115.21 (g): n/a – the agency conducts all investigations

115.21 (h): A review of the Crisis Call Center website shows that they are accredited or certified by several entities.

Standard 115.22 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.

115.22 (a): The Inspector General is responsible for conducting or assigning investigations related to sexual abuse or sexual harassment, both criminal and administrative. Investigators report that all allegations are investigated no matter the source of the information.

115.22 (b): AR 457 designates the Inspector General (IG) as the responsible entity to conduct investigations. AR 421 specifically states the IG will investigate allegations of sexual abuse and sexual harassment. Both ARs are found on the NDOC website at http://doc.nv.gov/About/Administrative_Regulations/Administrative_Regulations__400_Series/. All referrals are documented in NOTIS and kept on the "PREA tracking sheet" by the facility, which was reviewed by the auditors. Staff at the facility verified in interviews that they report all allegations to the IG's office.

115.22 (c): n/a – the agency conducts all investigations

115.22 (d): AR 457 governs investigations. As stated in AR 457 and confirmed by staff in the IG's office, the Inspector General determines the need for an investigation, the type/methodology of the investigation, and which staff are responsible for the investigation.

115.22 (e): n/a – the agency conducts all investigations

Standard 115.31 Employee training

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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115.31 (a): The NDOC Pre-Service Training includes a 4 hour PREA class. The lesson plan for this class was reviewed and contains all required elements of 115.31 (a). All staff interviewed demonstrated a good understanding of their responsibilities regarding prevention, detection, reporting, and response to sexual abuse and sexual harassment.

115.31 (b): The training provided has specific sections for the dynamics of sexual abuse in men's and women's facilities.

115.31 (c): AR 421.05.1 states all employees will have instruction on the requirements and responsibilities of PREA every 2 years with refresher training on current PREA policies in the interim years. All staff reported being trained in the topics outlined in this standard, both upon hire and annually.

115.31 (d): NDOC PREA training acknowledgement forms were reviewed for five randomly selected staff members.

The auditors were satisfied the facility is compliant with this standard given the familiarity and knowledge of PREA demonstrated in staff interviews, staff verification of ongoing PREA training, and thorough coverage of the requirements of this standard in the training documentation.

Standard 115.32 Volunteer and contractor training

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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115.32 (a): AR 421 requires that all volunteers and contractors receive training on their responsibilities regarding sexual abuse and sexual harassment. Two volunteers were interviewed and stated that they had been trained in these responsibilities. They accurately described prevention, detection, response and reporting mechanisms.

115.32 (b): The sergeant responsible for staff, contractor and volunteer training stated that all individuals who have contact with inmates are trained prior to having contact with inmates. Volunteers and contractors receive training very similar to employees but it is guided by the level of contact they have with inmates and the services they provide. The volunteer and contractor training presentation was reviewed by the auditor and it includes all information required by this standard.

115.32 (c): The signed Volunteer Training/Orientation Acknowledgement Form for two volunteers was requested from the facility but these documents have not yet been provided.

Corrective Action Plan:
(c) The facility must provide the auditor with the signed Volunteer Training/Orientation Acknowledgement forms requested. If acknowledgement forms have not been signed by volunteers, the facility will need to ensure all current volunteers sign the form. This documentation must be provided to the auditor no later than 5 months from the facility's receipt of this interim report to allow the auditor sufficient time to review the provided documents. The facility will be determined compliant when they meet all requirements of this standard.

Corrective Action:
The two Volunteer Training/Orientation Acknowledgement Forms requested were provided to the auditor. The forms were signed and dated by the volunteers indicating they had attended volunteer training which covered general PREA information, the agency's zero tolerance policy, how to avoid inappropriate relationships with inmates, how to report and that they understood their responsibilities as a volunteer.

Standard 115.33 Inmate 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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115.33 (a): AR 421 dictates inmates will receive orientation on the Department's zero-tolerance policy and reporting at initial intake. OP 504 states inmates will watch a PREA education information video upon arrival. All inmates interviewed reported receiving this information immediately upon their arrival at the facility. The intake case manager was interviewed and she stated that all inmates are informed of the zero-tolerance policy and reporting methods on the day they arrive. Inmates are provided with a pamphlet and inmate orientation handbook with this information.

115.33 (b): AR 421 dictates inmates will be provided comprehensive education within 30 days of intake. OP 421 states the Property Sergeant is responsible to provide the education required by standard 115.33 (b) within 30 days of intake. In practice, the comprehensive education typically takes place the same day that inmates arrive at the facility. All inmates interviewed reported receiving this information the day they arrived. The intake case manager stated that inmates watch a video and review this information with her.

115.33 (c): All inmates at the facility have received this education as all have either arrived at the facility or been transferred to the facility after the implementation of PREA. An inmate was interviewed who stated he has been in the prison system for over 40 years and he has received this information.

115.33 (d): Both the AR and OP state that education will be provided in formats accessible to everyone. The video reviewed at intake is closed-captioned, available in Spanish and available in Braille. Forms and other information are available in Spanish. Spanish speaking staff are available to translate as well as the contracted translation service.

115.33 (e): Documentation is maintained in NOTIS. Inmates sign the NDOC PREA Comprehensive Education acknowledgement form. This form was reviewed for four randomly selected inmates.

115.33 (f): Inmates are issued an inmate handbook upon arrival which contains pertinent reporting information. During the onsite inspection, posters with key information in both English and Spanish were posted throughout the facility.

Standard 115.34 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.

115.34 (a): AR 421 states all staff assigned to investigate allegations related to PREA will receive specialized training. An investigator was interviewed and he stated he had been trained to conduct sexual abuse investigations in confinement settings.

115.34 (b): AR 421 states all investigative staff will be trained on techniques for interviewing sexual abuse victims, Miranda and Garrity warnings, evidence collection, and evidenciary criteria. An agency investigator was interviewed who verified that he was trained in all the topics required by this standard as well as the general training required of all staff.

115.34 (c): Training records were reviewed for all agency investigators showing they completed the National Institute of Corrections PREA: Investigating Sexual Abuse in a Confinement Setting course.

115.34 (d): see (a) through (c)

Compliance with this standard was determined by interviews with an investigator and the Inspector General verifying that investigators have been trained in how to conduct sexual abuse investigations in confinement settings, review of training records for all agency investigators, and supported language in policy.

Standard 115.35 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.

115.35 (a): OP 613 requires that all medical and mental health staff complete annual training on the elements required in standard 115.35 (a). Interviews with medical and mental health staff support that this training is provided.

115.35 (b): n/a – The facility medical staff do not conduct forensic exams; inmates are transported to Sexual Assault Support Services in Reno.

115.35 (c): Training records were reviewed for medical and mental health staff showing course completion for PREA: Medical Health Care for Sexual Assault Victims in Confinement Setting and PREA: Behavioral Health Care for Sexual Assault Victims in a Confinement Setting both presented by the National Institute of Corrections.

115.35 (d): Training records were reviewed which show medical and mental health staff receive the same training as all staff. Medical and mental health staff who were interviewed stated they receive the same training as all other staff in addition to the specialized training.

Standard 115.41 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.

115.41 (a): AR 421 and AR 573 state all inmates will be assessed during an intake screening and upon transfer to another facility for their risk of being sexually abused by or abusive toward other inmates. OP 421 states inmates will meet with a caseworker who will assess incoming inmates during an intake screening. The intake case worker stated she screens all inmates during intake, typically within the first day.

115.41 (b): OP 421 states the screening with the caseworker will occur within 72 hours of arrival. AR 573 requires that inmates are not to be housed in two-man cells prior to PREA screening. OP 504 states inmates received during non-business hours will be placed into screening cells until the next business day. The intake case manager stated in her interview that all inmates are screened within 72 hours and typically within the first day after arrival.

115.41 (c), (d) and (e): The NDOC PREA Risk Assessment is an objective screening instrument that contains all requirements of 115.41 (d) and (e). It includes the following factors: former victim of correctional rape or sexual assault (adult or juvenile); whether the inmate has a mental, physical or developmental disability; age of inmate; physical build; first incarceration or prior incarcerations; criminal history is exclusively non-violent; prior convictions for sex offenses against an adult or child; LGBTI or gender non-conforming (admitted or perceived); previously experienced sexual victimization; presents as or claims vulnerability; prior acts of institutional sexual abuse; prior convictions for violent offenses; history of institutional violence. The facility does not detain anyone solely for civil immigration purposes. Inmates stated in interviews that they recalled being asked these questions soon after arrival at the facility.

115.41 (f): The same screening instrument mentioned above is used for reassessments. AR 573 states inmates will be reassessed within 30 days of arrival by a correctional caseworker, including additional information received since the initial screening. OP 504 also states that the reassessment will be completed within 30 days of the inmate's arrival. The intake case manager verified in her interview that this reassessment is completed as outlined in the policy and procedure. Reassessments were reviewed by the auditors for three randomly selected inmates. The facility utilizes a PREA Risk Assessment tracking sheet. It includes each inmate's name, date they were received at the facility (and thus the date the initial assessment was completed), when the 30 day reassessment is due, who it was completed by and what day the 30 day reassessment was actually completed. The sheet also notes if the inmate was transferred out of the facility prior to the 30 day reassessment.

115.41 (g): AR 573 states inmates will be reassessed when warranted. The intake case manager verified in her interview that reassessments will be conducted due to a referral, request, incident, or receipt of additional information.

115.41 (h): AR 573 states inmates may not be disciplined for not answering questions during assessments and it was verified during interviews that inmates are not disciplined.

115.41 (i): Completion of the risk assessment is noted in NOTIS along with a reference to an alert when applicable. The hard copy of the assessment is kept in the inmate's "I" file which is only accessible to individuals with a need to know.

Based on interviews with staff and inmates onsite, documentation in the form of policy, procedures, and the risk assessment instrument, and review of completed assessments, the facility is compliant with this standard.

Standard 115.42 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.

115.42 (a): AR 573 states the results of the risk assessment will be considered in classification and placement decisions and the information will be used to make informed housing, bed, work, education, and program assignments to keep inmates at high risk of being sexually victimized separate from those at high risk of being sexually abusive. Similar language is found in OP 504. However, both the intake case manager and PREA Compliance Manager reported that screening information is only used in housing assignments and is not considered in work, program or education assignments.

115.42 (b): AR 573 dictates that staff make individualized determinations about how to ensure the safety of each inmate.

115.42 (c): The Inspector General, who is also the NDOC PREA Coordinator, stated in her interview that transgender and intersex inmates are reviewed individually to determine the best and safest housing while taking into account the view point of the inmate. This includes reviewing information from medical and mental health staff and Central Office Offender Management. She reported that AR 573 is being revised to include information on this process of making individualized assessments.

115.42 (d): AR 573 states all inmates are reassessed every 6 months. This was verified in several staff interviews.

115.42 (e): Two transgender inmates were interviewed who reported they do not feel the facility considers their views with respect to their safety. Both indicated that they had not been asked questions regarding their safety. One transgender inmate reported not feeling comfortable taking a shower and feeling discriminated against by both inmates and officers because of comments that are made. Additionally, the facility has a policy of conducting health and welfare checks on all inmates in which they are required to strip down to their boxers in order for officers to check for injuries. Some inmates and staff reported that transgender inmates are allowed to keep their shirts on during this process, but other staff and inmates reported that transgender inmates are not allowed to keep their shirts on. A sergeant reported that the procedure is to allow transgender inmates to keep their shirts on during this process.

115.42 (f): The facility showers are separated by walls. Privacy curtains cover the front of each shower. Although inmates are allowed to shower separately based on the physical structure, the reports of transgender inmates as described in (e) above indicate that they do not feel safe. Therefore, safety in the shower area needs to be taken into consideration in addressing (e).

115.42 (g): OP 501 states inmates identified as LGBTI will not be housed in any dedicated unit or wing solely on the basis of such identification. Interviews with inmates and staff supported that LGBTI inmates are not housed in dedicated facilities, units or wings.

Corrective Action Plan:

(a) The facility must utilize the information from risk screenings to make informed decisions regarding work, program and education assignments. This can be individualized to ensure the safety of each individual inmate. Corrective action may include such things as inform staff members who are supervising a known victim and known abuser who are required to participate in the same assignments; assign these inmates to different groups; increase staff supervision to an area; stagger participation, etc. The facility must identify with the auditor a specific plan for utilizing the information from risk screening while still complying with 115.41(i). This must include training the staff involved in completing assessments and making program placement decisions. This must be completed and documentation provided to the auditor no later than 5 months from the facility's receipt of this interim report to allow the auditor sufficient time to review the provided documents.

(e) Although the facility currently reassesses inmates every six months, the facility must establish a more thorough process by which transgender and intersex inmates are assessed and asked specific questions regarding their safety. This should include questions about housing and showers. Concerns raised during these interviews should be considered on a case-by-case basis, taking into consideration both the inmate's health and safety and management and security problems. Documentation that this more thorough assessment has been conducted for current transgender and intersex inmates must be provided to the auditor. Additionally, the facility should establish a formal written procedure that creates consistency for how transgender inmates are searched during health and welfare checks and ensure that all staff are trained in the procedure. This must be completed and documentation provided to the auditor no later than 5 months from the facility's receipt of this interim report to allow the auditor sufficient time to review the provided documents.

Corrective Action:

(a) WSCC OP 504 Reception of Inmates at WSCC has been updated to comply with this standard. The update to the procedure states that casework staff will make individualized determinations about how to ensure the safety of each inmate to include housing and

programming assignments. Casework staff will assign known abusers and inmates identified as being at high risk for sexual assault to different work groups, program sessions, or class sessions, if available. The casework staff will advise any work supervisor, program administrator, or education provider any time that a known abuser and an inmate at high risk are assigned to the same work assignment, program session or education class. The shift supervisor will also be advised of any such assignments so that custody staff can make more frequent patrols of the area. The OP also states that this information will remain confidential and the work supervisor, program administrator, education provider, and shift supervisor will not disseminate the information to other staff or inmates. All caseworkers received supplemental training on this specific update to operational procedure on 03/22/17. Acknowledgement forms for this training for the four caseworkers and the Associate Warden were submitted to the auditor.

(e) WSCC OP 504 has been updated to comply with this standard. The update to the procedure states that during assessments of all LGBTI inmates, the inmate will be specifically asked if they feel safe in their housing assignments and if they feel safe while showering in their assigned unit. If an LGBTI inmate expresses concern for their safety, the caseworker will advise the PREA Compliance Manager and the Associate Warden who will meet with the inmate to develop a plan to insure the inmate's safety. All caseworkers received supplemental training on this specific update to operational procedure on 3/22/17. Acknowledgement forms for this training for the four caseworkers and the Associate Warden were submitted to the auditor.

On 02/02/17 all LGBTI inmates assigned to WSCC were interviewed by the PREA Compliance Manager, the Associate Warden, and the Warden. All inmates were questioned specifically about their perceived safety in regards to their housing assignments and their ability to safely shower in their unit. All inmates stated they had no safety concerns at this time. Case notes of these interviews were provided to the auditor.

WSCC OP 418 Main Control Operations and Count Procedures and OP 422 Searches have been updated to clarify how health and welfare counts and searches are conducted on all inmates, including transgender and intersex inmates. The updated procedures state that during a health and welfare check all inmates will remove all clothing except their underclothing. Transgender and intersex inmates will keep their bra and/or t-shirt on during the check. As confirmed by the PREA Compliance Manager, as of 03/30/17 all staff have received supplemental training on these updates.

Standard 115.43 Protective custody

☐ 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.

OP 501 states inmates identified as being at high risk of being sexually abused will not be placed in involuntary segregation and other available alternatives will be used. Based on staff interviews, this could include housing unit changes within the facility or transfer to a more suitable facility. OP 507 states inmates placed in administrative segregation for any reason are seen for an initial classification hearing within 3 working days. Administrative segregation at WSCC is for short term purposes only. Any long term assignment to administrative segregation is served in other facilities. WSCC does not have an administrative segregation unit. Anyone needing to be confined for administrative or disciplinary reasons until they can be moved to a more secure facility is housed in a single person cell.

Standard 115.51 Inmate 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.

115.51 (a): AR 421 and OP 421 provide for multiple reporting methods. Inmates can report verbally to staff, in written form through the grievance process, kites or letters, and by phone. In interviews, both inmates and staff identified multiple ways for reports to be made. All inmate phones have a message as soon as they pick up the phone with directions on how to make a report via phone. This was both reported by inmates and verified by the auditors during the onsite inspection. Addresses are posted throughout the facility for inmates to send reports by mail.

115.51 (b): Inmates can send a letter to report abuse or harassment to the New Mexico Department of Corrections PREA Coordinator. The address is provided to inmates in the inmate orientation handbook and on PREA posters, noted throughout the facility by the auditors. The auditors verified with staff that outgoing mail is not screened by the facility. When the New Mexico PREA Coordinator receives a report she immediately notifies the NDOC Inspector General's office.

115.51 (c): All reports, regardless of how they are received are documented and reported. All reports are forwarded to the Office of the Inspector General. This was verified in all staff interviews.

115.51 (d): Staff can report privately on the NDOC website. They can also contact the New Mexico DOC PREA Coordinator or the NDOC Inspector General. All staff interviewed verified that they have several methods by which they can report.

Standard 115.52 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.

115.52 (a): n/a – the agency has administrative procedures for addressing inmate grievances

115.52 (b): AR 740.03.7.A "Time frames are waived for allegations of sexual abuse, regardless of when the incident is alleged to have occurred." AR 740.04.1.B "Inmates are not required to use an informal grievance process, or to otherwise attempt to resolve with staff, an alleged incident of sexual abuse."

115.52 (c): AR 740.04.1.A "Allegations of sexual abuse will not be referred to a staff member who is the subject of the accusation of sexual abuse." If the person who would normally respond to a grievance is the subject of the grievance, the CCS III/AW will respond to the grievance.

115.52 (d): AR 740 outlines the NDOC grievance process. In this, the IG's office is required to make a final decision on the merits of a sexual abuse grievance within 90 days of the initial filing of the grievance. The IG's office may claim a 70 day extension but will notify the inmate in writing of any extension and provide the inmate with the date by which a decision will be made. OP 740 states an inmate may consider the absence of a response to be a denial at that level.

115.52 (e): AR 740 states that third parties can assist inmates in filing a grievance or file one on the inmate's behalf. Third party reporting of sexual abuse against an inmate is referred to the Warden or designee. The alleged victim is interviewed to determine if they wish to pursue administrative remedies. This is documented in NOTIS.

115.52 (f): AR 740.10 outlines the process for emergency grievances. Any emergency grievance alleging sexual abuse is immediately

forwarded to the highest ranking staff on duty so that they can take immediate action. The inmate receives an initial response within 48 hours and a final decision is made within 5 calendar days. The initial response and final decision are documented with action taken in response to the grievance.

115.52 (g): OP 740 "Inmates filing grievances alleging sexual abuse will not be disciplined unless is can be proven that the inmate filed the grievance in bad faith having full knowledge that the allegations were false."

Interviews with the Inspector General and facility staff, including the grievance coordinator, verified the process outlined in the policy and procedure. All grievances related to sexual abuse and sexual harassment are forwarded to the Inspector General's office for investigation and response. Facility staff verified that emergency grievances are forwarded to the highest ranking staff on duty.

Standard 115.53 Inmate 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.

115.53 (a): NDOC has a MOU with the Crisis Call Center, Inc. (CCC) in Reno which establishes that CCC advocates will provide emotional support services, crisis intervention, information and referrals to inmates who are victims of sexual abuse. A similar MOU exists with the Rape Crisis Center in Las Vegas. On 02/09/17, the auditors conducted a phone interview with representatives of the Rape Crisis Center. They described the services provided to inmates are guided by what the inmate needs and the logistics of what the Rape Crisis Center can provide. This may include providing support groups at a facility, sending support group workbooks by mail, sending reading material and books, or otherwise corresponding by mail. If an inmate has reported abuse and is going through the investigation process, they will advise them on what to expect during the process.

Contact information for these two entities is not made openly available to inmates. The Rape Crisis Center is mentioned in the inmate orientation handbook, but contact information is not provided. The address for the Rape Crisis Center is available on the PREA Victim Advocacy and Emotional Support Services poster which was only observed in the facility by the auditors in one location. However, while the auditors were still onsite, the PREA Compliance Manager ensured this information was also posted in each case manager's office. In interviews, several inmates reported not knowing about these services.

115.53 (b): The inmate handbook states that phone calls to these services are recorded but only reviewed by staff of the Inspector General's office. The poster with the contact information for the Rape Crisis Center was updated while the auditors were onsite to state that these phone calls are recorded.

115.53 (c): The agency has an MOU with the Crisis Call Center, Inc. and the Rape Crisis Center.

Corrective Action Plan:

(a) As this standard relates to confidential support services for any victim of sexual abuse and is separate from the standard requiring an outside reporting mechanism, the facility must make the contact information more available to inmates. Since the Rape Crisis Center is already mentioned in the inmate handbook, the auditor recommends the facility add to the handbook instructions for how to contact them. This must be completed and documentation provided to the auditor no later than 5 months from the facility's receipt of this interim report to allow the auditor sufficient time to review the provided documents. The facility will be determined compliant when the handbook is updated per the auditor's recommendation.

Corrective Action:
The WSCC Inmate Orientation Handbook has been updated to include the contact information for the Rape Crisis Center and was provided to the auditor. As confirmed by the PREA Compliance Manager, the updated handbook is now being distributed to all inmates received at WSCC.

Standard 115.54 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.

NDOC has a public website with information for third party reporting. Third parties can click a link which sends a report to the Office of the Inspector General, PREA Management Division. This link allows the sender to remain anonymous. The auditors submitted a test report on 12/28/2016 at 4:05pm and received a response on 12/29/2016 at 8:08am. The website also has a phone number, mailing address and an email address for third parties to make a report.

Standard 115.61 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.

115.61 (a): AR 421 and OP 421 require all staff to report anything regarding sexual abuse or sexual harassment. All staff interviewed stated that they are required to report.

115.61 (b): AR 421 and OP 421 require that information be kept confidential and shared only with those with a need or right to know. Interviews supported that staff understand information regarding sexual abuse and sexual harassment should only be shared with individuals with a need to know.

115.61 (c): OP 613 requires medical staff to report to the shift commander if an inmate reports being the victim of sexual abuse during incarceration. It also requires medical and mental health staff to obtain informed consent before reporting information about prior sexual victimization. In interviews, medical and mental health staff stated that they are required to report and that they obtain informed consent.

115.61 (d): The facility and/or the Inspector General's office ensures that all appropriate reports are made under mandatory reporting laws. This was verified in interviews.

115.61 (e): AR 421 and OP 421 require third party and anonymous reports be reported to the IG's office to be investigated. Investigation staff verified that all reports, regardless of the source, are investigated.

Standard 115.62 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.

NDOC has an emergency grievance process to ensure grievances alleging an inmate is subject to substantial risk of imminent sexual abuse are processed immediately. These are forwarded to the highest ranking staff on duty to assess the situation. Victim safety is assessed and they are separated from aggressors or possible aggressors. All reports of sexual abuse are immediately submitted to the IG's office. All staff interviewed reported that upon learning an inmate is at imminent risk of sexual abuse, they would take immediate action to protect the inmate.

Standard 115.63 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.

115.63 (a): AR 421 requires that reports of incidents that happened in another facility be reported to the Inspector General's PREA Management Office. OP 121 states the WSCC Warden will notify the head of the facility where the alleged abuse occurred. These documents state that the PREA Coordinator will also ensure a report is made to the administrator of the facility where the alleged abuse occurred. The PREA Coordinator confirmed this in her interview.

115.63 (b): AR 421 and OP 121 require that the report be made as soon as possible but no later than 72 hours after the allegation is made.

115.63 (c): OP 121 requires that the notification be documented in NOTIS. During interviews, staff confirmed that all reports, regardless of the source are documented.

115.63 (d): During the Warden's interview, he stated that if his facility receives a notification from another facility, they ensure the victim's safety and go through all the appropriate protocols for reporting, investigations, medical and mental health, etc. If the victim is no longer in their facility, they will also notify the facility housing the alleged victim.

Standard 115.64 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.

115.64 (a): OP 458 Crime Scene Procedures and the NDOC Crime Scene Preservation and Investigation Manual outline requirements for responding to any crime or incident, including separating the victim and abuser, protecting evidence and ensuring the alleged abuser does not destroy evidence. The facility utilizes a flow chart which depicts the steps staff must take when they receive a report of sexual abuse.

115.64 (b): All staff are trained in the protocols required by this standard. Every staff who was interviewed, whether they were security staff or non-security staff, accurately described first responder duties and had a clear understanding of their responsibilities to separate the victim and abuser, protect evidence, and make necessary reports.

Standard 115.65 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.

OP 458 establishes crime scene procedures. The facility also uses an incident flow chart and Forms A, B and C. Form A guides the shift supervisor and serves as the initial documentation of who the alleged victim is, who the alleged aggressor is and basic information about the potential assault. Forms B and C direct staff on the steps to take depending on if the abuse occurred within a time period that allows for collection of evidence. Together these documents serve as a response plan and a step by step process for staff to follow when an incident occurs. The plan includes notification to shift supervisor, medical care for injuries, forensic medical examinations, provision of a victim advocate, preservation of evidence, notification to mental health staff, and reports and notification to facility administration and the Inspector General's office. Staff are trained in this process and all staff interviewed demonstrated a good understanding of how to respond to an incident.

Standard 115.66 Preservation of ability to protect inmates from contact with abusers

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

N/A: The NDOC and State of Nevada do not participate in collective bargaining contracts.

Standard 115.67 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.

115.67 (a) AR 421 establishes the policy of protecting inmates and staff from retaliation and requires that the Warden designate a facility staff member(s) to monitor retaliation. Case managers are designated to conduct monitoring for inmates and the PREA Compliance Manager conducts monitoring for staff. The PREA Compliance Manager and a case manager verified in their interviews that they are responsible for monitoring retaliation.

115.67 (b) AR 339 provides for disciplinary action, up to and including termination, for an employee who retaliates against another employee or an inmate who reports or cooperates with an investigation. Agency administrators stated retaliation on the part of staff would be taken seriously and disciplinary action would be initiated if staff are found to be engaging in any retaliatory behavior. Facility staff verified that disciplinary action would be taken if inmates are involved in retaliation, including housing moves or transfers to other facilities.

115.67 (c) AR 421 requires monitoring for at least 90 days with the option to continue beyond 90 days if needed. Both a case manager and the PREA Compliance Manager were interviewed and verified that monitoring would take place for a minimum of 90 days and would include reviews of disciplinary reports, housing and program changes for inmates. For staff, monitoring would include reviews of performance, assignments, leaves of absence, etc. When an incident occurs, monitoring of inmates is initiated by the PREA Compliance Manager who notifies the case manager in the appropriate unit to begin monitoring. The case managers have a tracking system to document and ensure monitoring takes place.

115.67 (d) AR 421 requires that for inmates, monitoring include periodic status checks. The case manager stated they informally check in with inmates who are being monitored in addition to the items mentioned in (c).

115.67 (e) The facility reports they would take steps to protect any individual from retaliation but have not had anyone express a fear of retaliation.

115.67 (f) AR 421 allows for monitoring to be terminated if the allegation is unfounded.

Standard 115.68 Post-allegation protective custody

☐ 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.

See notes for 115.43. OP 501 states inmates identified as being at high risk of being sexually abused will not be placed in involuntary segregation. Available alternatives to segregation will be considered such as housing assignments in different wings, units, or transfer to another facility.

Standard 115.71 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.

115.71 (a): The Inspector General is responsible for investigating or assigning for investigation all incidents related to PREA. Six agency investigation reports were reviewed by the auditors and all were completed promptly, thoroughly and objectively.

115.71 (b): All investigators have received specialized training. See notes for 115.34.

115.71 (c): The Department and the facility have policies and procedures in place for gathering and preserving evidence and conducting investigations. Investigative staff verified in interviews that all relevant information is reviewed as part of an investigation, including physical evidence, electronic monitoring data, and interviews.

115.71 (d): An investigator who was interviewed stated prosecutors would be consulted before conducting compelled interviews.

115.71 (e): NDOC does not require inmates to submit to polygraphs. The credibility of victims, witnesses and suspects is assessed individually. The investigator interviewed stated they allow the evidence to speak for itself and do not make any assumptions.

115.71 (f): Investigators from the Inspector General's office conduct all PREA related administrative investigations. Investigative staff stated they review video footage and other information to determine if staff contributed to abuse by violating policies, regulations, or other actions or failures to act.

115.71 (g): Investigation reports reviewed by the auditors contained all relevant information necessary for each investigation. The reports included the source of the initial report and initial report details; description of the interviews with alleged aggressor, alleged victim, witnesses, and staff; and description of evidence collected. Written statements from inmates were also included when applicable. As described by an investigator, if video footage is reviewed, a description of what was viewed would also be included.

115.71 (h): All substantiated cases are referred to the applicable prosecutorial authority. This was verified by investigators and the Inspector General.

115.71 (i): As reported by the PREA Coordinator, the Department maintains all PREA cases, both administrative and criminal, separately from other non-PREA cases to ensure they are maintained according to this standard, as the state has a specified retention period that does not cover what is required by PREA. The reports related to PREA are maintained while the abuser is still employed or incarcerated within the Department and/or for 10 years after reporting to the Survey of Sexual Violence.

115.71 (j): The Department does not terminate an investigation if the alleged abuser or victim is no longer employed or controlled by the Department. This was stated in OP 421 and verified by investigators.

115.71 (k): See above items (a) through (i).

115.71 (l): The agency rarely, if ever, uses an outside agency to investigate. Staff in the Inspector General's office report that if an outside agency was needed, they would fully cooperate and remain informed throughout the process.

Based on interviews with the Inspector General and investigative staff, and review of policy, procedure, and completed investigative reports, the facility is compliant with this standard.

Standard 115.72 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.

A PREA Manual utilized by the Department states the Department shall impose no standard higher than a preponderance of the evidence in determining whether allegation(s) of sexual abuse are substantiated. This was verified by an investigator who was interviewed.

Standard 115.73 Reporting to inmates

☐ 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.

115.73 (a): Language in AR 421 and AR 457 is consistent with and supports this standard. When an investigation is completed, the Inspector General's office will make the notification to the inmate or will request that the facility do so. This was verified in interviews with investigative staff and facility staff and through documentation in the investigative file.

115.73 (b): There have been no circumstances where an outside agency was utilized to investigate incidents from this facility.

115.73 (c): Language in AR 421 is consistent with and supports this standard. The process of informing inmates was verified in interviews with the PREA Compliance Manager and the IG PREA Coordinator.

115.73 (d): Language in AR 421 is consistent with and supports this standard. The process of informing inmates was verified in interviews with the PREA Compliance Manager and the IG PREA Coordinator.

115.73 (e): Language in the NDOC PREA Manual is consistent with and supports this standard. Documentation is made in NOTIS that the inmate was notified.

115.73 (f): Language in the NDOC PREA Manual is consistent with and supports this standard.

Standard 115.76 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.

115.76 (a): AR 421 provides that staff will be subject to disciplinary sanctions up to and including termination for violating sexual abuse and sexual harassment policies.

115.76 (b): AR 339 outlines disciplinary sanctions for certain staff actions and clearly lists dismissal as the consequence for sexual abuse.

115.76 (c): AR 339, the employee code of ethics and conduct and disciplinary process, allows for disciplinary action to be based upon the nature and circumstances of the situation.

115.76 (d): AR 421 requires that terminations or resignations by staff who would have been terminated for violating sexual abuse or sexual harassment policies will be reported to law enforcement and relevant licensing bodies.

Interviews with the Warden, Deputy Director and Inspector General verified that the agency takes allegations of sexual abuse and sexual harassment very seriously and disciplinary action would be taken, including termination. The process and requirements of the above stated ARs was verified in these interviews.

Standard 115.77 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.

115.77 (a) and (b): AR 421 and OP 421 contain language that supports this standard. NDOC reports they have received no reports of sexual abuse or harassment by volunteers or contractors against inmates since the last PREA audit in 2014. They have made no referrals to law enforcement and have issued no "stop orders" on contractors or volunteers for violations of sexual abuse or sexual harassment. The PREA Compliance Manager, Warden and PREA Coordinator all state that volunteers and contractors who engage in any sexual abuse or sexual harassment will not remain in their position at the facility. Other NDOC facilities are also notified so they will not engage the same contractor or volunteer.

Standard 115.78 Disciplinary sanctions for inmates

☐ 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.

115.78 (a): Sexual assault and sexual harassment commited by an inmate are both class A major violations as stated in AR 707.

115.78 (b): Disciplinary guidelines provide a guide for the imposition of sanctions and allow the hearings officer to take into consideration analysis of each individual situation, including disciplinary history, the circumstances of the act, etc. Interviews with staff supported this information.

115.78 (c): Language in AR 421, OP 421, and the Disciplinary Manual, as well as interviews with staff, supported that this standard is followed.

115.78 (d): During an interview with the WSCC psychologist, he stated inmates are not required to participate in counseling as a condition of access to any other program or benefits.

115.78 (e): Language in AR 421 is consistent with this standard. There have been no incidents of this nature to review for this audit.

115.78 (f): Language in AR 421 and OP 421 is consistent with this standard.

115.78 (g): NDOC prohibits all sexual activity between inmates and will discipline inmates for such activity. However, they do not constitute this activity as sexual abuse if it is determined it was not coerced.

Standard 115.81 Medical and mental health screenings; history of sexual abuse

☐ 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.

115.81 (a): AR 643 requires all newly arrived inmates be evaluated by mental health staff for level of intellectual functioning, level of aggression, deviant sexual behavior and history of sexual abuse. Inmates referred for non-emergency mental health care will be evaluated within 14 days. This was verified by the WSCC psychologist.

115.81 (b): AR 643 requires that inmates with a history of sexual abuse, whether aggressor or victim, be offered a referral to medical and/or mental health, that this referral must be made within 72 hours of the assessment and the inmate must be seen within 14 days. Language consistent with this standard is also in OP 504 and OP 613. This process was verified by the WSCC psychologist.

115.81 (c): n/a – this substandard applies to jails

115.81 (d): OP 121 requires information concerning sexual abuse or sexual harassment remain confidential and only provided to staff with a need to know, such as medical/mental health staff and investigators. Confidentiality of information was verified in staff interviews.

115.81 (e): OP 613 requires medical and mental health staff to obtain informed consent. Both medical and mental health staff who were interviewed verified they obtain informed consent in accordance with this standard.

Standard 115.82 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.

115.82 (a): OP 613 requires medical staff be notified an inmate has been sexually abused and that medical staff complete a cursory exam. The victim is offered mental health treatment. If the assault occurred within 72 hours, the victim is offered a forensic exam and must agree to the exam. This was verified in interviews with security staff and medical/mental health staff. Medical and mental health staff who were interviewed stated the scope of the services offered are determined according to policy and their professional judgement and were confident that if they determined an inmate needed services beyond what is available at the facility, the inmate would be provided what was clinically necessary.

115.82 (b): See notes in 115.62 and 115.64. All staff are trained in first responder duties. The agency response plan outlines the process to ensure victims receive medical care and mental health follow-up.

115.82 (c): As required in OP 613, victims are offered an appointment with the medical provider where information, testing and treatment for sexually transmitted infections is offered. This was verified during the interview with medical staff.

115.82 (d): OP 421 states medical services and treatment will be provided at no cost regardless of whether the victim cooperates with an investigation.

Standard 115.83 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.

115.83 (a): AR 643 requires that inmates with a history of sexual abuse, whether aggressor or victim, be referred to medical and/or mental health within 72 hours of the assessment and must be seen within 14 days. Medical and mental health staff verified in interviews all inmates who have a history of abuse in institutional settings are offered follow-up care.

115.83 (b): OP 504 states inmates who have been the victim of sexual abuse will be offered follow-up meetings with medical and/or mental health care staff. Medical and mental health staff reported they follow a treatment plan and base services on an individual basis with outside services utilized when necessary.

115.83 (c): Medical and mental health staff report the level of care in the facility is equal to, and in some cases better than, services in the community due to the services available and quick response of staff within the facility. The onsite inspection included the medical clinic; the size and services of which appear adequate and equivalent to other facilities of similar size and function.

115.83 (d): n/a – WSCC does not house female inmates

115.83 (e): n/a – WSCC does not house female inmates

115.83 (f): Victims are offered an appointment with the medical provider where information, testing, and treatment for sexually transmitted infections is offered. This was verified by medical staff.

115.83 (g): OP 421 states medical services and treatment will be provided at no cost regardless of whether the victim cooperates with an investigation. Medical and mental health staff verified that services are at no cost.

115.83 (h): Language in OP 613 supports this standard. Mental health staff verified they conduct this evaluation for abusers in accordance with policy.

Standard 115.86 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.

115.86: AR 421 and OP 421 contain language that supports this standard. The Warden, PREA Coordinator, and PREA Compliance Manager verified in interviews that these reviews occur in accordance with the standard. The facility only had one such review in the last year. The auditors reviewed the documentation for the review. It was completed within 30 days of the completion of the investigation and covered all information required by the standard. The Warden reviewed the information from the review, including recommendations, and documented there was no need for any modifications based on the committee's findings.

Standard 115.87 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.

115.87 (a): The Inspector General's PREA Management Team is responsible for collecting accurate, uniform data for every allegation of sexual abuse from the NDOC. Staff in the IG's office confirmed they collect this data and comply with all elements of this standard.

115.87 (b): The data is aggregated annually and posted on the NDOC website.

115.87 (c): NDOC responds to the Survey of Sexual Violence conducted by the Department of Justice, therefore the data they collect is adequate for this standard.

115.87 (d): The NDOC PREA Manual states the Department will maintain, review, and collect data as needed from all incident based documents. Staff in the IG's office confirmed they collect this data and comply with all elements of this standard.

115.87 (e): n/a – the NDOC does not contract for confinement

115.87 (f): The NDOC PREA Manual states data will be provided to the DOJ upon request.

Standard 115.88 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.

115.88 (a): Data collected pursuant to 115.87 is reviewed by the Director or designee, Deputy Director of Operations, and the IG PREA Coordinator, taking into consideration the requirements of this standard. An annual report is created which includes data from the agency as a whole and each facility. The annual report was reviewed by the auditors.

115.88 (b): The annual report discusses progress made Department wide and at each facility, including actions taken to comply with PREA.

115.88 (c): The report is signed by the IG PREA Coordinator and the NDOC Director and is available online at the NDOC website. http://doc.nv.gov/uploadedFiles/docnvgov/content/About/NDOC_Office_of_the_Inspector_General/PREA%20Annual%20Report%202015.pdf

115.88 (d): The report only includes aggregate data and does not include any information that would present a threat to safety and security of a prison.

Standard 115.89 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.

115.89 (a): All data is securely maintained by the Inspector General's office. While onsite, the Inspector General showed the auditors where records are kept at the central office.

115.89 (b): The agency has aggregated sexual abuse data available on its website back to 2009. The data shows incidents by type and outcome.

115.89 (c): There is no personally identifiable information in the data provided on the website.

115.89 (d): The data online dates back to 2009 which was the first year it was collected by NDOC. The NDOC PREA Manual states the Department will maintain data for a minimum of 10 years.

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.

Michele Morgenroth 04/10/17

Auditor Signature Date