

**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***

**U.S. Department of Justice
Office on Violence Against Women**

August 2013

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Acknowledgements

The Office on Violence Against Women is grateful to all of the individuals involved in this project for their dedication to ensuring that those who suffer sexual assault while incarcerated are afforded the same care and attention as those who are assaulted in the community. Special thanks to the Federal Bureau of Prisons, Vera Institute of Justice, Kristin Littell, and the work group participants for their time, energy, and contributions.

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Recommendations at a Glance for Administrators of Prisons, Jails, and Community Confinement Facilities

(See the *Introduction to the Guide* for more background information and more explanation of terms used in *Recommendations at a Glance*.)

This guide is designed to assist administrators of prisons, jails, and community confinement facilities in drafting or revising protocols for an immediate response to reports of sexual assault.

Sexual assault is a persistent problem in correctional environments with life-altering consequences for victims as well as for the integrity of correctional institutions and the fundamental principles of justice.¹ The U.S. Department of Justice's *National Standards to Prevent, Detect, and Respond to Prison Rape*² set minimum requirements for correctional facilities to increase their overall capacity to address the problem of sexual assault. This guide is intended to help these facilities comply with the Prison Rape Elimination Act (PREA) standards, which require correctional agencies to (1) follow a uniform evidence protocol when responding to sexual assault,³ which as appropriate is based on the U.S. Department of Justice's [A National Protocol for Sexual Assault Medical Forensic Examinations: Adults/Adolescents](#), 2d.⁴ (referred to in this guide as the *National Protocol*), and (2) coordinate responses to sexual assault among involved professionals.⁵ In acknowledgement that professionals outside of the correctional field may also be reading this guide, it includes some explanation of basic corrections terms, issues, and activities. Note that beyond the stipulations of the Department of Justice's PREA standards, the recommendations in this guide are not meant to supersede or invalidate previously established institutional protocols, policies, or practices that address the immediate response to sexual assault in correctional settings.

Recommendations at a Glance highlights the key recommendations offered in this guide for customizing the [National Protocol](#) to address sexual assault occurring in correctional facilities (often referred to in this guide as corrections-based sexual assault). It is not meant to be a stand-alone checklist for drafting or revising facility protocols on an immediate response to sexual assault. Rather, the full guide should be read to understand the complex issues surrounding this crime and to utilize the comprehensive recommendations in Section III to assist in policy development. The guide should be used in conjunction with the *National Protocol*, as together they offer best practices for an immediate response to sexual assault in correctional settings. As explained in Section II of the guide, elements of an immediate response to sexual assault can include:⁶

- Protection for victims from threats of imminent harm;
- Provision of medical care for victims (for acute injuries and health concerns related to the assault such as risk of HIV/AIDS, sexually transmitted infections, and pregnancy);
- Collection of forensic evidence from victims, which may aid investigations;
- Preliminary documentation and investigation (which may lead to criminal charges against suspects, prosecution, and conviction, as well as administrative findings of sexual assault, a formal disciplinary process, and/or disciplinary sanctions); and
- Support, crisis counseling, information, and referrals for victims (and their families as applicable), as well as advocacy to ensure victims receive appropriate assistance.

A sexual assault medical forensic examination (referred to in this guide as the medical forensic examination or examination) addresses victims' health care needs related to the assault and the collection of forensic evidence.⁷ The process of facilitating this examination for victims housed in correctional facilities (referred to in this guide as the examination process) can involve all the elements of

¹ National Prison Rape Elimination Commission, *Standards for the Prevention, Detection, Response, and Monitoring of Sexual Abuse in Adult Prisons and Jails* (2009), p.iii.

² *National Standards to Prevent, Detect, and Respond to Prison Rape, Final Rule*, 77 Fed. Reg. 37106-37232 (June 20, 2012) (to be codified at 28 C.F.R. §115).

³ 28 C.F.R. §§ 115.21, 115.121, 115.221, and 115.321.

⁴ Office on Violence Against Women, *A National Protocol for Sexual Assault Medical Forensic Examinations, Adults/Adolescents*, 2d., Washington, D.C.: U.S. Department of Justice (2013).

⁵ 28 C.F.R. §§ 115.65, 115.165, 115.265, and 115.365.

⁶ Bullets adapted from Office on Violence Against Women, *A National Protocol* (2013), p.12.

⁷ Adapted from Office on Violence Against Women, *A National Protocol* (2013), p.17.

an immediate response. Hence, the guide discusses an immediate response to corrections-based sexual assault. Note that while it focuses on response to recent sexual assault, the guide recognizes and speaks to the fact that it is not uncommon for victims to delay reporting for days, weeks, months, and even years after an assault has occurred.⁸

The [National Protocol](#) provides guidelines for jurisdictions on responding to the immediate needs of sexual assault victims in a way that is sensitive and promotes offender accountability. It offers recommendations on overarching issues such as coordination, victim-centered care (including issues commonly faced by victims from special populations), informed consent, confidentiality, reporting to law enforcement, and payment for the medical forensic examination under the Violence Against Women Act (VAWA). It also provides specific process and procedural recommendations regarding operational issues and the examination process. The *National Protocol* does not provide guidance on customizing protocols for institutional settings. Correctional protocols should draw from the existing best practices as outlined in the *National Protocol*, but should also be tailored to the unique circumstances of correctional environments as described in this guide.

Recommendation Highlights

(See Section III for the comprehensive recommendations.)

The recommendations in this guide customize the *National Protocol* to address corrections-based sexual assault, specifically around (1) the provision of victim-centered care (interventions provided in a timely manner that are systemically and deliberately focused on the physical, mental, and emotional needs of each victim) and (2) a coordinated team approach to response.⁹ Note that in this section and in the guide, a victim-centered care recommendation is denoted with a “V,” while a coordination recommendation is denoted with a “C”. For recommendations that apply to specific confinement settings, the setting is highlighted. Where there are variations in a recommendation for different confinement settings, those variations are noted in Section III. Refer to the [National Protocol](#) for guidance on other aspects of the examination process, as only areas presenting unique challenges in confinement settings are covered in this guide.

Note that for the purposes of this guide:

- This guide primarily refers to prisons and jails, as well as community confinement. Appendix B provides an overview of some of the potential issues for lockups.
- Community confinement refers to community-based, court-mandated residential programs where residents stay overnight.
- This guide does not address the examination process for youth confined in juvenile detention facilities. Appendix C discusses some issues specific to this setting.
- Correctional “environments,” “facilities,” “institutions,” and “confinement settings” are used as umbrella terms to encompass prisons, jails, and community confinement facilities. Specific settings are referenced as needed. Administrators of these facilities are referred to as “corrections administrators,” unless there is a need to be more specific regarding their setting.

Recommendations for Victim-Centered Care

V1. Ensure that victims in correctional facilities have access to a full range of specialized services they may need in the aftermath of a report of sexual assault.

⁸ The definition of a recent sexual assault is usually based on jurisdictional policies regarding a standard cut-off time to collect evidence on victims’ bodies and clothing, using the jurisdiction’s designated evidence collection kit. Most jurisdictions allow some flexibility in cut-off times, given that it is conceivable under some circumstances that evidence may still be available even after the cut-off time. Delayed reporting of a sexual assault thus refers to reports made after the jurisdiction’s cut-off time.

⁹ When responders coordinate their immediate response to reports of sexual assault, it can afford victims protection, access to immediate care, and help to minimize trauma, while simultaneously facilitating an investigation. In correctional facilities, not only do responding corrections staff need to coordinate their actions, they also need to work in a coordinated manner with responders external to the facility.

V2. Maximize victim safety.

- In cases of sexual assault by perpetrators housed in the correctional facility, immediately separate victims and perpetrators.
- If victims report staff sexual misconduct and name their perpetrators, those perpetrators should not be involved in any aspect of the facility's response.
- Following an examination, continue to keep victims separated from their perpetrators, whether the perpetrators are corrections staff or other individuals housed in the facility.¹⁰

V3. Balance victims' needs with the safety and security needs of the correctional facility.

- Protect victims without taking measures that they may perceive as punitive, to the extent possible.
- Consider ways for victims to seek protection and services as confidentially as possible.¹¹
- Strictly limit who within the correctional facility needs to know about a report of sexual assault.¹²

V4. Offer victims privacy at the correctional facility, to the extent possible, in the aftermath of a report of sexual assault.

- Exercise discretion in ways appropriate to the confinement setting to avoid the victims' embarrassment of being identified by others in the correctional facility as a victim, and to increase their safety and comfort in seeking help.
- Consider the extent of victim information that each responder requires to appropriately intervene. Avoid sharing victim information unless it is critical to response.¹³
- Ensure that the area where community-based victim advocates talk to victims is as private as possible, and safe for both advocates and victims.

V5. Make every reasonable effort to include community-based sexual assault victim advocates in an immediate response to victims in confinement settings.¹⁴

- Identify local community-based victim advocacy programs (often referred to as rape crisis centers).
- Facilitate discussions between corrections staff and representatives of the community-based victim advocacy program on how to provide advocacy services to sexual assault victims housed in the correctional facility.¹⁵
- Facilitate cross-training for corrections staff and victim advocates.
- Delineate the relationship between the correctional facility and community-based victim advocacy program in a memorandum of understanding (MOU).

V6. Train at least one staff person (either security or non-security) in the correctional facility to serve as an internal victim resource specialist to provide general information and guidance to victims during the immediate response and beyond.

- Clarify this position's role in the correctional facility.
- Recognize that the internal victim resource specialist is not intended to be a substitute for a community-based victim advocate.
- Decide who within the correctional facility is eligible to fill this position.

V7. Ensure that victims have access to sexual assault forensic examiners to perform the medical forensic examination.¹⁶

- When possible, consider utilizing independent forensic examiners, i.e., those not employed by the correctional facility or under contract with the correctional agency.
- Identify local or regional forensic examiners/forensic examiner programs.
- Facilitate dialogue among corrections staff, forensic examiners, and other examination site staff as applicable on how to coordinate the examination.

¹⁰ 28 C.F.R. §§ 115.67, 115.167, 115.267 and 115.367.

¹¹ 28 C.F.R. §§ 115.51, 115.151, 115.251, and 115.351.

¹² 28 C.F.R. §§ 115.61, 115.161, 115.261, and 115.361.

¹³ 28 C.F.R. §§ 115.81 and 115.381.

¹⁴ 28 C.F.R. §§ 115.21, 115.121, 115.221, 115.321, 115.53, 115.253, and 115.353.

¹⁵ 28 C.F.R. §§ 115.53, 115.253, and 115.353.

¹⁶ 28 C.F.R. §§ 115.21, 115.121, 115.221, and 115.321.

- Facilitate cross-training for corrections staff and sexual assault forensic examiners and other examination site staff.
- Delineate the relationship between the correctional facility and the forensic examiner/examination site in a written MOU.

V8. Offer a medical forensic examination to sexual assault victims when appropriate.¹⁷

- Recognize that this examination addresses the full spectrum of sexual assault, not only attempted and/or completed sexual penetration.
- Understand that this examination in its entirety speaks to victims' medical and evidentiary needs.
- Recognize that one of the primary reasons victims seek help is concern about their physical health.
- To determine whether this examination is appropriate in a specific case, consider: the victim's health needs and concerns; the jurisdiction-accepted timeframe for evidence collection (e.g., as per policies for use of the jurisdiction's sexual assault evidence collection kit); and the specific circumstances of the assault.¹⁸
- If there is a question of whether evidence might exist, err on the side of caution and refer victims for this examination.
- The victim shall not assume the financial cost related to evidence collection.¹⁹
- When this examination is deemed appropriate, the victim must have the option of having the examination even if they are undecided about cooperating with a criminal investigation.²⁰
- Never force a victim to undergo this examination.²¹
- In instances when this examination is not conducted, discuss with victims their needs and options and help them access services they want, to the extent possible, as per facility policies and as appropriate to the circumstances of the case.

V9. If, for security purposes, victims from prisons and jails must be shackled or otherwise restrained, ensure the level of shackling/restraint correlates with their security status. However, shackle or restrain only if necessary for security.

V10. Facilitate victims' access to their personal support persons, if requested.²²

- Be aware that when and how victims are able to access personal support persons can differ based on the type of correctional setting.

V11. Devise correctional facility practices that address, to the extent possible, victims' concerns related to reporting.²³

- Educate all corrections staff, external agencies and professionals who interact with individuals housed in the correctional facility, and other relevant entities (e.g., employers of residents in community confinement settings) of the facility's zero tolerance policy towards sexual assault.²⁴
- Upon intake to the correctional facility, provide individuals with information about sexual assault.²⁵
- Make accommodations as needed to ensure access to this information for all individuals housed in the facility, including those who have limited English proficiency, are low literate or illiterate, are deaf, or have a disability that might impact their vision or ability to process information.²⁶

¹⁷ 28 C.F.R. §§ 115.21, 115.121, 115.221, and 115.321.

¹⁸ See Office on Violence Against Women, *A National Protocol* (2013), pp.71-71, for more information on these kits. See Office on Violence Against Women, *A National Protocol* (2013), pp.73-74, for more on timing considerations for collecting evidence.

¹⁹ See Office on Violence Against Women, *A National Protocol* (2013), p.55 and 28 C.F.R. §§ 115.21, 115.121, 115.221 and 115.321.

²⁰ The Department of Justice's PREA standards indicate that the victim can receive emergency medical care without having to name the abuser. See 28 C.F.R. §§ 115.82, 115.182, 115.282, and 115.382. Also see Office on Violence Against Women, *A National Protocol* (2013), pp.51-54.

²¹ See Office on Violence Against Women, *A National Protocol* (2013), pp.39-41.

²² If your facility/local community-based advocacy program does consider victim advocates as personal support persons, note that advocates should be permitted to accompany victims at the examination site.

²³ 28 C.F.R. §§ 115.51, 115.151, 115.251, and 115.351.

²⁴ To save time and costs, facilities may want to consider incorporating this information into their current training modules. 28 C.F.R. §§ 115.31, 115.131, 115.231, 115.331, 115.32, 115.132, 115.232, and 115.332.

²⁵ 28 C.F.R. §§ 115.33, 115.233, and 115.333.

²⁶ 28 C.F.R. §§ 115.16, 115.116, 115.216, and 115.316.

- Make facility policies on reporting sexual assault as easy, private, and secure as possible.
- Ensure there is at least one way for victims in correctional facilities to report sexual assault to an outside public or private entity or office that is not part of the agency.²⁷
- Ensure that corrections staff and external agencies consistently respond to sexual assault in a manner that demonstrates to those housed in the correctional facility that they take reports of sexual assault seriously and will strive to help victims and hold perpetrators accountable for their behaviors.
- Use case-by-case assessment, including consulting with security staff and talking to victims about their safety concerns and possible precautions, to reduce protective actions taken that victims could perceive as punitive.²⁸
- Whenever possible, provide victims with access to community-based victim advocates for confidential emotional support and counseling related to healing from sexual assault.²⁹
- Strictly limit who within the correctional facility and external agencies can access information about a report of sexual assault.³⁰

V12. Offer victims information following their sexual assault.³¹

- Develop written information on sexual assault topics that can be offered to victims.
- Where possible and practical, use a three-tiered system to deliver the information: corrections staff members to provide information about what will happen at the correctional facility in response to the report; forensic examiners to provide information on medical and forensic issues; and community-based victim advocates to provide information on what symptoms/reactions they might experience in the aftermath of the assault, emotional support, recovery options, and the criminal justice response to a sexual assault.
- Make accommodations as needed to ensure access to this information for victims who have limited English proficiency, are low literate or illiterate, are deaf, or have a disability that might impact their vision or ability to process information.³²

Recommendations for Promoting a Coordinated Team Approach³³

C1. Form a planning committee to facilitate the development/revision of a correctional protocol for an immediate response to sexual assault. This committee can also periodically review the protocol for effectiveness and revise as needed.

- Assess the current immediate response when individuals housed in the correctional facility report sexual assault to learn what works and where gaps exist. (See Appendix D and E.)
- Map out a strategic plan for an ideal response that builds upon strengths in the current response and addresses gaps. (See Appendix D and E.)

C2. Consider participating in a community-based sexual assault response team (SART), if one exists, or forming a SART for the correctional facility.

- If a community SART exists, consider hosting a SART meeting at the correctional facility to learn more about how the local SART functions, as well as to provide a tour of the facility, educate SART members regarding needs of victims in confinement settings, and get input on whether the local SART or a facility-based SART would be most appropriate for victims in the correctional facility.
- Consider the logistical tasks and challenges involved in developing a SART response specific to the correctional facility. (See Appendix D.)
- Based on resources and corrections-specific issues, decide whether to become active in the local SART or form a facility-based SART.

²⁷ 28 C.F.R. §§ 115.51, 115.151, 115.251, and 115.351.

²⁸ 28 C.F.R. §§ 115.41, 115.141, 115.241, 115.341, 115.42, 115.242, 115.342, 115.43, 115.342, 115.68, and 115.368.

²⁹ 28 C.F.R. §§ 115.53, 115.253, and 115.353. Also, note that California's Paths to Recovery project (a joint program of Just Detention International and the California Department of Corrections and Rehabilitation) is one example. See <http://www.justdetention.org/en/reaching.aspx> for more information on the program.

³⁰ 28 C.F.R. §§ 115.82, 115.282, and 115.382.

³¹ Office on Violence Against Women, *A National Protocol* (2013), p.42 and 28 C.F.R. §§ 115.82, 115.282, and 115.382.

³² 28 C.F.R. §§ 115.16, 115.116, 115.216, and 115.316.

³³ 28 C.F.R. §§ 115.65, 115.165, 15.265, and 115.365.

- Partner with the local SART (if one exists) to maximize communications across SARTs and resource sharing, and to receive guidance, even if a facility-based SART is formed.

C3. Ensure core responders are appropriately trained.³⁴

- Provide training to core responders, both internal and external to the correctional facility, to promote zero-tolerance of corrections-based sexual assault.
- Ensure that all core responders are trained on the specifics of how to intervene in a sexual assault reported in the correctional facility.
- Conduct both initial and refresher trainings.³⁵

C4. Sexual assault reported in community confinement facilities should, to the extent possible, be handled like any other sexual assault in the community, as per the *National Protocol*, with the exceptions noted in this guide's recommendations.

- Victims reporting sexual assault to corrections staff should be informed of whether they also have the option of reporting to law enforcement.
- Staff at community confinement facilities should contact 9-1-1 for resident victims with acute medical needs (if victims cannot make the call for themselves) or when there are life threatening/serious safety issues that cannot be addressed by staff at the facility.
- Victims with non-acute medical needs and concerns should be encouraged to seek medical attention, either prior to and during the medical forensic examination or from another medical professional.
- Victims should be directed to the nearest facility that provides sexual assault medical forensic examinations using trained forensic examiners.
- Victims should be encouraged to explore transportation options to get to/from the examination site with law enforcement, victim advocates, and/or corrections staff.
- Ensure that core responders are trained that victims' conditions of release may require notification to the community confinement facility of their travels/whereabouts. Core responders should understand their role, if any, in facilitating this notification.

C5. Facilitate examination site readiness for victims from prisons and jails.

- Determine whether examinations will be conducted at the correctional facility or a local examination site (e.g., a hospital, health care facility, or other facility that has specially educated and clinically prepared forensic examiners conducting the medical forensic examination).
- Facilitate training for non-corrections-based health care providers who interact with sexual assault victims on issues specific to conducting the examination with sexual assault victims from prisons or jails.

C6. Ensure that policies are in place for reporting sexual assault occurring in other correctional facilities.³⁶

- If an individual in a correctional facility reports being sexually assaulted while housed at another correctional facility, the facility that receives the report has a duty to notify the institution where the assault occurred, regardless of the amount of time that has lapsed from the incident to the reporting of the sexual assault.
- The institution currently housing the victim should obtain/receive information about investigation findings from the institution where the assault occurred.³⁷
- Victims reporting sexual assault that occurred at another confinement facility should have access to the same coordinated response as other sexual assault victims.

³⁴ 28 C.F.R. §§ 115.31, 115.131, 115.231, 115.331, 115.32, 115.132, 115.232, and 115.332.

³⁵ 28 C.F.R. §§ 115.31, 115.131, 115.231, 115.331, 115.32, 115.132, 115.232, 115.332, 115.34, 115.134, 115.234, 115.334, 115.35, 115.135, 115.235, and 115.335.

³⁶ 28 C.F.R. §§ 115.63, 115.163, 115.263, and 115.363.

³⁷ Note that the Department of Justice PREA standards require notifying an individual housed in a correctional facility about the findings of an investigation (if another agency conducts the investigation, the correctional facility should request the relevant information from the investigative agency in order to inform the individual). See National Standards to Prevent, Detect, and Respond to Prison Rape, Final Rule, 77 Fed. Reg. 37106-37232 (June 20, 2012) (to be codified at 28 C.F.R. §§ 115.73, 115.273, and 115.373).

C7. Initiate regular clinical reviews of the facility's response to sexual assaults and responder performance to determine strengths, weaknesses, gaps, and areas where additional training or revisions to policy are indicated.³⁸

- In addition to corrections staff, involve outside community-based victim advocates and/or SART members in these reviews whenever possible for perspective and guidance.³⁹

³⁸ 28 C.F.R. §§ 115.86, 115.186, 115.286, and 115.386.

³⁹ The Pennsylvania Coalition Against Rape may be a resource for states and counties on this practice. Contact information available through <http://www.pcar.org/>.

Introduction to the Guide

“Sexual abuse is among the most destructive of crimes, brutal and devastating in the moment and carrying the potential to haunt victims forever.”⁴⁰

No one deserves to be sexually assaulted, no matter the circumstances. In correctional environments, sexual violence is a persistent problem with life-altering consequences for victims, as well as for the integrity of correctional institutions and the fundamental principles of justice.⁴¹ Corrections administrators must continue to work diligently to develop policies and practices to remedy this problem,⁴² including how to respond when sexual assault occurs in their facilities.

1. Purpose and Scope

This guide is designed to assist administrators of prisons, jails, and community confinement facilities in drafting or revising protocols for an immediate response to reports of sexual assault. Correctional protocols should draw from the existing best practices outlined in the U.S. Department of Justice’s Office on Violence Against Women publication, [National Protocol for Sexual Assault Medical Forensic Examinations: Adults/Adolescents, 2d.](#)⁴³ (referred to in this guide as the *National Protocol*), but be tailored to the unique circumstances of secure and community confinement settings. This guide supplements the *National Protocol* to facilitate this customization.

Specifically, the *National Protocol* provides guidance related to facilitating the sexual assault medical forensic examination (referred to in this guide as the medical forensic examination or the examination). Hence, this guide discusses an immediate response to corrections-based sexual assault. Note that while it focuses on an immediate response to recent sexual assault, the guide acknowledges that it is not uncommon for victims to delay reporting for days, weeks, months, and even years after an assault occurred.

In particular, this guide explores how corrections administrators can apply two key principles from the *National Protocol* to correctional environments: victim-centered care and coordinated interventions across responders. Victim-centered care of sexual assault victims refers to interventions provided in a timely manner that are systemically and deliberately focused on the needs of each victim. When responders coordinate their interventions, it can afford victims protection, access to immediate care, and help to minimize trauma, while simultaneously facilitating the investigation. In correctional facilities, not only do facility responders need to coordinate their actions, they also need to work in coordination with responders external to the facility. Thus, the approach taken for the Guide’s development was to focus on how corrections staff and involved external responders can provide victim-centered care and coordinate their interventions when a corrections-based sexual assault is reported. Recommendations related to victim-centered care and a coordinated response in the *National Protocol* were considered for

For the purpose of this guide:

- Secure confinement refers to prisons and jails. Appendix B provides a brief discussion of issues for lockups.
- Community confinement refers to community-based, court-mandated residential programs where residents stay overnight.
- While this guide does not address the examination process for youth in juvenile detention facilities, Appendix C includes preliminary information on this topic.
- Correctional “environments,” “facilities,” and “institutions,” and “confinement settings” are used as umbrella terms to encompass prisons, jails, and community confinement facilities. Specific settings are referenced as needed. Administrators of these facilities are referred to as “corrections administrators,” unless there is a need to be more specific regarding their setting.

⁴⁰ National Prison Rape Elimination Commission, *National Prison Rape Elimination Commission Report* (2009), p.25.

⁴¹ National Prison Rape Elimination Commission, *Standards for the Prevention, Detection, Response, and Monitoring of Sexual Abuse in Adult Prisons and Jails* (2009), p.iii.

⁴² National Prison Rape Elimination Commission, *Report* (2009), p.1.

⁴³ Office on Violence Against Women, *A National Protocol for Sexual Assault Medical Forensic Examinations, Adults/Adolescents, 2d.*, Washington, D.C.: U.S. Department of Justice (2013).

their applicability to correctional environments and modified as needed. To the extent that noncorrectional responders may also read this guide, it includes some explanation of basic corrections terms, issues, and activities.

Corrections administrators are encouraged to use both the guide and the *National Protocol* as tools to customize their protocols for an immediate response to sexual assault. First, they can review recommendations in this guide related to victim-centered care and a coordinated response in confinement settings, as well as background information on corrections-based sexual assault and the elements of an immediate response to victims in correctional environments. Second, they can review the *National Protocol* for recommendations on issues not covered in this guide. The guide made few changes to the recommendations in the *National Protocol* related to operational issues or the medical and forensic components of the examination process, as they are considered best practices no matter where an assault occurs or where the examination is conducted. Many of these recommendations are technical in nature or require adherence to specific legal requirements or medical practices. Reviewing the *National Protocol* can aid administrators in determining if they are following the practices relevant to their authority and responsibilities under the law. For issues outside the purview or expertise of correctional facilities, such as those related to conducting a medical forensic examination, a review of these sections can help administrators ensure they establish formal relationships with agencies and professionals that meet the criteria included in the *National Protocol*.

The [National Protocol](#) provides detailed guidelines for local communities on responding to the immediate needs of sexual assault victims in a way that is sensitive to victims and promotes offender accountability. It addresses:

- A. Overarching issues—coordinated team approach, victim-centered care, informed consent, confidentiality, reporting to law enforcement, and payment for the examination under the Violence Against Women Act (VAWA);
- B. Operational issues—sexual assault forensic examiners, facilities, equipment and supplies, sexual assault evidence collection kit, timing considerations for collecting evidence, and evidence integrity; and
- C. Medical and forensic components of the examination process—initial contact, triage and intake, documentation by health care personnel, medical forensic history, photography, examination and evidence collection procedures, drug-facilitated sexual assault, STI evaluation and care, pregnancy risk evaluation and care, discharge and follow-up, and examiner court appearances.

The *National Protocol* does not address how to customize protocols for sexual assault occurring in different types of institutional settings. This guide offers information on customization for sexual assault reported in correctional facilities.

2. Limitations in Scope

Note the following limitations regarding the guide's scope:

- **Exclusion of juvenile detention settings**—this guide is limited to adult and adolescent victims of sexual assault in prisons, jails and community confinement facilities, and does not include youth held in juvenile detention facilities.⁴⁴ The primary reason for this omission is that the *National Protocol* does not comprehensively address the myriad legal issues regarding child sexual abuse. Protocols for juveniles must address such specific issues as mandatory reporting, consent to treatment, parental notification, and scope of confidentiality. In addition, the *National Protocol* does not include guidance for conducting a pediatric medical forensic examination, i.e. for pre-pubescent youth. While the vast majority of youth held in juvenile facilities have reached puberty, some have not, and thus any attempt to provide comprehensive guidance for juvenile facilities based upon the *National*

⁴⁴ Additionally, this guide does not provide specific recommendations for addressing sexual assault of pre-pubescent youth held in adult prisons, jails, or community confinement facilities. For some guidance on those cases, readers might find it helpful to review Recommendation J3. in Appendix C.

Protocol would necessarily be incomplete. (See Appendix C for a few recommendations for juvenile detention facilities.)

- **Exclusion of suspect examinations**—this guide, as well as the *National Protocol*, focuses on response to victims and does not address suspect examinations in any detail. However, correctional facilities can encourage dialogue among responders regarding an optimal approach to gathering potential forensic evidence on suspects and identify areas where their collaboration may be beneficial.

3. Background

Landmark federal legislation heralded the creation of national standards to address the response to sexual assault occurring in local communities, as well as specifically in confinement settings. These standards set the stage for the development of this guide.

The Department of Justice's Office on Violence Against Women created the first edition of the *National Protocol* in 2004, pursuant to the Violence Against Women Act (VAWA) of 2000.⁴⁵ As described earlier, the *National Protocol* recommends best practices for conducting the sexual assault medical forensic examinations for adult and adolescent victims. By the early 2000s, many jurisdictions had exemplary practices in place for an immediate response to sexual assault and collaboration among responders. However, as information gathering during the development of the first *National Protocol* revealed, much remained to be done to create a baseline of effective immediate response practices across the nation. Promulgation of the *National Protocol* was a way to help communities review their practices related to an immediate response, address gaps, and implement specific standards tailored to local needs. In April 2013, the second edition of the [National Protocol](#) was released.

Until very recently, national efforts to address sexual assault and improve victim care in local communities did not typically extend to men, women, and children who were sexually assaulted behind bars. Instead, society has generally viewed sexual assault as an inevitable part of any jail or prison sentence. This view began to change in 2003 when Congress unanimously passed the Prison Rape Elimination Act (PREA). While a vocal minority of victim advocates, attorneys, and survivors had been striving to shed light on this issue for more than two decades, the passage of PREA was a watershed moment. For the first time in U.S. history, Congress affirmed the duty of correctional agencies to protect incarcerated individuals from sexual abuse (which is referred to as sexual assault in this guide).⁴⁶ PREA established a zero tolerance standard for sexual abuse in America's correctional facilities, calling for the creation of a national commission to study the causes and consequences of sexual abuse in confinement settings and to issue national standards for its prevention, detection, and response. Over the course of five years, the National Prison Rape Elimination Commission (the Commission) convened public hearings and committee meetings of experts from around the country to fully understand this problem.

In June 2009, the Commission released its final report and four sets of standards, which addressed sexual abuse in adult prisons and jails (with supplemental standards for immigration detention facilities), juvenile detention facilities, community corrections, and lockups.⁴⁷ In both its report and its standards, the Commission called on correctional facilities to respond immediately and consistently to all incidents of sexual abuse. It urged facilities to follow a uniform evidence protocol based on the *National Protocol* and to coordinate the actions of all responders to sexual abuse. In 2012, the U.S. Department of Justice issued its final standards on PREA, which built on the work of the Commission.⁴⁸ These final PREA standards turned many of the Commission's recommendations, including the standards regarding evidence and coordinated response, into mandatory requirements.⁴⁹ Fundamental to the Commission's

⁴⁵ This statutory requirement can be found in Section 1405 of VAWA 2000, Public Law 106-386.

⁴⁶ Adapted from National Prison Rape Elimination Commission, *Report* (2009), p.1. See the explanation of terms in the *Introduction to the Guide* for the definitions of sexual abuse and sexual assault used in this guide.

⁴⁷ National Prison Rape Elimination Commission, *Report* (2009), Appendix B. National standards.

⁴⁸ The Department of Justice's final standards do not apply to immigration detention facilities. Rather, the Department of Homeland Security is promulgating a rule to govern such facilities. See Standards To Prevent, Detected, and Respond to Sexual Abuse and Assault in Confinement Facilities, Notice of Proposed Rulemaking, 77 Fed. Reg. 75300 (Dec. 19, 2012).

⁴⁹ 28 C.F.R. §§ 115.21, 115.121, 115.221, 115.321, 115.65, 115.165, 115.265, and 115.365.

recommendations and the Department of Justice's PREA standards is the belief that sexual assault should never be a part of any incarceration, but when it occurs, victims in confinement deserve competent, compassionate care by trained professionals. In addition to helping victims heal, victim-centered care is the surest way to improve reporting and victim cooperation with investigations, hopefully leading to convictions.⁵⁰

This guide extends the efforts of the Commission and the Department of Justice to address an immediate response to sexual assault in correctional environments by:

- Offering guidance to correctional facilities on how to comply with the PREA standards to follow a uniform evidence protocol and coordinate response activities;⁵¹ and
- Helping correctional facilities strive towards the standards in the *National Protocol*.

This guide was developed with input from practitioners working in prisons, jails, and community confinement facilities, as well as from national sexual assault experts and victim advocates.

The Department of Justice's PREA standards set minimum standards for correctional facilities to increase their overall capacity to address the problem of sexual assault. This guide, in conjunction with the [National Protocol](#), offers best practices for an immediate response to sexual assault. Correctional facilities are urged to go beyond the Department of Justice's PREA standards and set the highest standards possible for their protocols. Corrections administrators can tailor their facilities' protocols to incrementally move toward full implementation of these best practices.

Note that the guide focuses on leveraging resources already available in correctional facilities and their surrounding communities to improve the immediate response to sexual assault, rather than requiring significant additional resources.

4. Organization

This guide is organized into three main sections:

- Section I offers a primer on sexual assault in correctional environments.
- Section II provides an overview of the sexual assault medical forensic examination process for victims in correctional facilities, and discusses the usefulness of a correctional protocol for an immediate response to sexual assault.
- Section III offers recommendations for prison, jail, and community confinement administrators for drafting or revising protocols for their facilities for an immediate response to sexual assault. Because prisons, jails, and community confinement facilities may differ in how they respond to sexual assault, some recommendations, either in whole or part, are specific to a particular type of confinement. Variations primarily occur between prisons/jails and community confinement facilities,⁵² although prisons and jails (particularly small jails) also have differences.⁵³

⁵⁰ National Prison Rape Elimination Commission, *Report* (2009), pp.3, 14-16, 114-117, & 132-134.

⁵¹ Note that beyond supporting the requirements of the Department of Justice's PREA standards, the recommendations in this guide are not meant to supersede or invalidate previously established institutional protocols, policies, or practices that address the immediate response to sexual assault.

⁵² Variations between prisons/jails and community confinement stem mainly from the fact that residents of community confinement facilities typically have freedoms that are not available to those in prisons and jails—to physically flee a perpetrator, to report directly to local law enforcement instead of or in addition to reporting to correctional authorities, to seek services directly from local agencies, and to work in the community. Also, most community confinement facilities have a limited scope of in-house services, heightening the need to refer and connect resident sexual assault victims with community-based services and programs to address their needs.

⁵³ Note that some differences between prisons and jails may have logistical implications for the initial response to sexual assault: Prisons typically house individuals whose sentences are usually longer than one year. Jails hold individuals mainly awaiting trial/sentencing or serving shorter sentences. Community-based service providers may need security clearance to enter prisons or jails. Large- and medium-sized jails may be more like prisons in their operations, as compared with small jails. In the U.S., there are large jails in urban centers and medium-sized jails in suburban areas. But the majority of jails are small facilities in rural locations. Large- and medium-sized facilities may have more staff, programming, and security, like prisons. Some jails may hold those whose sentences are longer than a year, under agreement with prisons. Small jails typically have limited staff and physical space. In rural areas, correctional facilities often have few local resources at their disposal.

Appendices include: (A) a bibliography; (B) issues and recommendations for lockups; (C) issues and recommendations for juvenile detention facilities; (D) potential roles for core responders; and (E) an assessment tool for corrections administrators drafting or revising protocols for an immediate response to sexual assault.

5. Explanation of Terms⁵⁴

Corrections administrators should understand how the following terms are used in this guide. The terms are listed in alphabetical order.

Community confinement facility: Community-based, court-mandated residential programs— treatment centers, halfway houses, restitution centers, mental health facilities, alcohol or drug rehabilitation centers, re-entry centers, etc.—where individuals stay overnight as part of a term of imprisonment or as a condition of pre-trial release or post-release supervision, while participating in gainful employment, employment search efforts, community service, vocational training, treatment, educational programs, or similar facility approved programs during nonresidential hours.

Community-based victim advocate: Community-based sexual assault victim advocacy programs— often referred to as rape crisis centers—typically use paid and/or volunteer victim advocates to provide services to victims and their personal support network. Specific services vary from one agency to the next, but typically include accompaniment and support for victims through the medical forensic examination process, the recovery process, and the investigatory process. Victim advocates offer emotional support, crisis intervention, information, referrals, and advocacy to ensure that victim needs related to the assault are addressed to the extent possible. Many advocacy programs provide a crisis hotline. Crisis hotlines and accompaniment for the medical forensic examination are typically available 24 hours a day, every day of the year. Many also offer a range of follow-up services, such as support groups, counseling, and ongoing medical/legal accompaniment. (For information on locating a rape crisis center in a specific area, see Section III, V5.)

Community-based victim advocates are distinguished from government-based victim-witness specialists who offer victim assistance in cases in which a crime is reported to law enforcement. Community-based victim advocates can serve victims of sexual assault regardless of whether they have made a report. Also, information that victims share with government-based victim-witness specialists usually becomes part of the criminal justice record, while community-based victim advocates typically can provide some level of confidential communication for victims (see explanation below of “Confidentiality of victim/advocate communication”). In addition, community-based victim advocates commonly receive specialized education specific to the medical forensic examination process, providing victim support, and sexual assault issues in general. In some areas, rape crisis centers are part of a governmental unit. Advocates from these programs are still considered “community-based victim advocates” as long as they are not part of the criminal justice system (such as a law enforcement agency) and offer a comparable level of confidentiality as a nongovernmental organization advocate.

Confidentiality of victim/advocate communication: Confidentiality of victim/advocate communication means that victim information cannot be released to a third party by the community-based victim advocacy program unless (1) it is required by law (e.g., all states have mandatory reporting requirements related to reporting abuse and neglect of children and vulnerable adults, as well as of emergency situations involving an imminent risk of serious harm), (2) the victim gives permission, or (3) it is successfully subpoenaed (even in states where community-based advocacy programs do not fit the criteria for privileged communication, courts are generally reluctant to allow communication between victims and community-based victim advocates to be breached).

⁵⁴ The explanation of terms is drawn in part from Office on Violence Against Women, *A National Protocol* (2013), pp.14-19; National Prison Rape Elimination Commission, *Standards for the Prevention, Detection, Response, and Monitoring of Sexual Abuse in Adult Prisons and Jails* (2009), pp.3-7, and *Standards for the Prevention, Detection, Response, and Monitoring of Sexual Abuse in Community Corrections* (2009), pp.5-10; 28 C.F.R. §§ 115.5, and 115.6; as well as other sources cited.

Community-based sexual assault victim advocacy programs usually can provide some level of confidentiality for victim/advocate communication, depending upon applicable jurisdictional statutes. The extent of victim/advocate confidentiality may also vary in cases of corrections-based sexual assault. It can be extremely useful for advocacy programs to work with corrections facilities to discuss and clarify its scope and limitations in advance so that individual cases will be handled properly. Many states have laws providing some level of privilege to communications of sexual assault/rape crisis and domestic violence counselors. A few states have laws that apply to victim counselors in general (most require that counselors must complete a certain number of training hours to qualify for the privilege). Privilege varies from state to state.⁵⁵

Core responders: Those professionals involved in an immediate response to a report of corrections-based sexual assault, both those internal and external to the correctional facility. (See Appendix D for a description of possible roles.)

Corrections-based sexual assault: Sexual assault that occurs in a correctional environment.

Corrections staff: Correctional facility employees, contractors, and volunteers.

Examination site: The site where the sexual assault medical forensic examination is conducted. Examination sites are commonly located in hospitals (often in the emergency department), other health care facilities, or other facilities that have forensic examiners/forensic examiner programs. If prisons or jails choose to perform these examinations at their facilities, it is most typically done in a private area in a facility's medical unit or another appropriate place in a facility if it does not have a medical unit. (See Section III, V7 and C5.) Regardless of the location, a specially educated and clinically prepared forensic examiner should conduct the examination.⁵⁶

Gender nonconforming: A person whose appearance or manner does not conform to traditional societal gender expectations.

Incarcerated individual: Any person confined in a prison, jail, or lockup (although in this guide, incarcerated individual is used mainly to refer to those in prisons and jails).

Intersex: A person whose sexual or reproductive anatomy or chromosomal pattern does not seem to fit typical definitions of male or female. Intersex medical conditions are sometimes referred to as variations of sex development.

Jail: A confinement facility of a federal, state, or local law enforcement agency whose primary use is to hold persons pending adjudication of criminal charges, persons committed to confinement after adjudication of criminal charges for sentences of one year or less, or persons adjudicated guilty and awaiting transfer to another correctional facility.

Lockup: A facility that contains holding cells, cell blocks, or other secure enclosures that are (1) under the control of a law enforcement, court, or custodial officer; and (2) are primarily used for the temporary confinement of individuals who have recently been arrested, detained, or are being transferred to or from a court, jail, prison, or other agency.

Perpetrator: Because this guide uses a multidisciplinary response, the term perpetrator is not used in a strictly criminal justice/corrections context (i.e., it doesn't make a distinction between alleged perpetrator and a person who has been found guilty of sexual assault). Thus, a perpetrator in this guide refers to an individual whom an incarcerated person in a prison or jail/resident in a community confinement facility reports has committed a sexual assault or someone who is suspected of committing a sexual assault. A

⁵⁵ See Office on Violence Against Women, *A National Protocol* (2013), pp.47-49, for a broader discussion of confidentiality as it relates to sexual assault cases.

⁵⁶ See Office on Violence Against Women, *A National Protocol* (2013), pp.59-61, for more concerning requirements to become a sexual assault forensic examiner.

perpetrator may also be referred to as a suspect. In corrections-based sexual assault, perpetrators are either offenders housed in the correctional facility or are employees, volunteers, or contractors to that facility.

Personal support person: In this guide, personal support person refers to victims' family, friends, or others that they may informally seek emotional support from in the aftermath of a sexual assault. It does not refer to community-based victim advocates, which are part of a formal support network for victims.

Prison: An institution under federal or state jurisdiction with a primary use of confining individuals convicted of a serious crime, usually for sentences in excess of one year in length, or a felony.

Recent sexual assault: The definition of a recent sexual assault is usually based on jurisdictional policies regarding a standard cut-off time to collect evidence on victims' bodies and clothing, using the jurisdiction's designated evidence collection kit. The reason for the cut-off is that after a certain period of time, such evidence is often lost or damaged. However, most jurisdictions allow some flexibility in cut-off times, given that it is conceivable under some circumstances that evidence may still be available even after the cut-off times. Delayed reporting of a sexual assault thus refers to reports made after the jurisdiction's cut-off times.

Resident: Any person confined or detained in a community confinement facility.

Security staff: Employees primarily responsible for the supervision and control of inmates or residents in housing units, recreational areas, dining areas, and other program areas of the facility.⁵⁷

Sexual abuse: In this guide and the [National Protocol](#), sexual assault describes what the corrections field and the U.S. Department of Justice's PREA standards refer to as sexual abuse, both staff-on-inmate sexual abuse (also commonly referred to as staff sexual misconduct) and inmate-on-inmate sexual abuse. In the PREA standards, (1) inmate refers to an incarcerated person at a prison or jail, (2) detainee refers to an incarcerated person at a lockup, and (3) resident refers to a person held in a community confinement facility or a juvenile detention facility. The PREA standards make the following distinctions:

- *Sexual abuse by a corrections staff member, contractor or volunteer* includes: (1) contact between the penis and the vulva or the penis and the anus, including penetration, however slight; (2) contact between the mouth and the penis, vulva, or anus; (3) contact between the mouth and any body part where the staff member, contractor, or volunteer has the intent to abuse, arouse, or gratify sexual desire; (4) penetration of the anal or genital opening, however slight, by a hand, finger, object, or other instrument, that is unrelated to official duties or where the staff member, contractor, or volunteer has the intent to abuse, arouse, or gratify sexual desire; (5) any other intentional contact, either directly or through the clothing, of or with the genitalia, anus, groin, breast, inner thigh, or the buttocks, that is unrelated to official duties and/or where the staff member, contractor, or volunteer has the intent to abuse, arouse, or gratify sexual desire; (6) any attempt, threat, or request by a staff member, contractor, or volunteer to engage in the activities described in paragraphs (1)-(5); (7) any display by a staff member, volunteer, or contractor of his or her uncovered genitalia, buttocks, or breast in the presence of an inmate, detainee, or resident; and (8) voyeurism by a staff member, contractor, or volunteer.⁵⁸ Persons housed in correctional facilities cannot legally consent to sexual activity with corrections staff (See Section I).
- *Inmate-on-inmate sexual abuse* includes any of the following acts, if the victim does not consent, is coerced into such act by overt or implied threats of violence, or is unable to consent or refuse: (1) contact between the penis and the vulva or the penis and the anus, including penetration, however slight; (2) contact between the mouth and the penis, vulva, or anus; (3) penetration of the anal or genital opening of another person, however slight, by a hand, finger, object, or other instrument; and (4) any other intentional touching, either directly or through the clothing, of the genitalia, anus, groin,

⁵⁷ 28 C.F.R. § 115.5.

⁵⁸ This guide and the [National Protocol](#) do not speak to several forms of sexual misconduct addressed in the PREA standards: sexual harassment and staff-on-inmate indecent exposure, voyeurism, and solicitation to engage in sexual contact. These complaints, in and of themselves, do not constitute sexual contact and thus would not warrant a sexual assault medical forensic examination.

breast, inner thigh, or the buttocks of another person, excluding contact incidental to a physical altercation. Although many seemingly consensual acts between inmates often violate facility policies, if both inmates truly consented and had the capacity to consent, it should not be considered sexual abuse.

Sexual assault: Generally refers to sexual contact by one person with another without consent or without legal consent due to age, mental or physical incapacity, or custodial relationship with the other person.⁵⁹ Sexual assault can include a wide range of behaviors, including rape, unwanted/forcible anal or oral sex, unwanted/forcible object penetration, and unwanted intentional sexual touching (either directly or through clothing). The specific legal definitions for sexual assault that apply to a correctional facility will depend on the statutes/codes of the governing jurisdiction(s). In this guide and the *National Protocol*, sexual assault describes what the corrections field and the Department of Justice's PREA standards refer to as sexual abuse. (See the explanation for sexual abuse.)

Sexual assault coalition: There are 55 sexual assault coalitions, one for each state, the District of Columbia, and U.S. territories (some coalitions are combined with their domestic violence coalition). State sexual assault coalitions serve as membership associations for local services providers, mainly rape crisis centers, and also often advocate for improvements in laws, services, and resources for victims and their members.⁶⁰ (Section III, V5 describes how to get contact information for a specific sexual assault coalition.)

Sexual assault forensic examiner: The health care provider conducting the sexual assault medical forensic examination. This examiner should have specialized education and clinical preparation in the collection of forensic evidence and treatment of sexual assault patients. A sexual assault nurse examiner (SANE) is the most common type of sexual assault forensic examiner. SANE programs are available in many communities. (Section III, V7 provides information on how to find a forensic examiner program in a specific area.)

This guide recommends that correctional facilities consider using independent sexual assault forensic examiners. Independent in this case means a sexual assault forensic examiner not employed by the correctional facility where the assault was reported. Using independent forensic examiners can help avoid the possibility that an incarcerated person or resident in a community confinement facility will be examined by someone who sexually assaulted them. It can help avoid conflict of interest or the appearance of such a conflict for the correctional facility investigating the sexual assault.

Sexual assault medical forensic examination: An examination of a sexual assault patient by a health care provider, preferably one who has specialized education and clinical experience in the collection of forensic evidence and treatment of sexual assault victims. The examination includes gathering information from the patient for the medical forensic history, examining the patient, coordinating treatment of injuries, documenting biological and physical findings, collecting evidence from the patient, providing care for sexually transmitted infections (including post-exposure prophylaxis to prevent HIV), assessing pregnancy risk and discussing treatment options, including emergency contraception, and follow-up as needed to document additional healing, treatment, or evidence. In this guide, it is referred to as the medical forensic examination or the examination. It is referred to as the forensic medical examination under VAWA.

Sexual assault response team (SART): Also called a sexual assault response and resource team (SARRT). A SART/SARRT is a multidisciplinary team that provides a specialized, coordinated immediate response to victims of recent sexual assault. For corrections-based sexual assault, the team should include corrections staff, health care personnel at the examination site, community-based victim advocates, and law enforcement representatives (as applicable to the case). It is helpful if prosecutors are available on-call to consult with responders. Other agencies and professionals may be involved,

⁵⁹ Adapted in part from Office for Victims of Crime, *SART Toolkit*, Washington, D.C.: Department of Justice, Office of Justice Programs (2011), Learn About SARTs.

⁶⁰ Description drawn from the Resource Sharing Project at <http://www.resourcesharingproject.org/>.

depending upon the correctional facility and community. Team members do not have to physically come together to provide interventions, but instead follow protocols that allow them to coordinate their responses so they are streamlined and victim-centered.

Transgender: Individuals whose gender identity, expression, or behavior is not traditionally associated with their birth sex.

Victim: Because this guide uses a multidisciplinary response, the term victim is not used in a strictly criminal justice/corrections context (and therefore doesn't make a distinction between an alleged victim and a victim whose perpetrator has been found guilty). In the case of corrections-based sexual assault, a victim refers to a person who reports being sexually assaulted while in the custody of a correctional facility. Individuals who report a sexual assault should have access to certain services and interventions designed to help them be safe, recover, and seek justice. A victim may also be referred to as a survivor. Health care providers typically refer to victims they interact with as patients.

Victim-centered approach: This approach to sexual assault response recognizes that sexual assault victims are central participants in an immediate response and the examination process, and they deserve timely, compassionate, respectful, and appropriate care that addresses their self-identified needs. Like any sexual assault victim, victims in correctional environments have the right to be fully informed in order to make their own decisions about participation in various components of the examination process. Responders need to explain possible options, the consequences, if any, of choosing one option over another, and available resources, as well as support victims in their choices to the extent possible.

I. A Primer on Corrections-Based Sexual Assault

This section provides a brief overview of the problem of corrections-based sexual assault, including:

- Dynamics
- Prevalence and Incidence
- Reporting: Too Many Risks, Not Enough Benefits?
- Who is Most at Risk?
- Potential Repercussions

1. Dynamics⁶¹

There are several manifestations of sexual assault that occur in correctional environments.⁶² Corrections staff, incarcerated persons, and residents in community confinement facilities may sexually coerce or violently sexually assault individuals housed in correctional facilities. The primary motivation for perpetrators of sexual assault is generally not sexual gratification, although that may be part of it. More commonly, they use sexual violence as a tactic to overpower, control and/or humiliate another person.⁶³

Nonconsensual sexual contact between individuals housed in a correctional facility. An individual housed in a correctional facility may engage in sexual activity with another through coercive means—for example, a person may agree to sexual contact as a result of being threatened, intimidated, or bribed, or to pay off debts for protection, items, or services.⁶⁴ Protective pairings are quite common in male prisons and jails, whereby a vulnerable inmate exchanges sex with a physically stronger inmate for protection from rival gangs or violent inmates. A dynamic more unique to females in prisons and jails is participation in facility-based “families” (whereby females housed in the facility band together and even take on roles of parent, sister, aunt, etc.) and intimate relationships.⁶⁵ Females may report sexual assault occurring to someone in their “family” as a protective measure. For example, they might report their concern that a fellow inmate is unable to extricate herself from a sexual “relationship” with a corrections staff member who has a history of abusing women. In female facilities, there may also be domestic violence occurring between female “couples” that includes sexual assault.⁶⁶

It is important to note that coercive sex may not be recognized as sexual assault either by victims or corrections staff, especially if it does not involve a threat of physical violence. Violent sexual assault, on the other hand, is characterized by the use of physical force and/or violence by one individual housed in the correctional facility against another.⁶⁷

Administrators should have a general understanding of their state statutes related to sexual assault in general, as well as any specific laws that cover inmate-on-inmate or resident-on-resident sexual assault.

Sexual abuse by corrections staff (also known as staff sexual misconduct). No sexual activity between corrections staff (employees, contractors, and volunteers) and persons housed in their facilities is

⁶¹ National Institute of Corrections/American University, Washington College of Law, Project on Addressing Prison Rape offers useful training materials for corrections staff on this and other topics related to corrections-based sexual assault, including *Curriculum: Investigating Allegations of Staff Sexual Misconduct with Offenders* (Washington, D.C., 2010) and *Responding to Inmate on Inmate Sexual Violence* (Washington, D.C., 2008).

⁶² C. Abner, J. Browning, & J. Clark, *Preventing and Responding to Corrections-based Sexual Abuse: A Guide for Community Corrections Professionals* (Lexington, KY.: American Probation and Parole Association, with International Community Corrections Association and Pretrial Justice Institute, 2009), p.8.

⁶³ While sexual harassment is critical for corrections administrators to address in their response to the continuum of sexual abuse in their facilities, it is not addressed in this guide due to the guide’s focus solely on nonconsensual sexual contact.

⁶⁴ Drawn from C. Abner, J. Browning, & J. Clark, *Preventing and Responding to Corrections-based Sexual Abuse*, p.9.

⁶⁵ Participation in these “families” appears more common for women in prison than jail. Vera Institute of Justice, *Summary Memos for the Sexual Assault Forensic Protocol in Jail Work Group Meetings* (Washington, D.C.: Unpublished, 2011).

⁶⁶ For further explanation on the dynamics of inmate on inmate assault, see National Institute of Corrections/American University, Washington College of Law, Project on Addressing Prison Rape, *Responding to Inmate on Inmate Sexual Violence* (Sexual Behavior in Institutional Settings).

⁶⁷ Paragraph adapted from Abner, Browning, & Clark, *Preventing and Responding to Corrections-based Sexual Abuse* (2009), p.9.

considered consensual (even if one or both parties believes that to be the case). Given the custodial authority that corrections staff have over individuals in their facilities, there is an unequal power dynamic between the two parties.⁶⁸

In addition to sex that is misinterpreted to be consensual, corrections staff in prisons and jails may coerce sex from inmates. For example, they may threaten loss of good time, privileges, or protection for other incarcerated individuals. Corrections staff in community confinement facilities may use residents' conditional release status or other freedoms as tools for sexual coercion and/or to keep them silent about a sexual assault. For example, a corrections officer could threaten to falsely report that a resident is not complying with the conditions of their community supervision, which could result in that resident being returned to prison or jail. Of course, corrections staff may also perpetrate violent sexual assault against individuals housed in their facility.

Federal law prohibits corrections staff sexual misconduct.⁶⁹ It is also prohibited in all 50 states and the District of Columbia and is a felony in most states.⁷⁰ Some forms of community corrections facilities and staff are covered under these laws in 44 states and the District of Columbia.⁷¹ Corrections administrators should be aware of state law related to staff sexual misconduct and its application to their facilities, as well as their facilities' policies prohibiting staff sexual misconduct.⁷²

A Note about Sexual Assault in Community Confinement Facilities

Just as in prisons and jails, sexual abuse and assault can be an issue for individuals housed in community confinement facilities. They can also be vulnerable to staff sexual misconduct. In both secure and community confinement, staff have virtually unlimited access to individuals housed in their facilities. Staff of community confinement facilities, however, may operate with less direct supervision than do prison and jail staff; reduced oversight might make it easier to conceal sexual assault. Staff roles may also be more varied than in prisons and jails—not only do many community confinement staff operate as public safety officers, they also act as counselors and social workers to residents as they reintegrate into the community. In smaller communities, staff may even have gone to the same schools or churches or shared social circles with residents. The complexity of staff-resident relationships in community confinement facilities can make it difficult for staff to draw and maintain boundaries with residents, which might lead to blurred lines related to sexual contact.⁷³

2. Prevalence and Incidence

Based on an analysis of data compiled by the Bureau of Justice Statistics (BJS) in 2011 and 2012, approximately 80,600 adults in prisons and jails in the United States suffered some form of sexual abuse (defined using PREA definitions) while incarcerated during the preceding year.⁷⁴ This analysis suggests 4.0 percent of the prison population and 3.2 percent of the jail population in this country suffered sexual

⁶⁸ Paragraph adapted from Abner, Browning, & Clark, *Preventing and Responding to Corrections-based Sexual Abuse* (2009), p.10.

⁶⁹ Smith & Yarussi, *Legal Responses to Sexual Violence in Custody: State Criminal Laws Prohibiting Staff Sexual Abuse of Individuals Under Custodial Supervision* (2007), p.3.

⁷⁰ National Institute of Corrections/American University, Washington College of Law, Project on Addressing Prison Rape, *Curriculum: Investigating Allegations of Staff Sexual Misconduct with Offenders* (Module 3) and *Fifty-State Survey of Criminal Laws Prohibiting Sexual Abuse of Individuals in Custody* (Washington, D.C., 2009). For more detailed information on this topic, see Smith & Yarussi, *Legal Responses to Sexual Violence in Custody: State Criminal Laws Prohibiting Staff Sexual Abuse of Individuals Under Custodial Supervision*. Information on state-specific official misconduct statutes (National Institute of Corrections/American University, Washington College of Law, Project on Addressing Prison Rape, 2009) is available electronically through <http://www.wcl.american.edu/nic/>.

⁷¹ National Institute of Corrections/American University, Washington College of Law, Project on Addressing Prison Rape, *State Criminal Laws Prohibiting Sexual Abuse of Individuals Under Community Corrections Supervision* (Washington, D.C., 2009).

⁷² Paragraph from Abner, Browning, & Clark, *Preventing and Responding to Corrections-based Sexual Abuse* (2009), p.10.

⁷³ Paragraph from National Prison Rape Elimination Commission, *Report* (2009), p.168.

⁷⁴ See A. Beck, P. Harrison, M. Berzofsky, R. Caspar, & C. Krebs, *Sexual Victimization in Prisons and Jails Reported by Inmates, 2011-12, National Inmate Survey, 2011-12* (Washington, D.C.: U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics, 2013), pp.6-8.

abuse during that year. In some prisons, nearly 9 percent of the population disclosed sexual abuse within that time; in some jails the corresponding rate approached 8 percent.^{75,76}

However, the actual prevalence of sexual assault for the corrections populations in the United States is likely higher. One reason is that people in lockups and under community supervision, which includes those housed in community confinement facilities, are not included in these numbers. No national statistics yet exist on the sexual victimization of these populations.⁷⁷

The Bureau of Justice Statistics' National Prison Rape Statistics Program collects data through (1) an annual national review of institutional records documenting allegations of sexual abuse in correctional facilities (prisons, jails, and juvenile detention facilities), and (2) an annual national survey of persons incarcerated in prisons and jails, and youth in juvenile detention facilities. The statistics based on institutional reports reflect a much lower level of sexual abuse than do those based on surveys of incarcerated persons. In all likelihood, the institution-reported data significantly undercounts the number of actual victims due to underreporting. Indeed, in the 2008-09 survey of incarcerated adults,⁷⁸ between 69 and 82 percent of those who indicated experiencing corrections-based sexual abuse said they never reported to corrections officials.⁷⁹ Rates of underreporting were similar in the survey of former state prisoners.⁸⁰

Similar to victims of sexual abuse in correctional settings, significant numbers of non-incarcerated women and men disclosed in national surveys that they experienced sexual assault, but the vast majority did not report these crimes to law enforcement.⁸¹

3. Reporting: Too Many Risks, Not Enough Benefits?

As discussed earlier, the low rates of reporting of sexual assault in correctional settings are far from an anomaly, but reflective of a similar phenomenon in the community at large. Victims are more likely to remain silent if their fears and concerns related to reporting outweigh the benefits. This section explores those potential benefits and risks for victims in confinement.

⁷⁵ See A. Beck, P. Harrison, M. Berzofsky, R. Caspar, & C. Krebs, *Sexual Victimization in Prisons and Jails Reported by Inmates, 2011-12, National Inmate Survey, 2011-12* (Washington, D.C.: U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics, 2013), pp.6-8.

⁷⁶ At least 12 percent of juveniles held in state operated juvenile correctional facilities and large local or privately operated facilities that house adjudicated youth disclosed having suffered sexual abuse since admission at the facility (or within the past 12 months, whichever is shorter), with rates as high as 36 percent in specific facilities. See A. Beck, P. Harrison, & P. Guerino, *Sexual Victimization in Juvenile Facilities Reported by Youth, 2008-09* (Washington, D.C.: U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics, 2010), pp.1 & 4.

⁷⁷ Another challenge to obtaining accurate measures of prevalence, both in the community and the corrections population, is that estimates can vary significantly from study to study, due to differences in what offenses are measured, specific populations studied, data sources, questions asked of survey respondents, and methods used to gather data. For example, victims may be more likely to disclose sexual assault in anonymous/confidential surveys rather than face-to-face interviews. Written forms may be difficult to fill out for persons who have low literacy or are illiterate.

⁷⁸ Beck, Harrison, Berzofsky, Caspar, & Krebs, *Sexual Victimization in Prisons and Jails Reported by Inmates, 2008-09*.

⁷⁹ Paragraph from U.S. Department of Justice, *Initial Regulatory Impact Analysis* (2011), p.8.

⁸⁰ An estimated 37% of victims of inmate-on-inmate sexual victimization reported at least one incident to facility staff while approximately 21% of unwilling victims of staff sexual abuse reported at least one incident to facility staff. See A. Beck & C. Johnson, *Sexual Victimization Reported by Former State Prisoners, 2008*. (Washington, D.C.: U.S. Department of Justice, Bureau of Justice Statistics, 2012), p.30.

⁸¹ Note that rape and sexual assault are among the least likely violent offenses measured by the *National Crime Victimization Survey (NCVS)* to be reported to law enforcement. As cited in M. Rand, *Crime Victimization Survey: Criminal Victimization 2008*, Bureau of Justice Statistics bulletin (Washington, D.C.: U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics, 2009). The 2005 *National Crime Victimization Survey (NCVS)* indicated that less than 40 percent of rapes and sexual assaults (victims age 12 and up) were reported to law enforcement. As cited in S. Catalano, *National Crime Victimization Survey: Criminal Victimization, 2005* (Washington, D.C.: U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics, 2006). The *National Violence Against Women Survey*—which estimated that 1 in 6 women and 1 in 33 men in the United States (18 years and older) had experienced attempted or completed rape in their lifetimes—indicated only about 19 percent of those women and 13 percent of those men reported their victimization to law enforcement. As cited in P. Tjaden & N. Thoennes, *Prevalence, Incidence and Consequences of Violence Against Women: Findings from the National Violence Against Women Survey* (Washington, D.C.: U.S. Department of Justice, National Institute of Justice, 1998); and P. Tjaden & N. Thoennes, *Extent, Nature and Consequences of Rape Victimization: Findings from the National Violence Against Women Survey (Special Report)* (Washington, D.C.: U.S. Department of Justice, National Institute of Justice, 2006).

Reporting may be the only vehicle by which victims in prisons and jails can obtain the help they need in the aftermath of a sexual assault; residents in community confinement facilities may have a few more options. Many victims report in a desperate attempt to protect themselves from their perpetrators and prevent further attacks. They may have physical injuries and other related health care concerns. They may be suffering emotional trauma that impacts their ability to function. Ideally, reporting allows victims access to protective measures, medical/mental health care, and emotional support. However, in reality, the help available to those who report sexual victimization to correctional authorities has traditionally been very limited. In addition, few reports of sexual assault in correctional environments are substantiated, meaning correctional authorities determine there is insufficient evidence that the assault occurred.⁸² By reporting, victims may inadvertently be at greater risk for harm and humiliation, as well as loss of coveted privileges or freedoms.

When correctional facilities have protocols for an immediate response to sexual assault that address victims' fears and concerns related to reporting, victims may be more likely to report and seek help. The following list offers examples of fears and concerns that victims in confinement may have in the aftermath of a sexual assault that inhibit them from reporting.⁸³

Victims may fear that as a consequence of reporting, they will:⁸⁴

- Be placed in isolation within the prison or jail (e.g., administrative segregation or protective custody) which may limit an individual's access to facility programs, services, and activities and be potentially detrimental to a person's mental health;
- Be sent back to prison or jail if they are living in a community confinement facility (e.g., if separation from their perpetrators is not possible in their current facility);
- Face retaliation by perpetrators who are fellow inmates/residents;
- Face retaliation by perpetrators who are corrections staff (who may threaten continued violence, disciplinary sanctions, or loss of privileges or freedoms);
- Be targeted by sexual predators in the facility if their victim status is made public; and
- Be labeled a "snitch" or a "rat" by others in the facility and face retribution (those in prisons and jails, in particular, may face reprisals if they challenge the "code of silence"—an unspoken rule among inmates not to report behavior violations or criminal activities committed by one another⁸⁵—that is especially prevalent among gangs and within ethnic/cultural groups).

Victims may fear their reports will not be acted upon appropriately or at all by corrections officials, either because they don't believe them or consider them worthy or deserving of help due to their criminal status. They may also believe that corrections officials will ignore reports of staff sexual misconduct out of loyalty to their colleagues. Some victims' fear of reporting might stem from experiences of victimization that occurred prior to their incarceration. Others might fear reporting because of past negative experiences in their facility, such as having reported a sexual assault or observing another inmate/resident making a report and being treated with contempt or disbelief, punished, or put at more risk for harm.

Those at high risk for sexual assault (as discussed earlier) may also choose not to report for self-preservation. Consider, for example, transgender females in male facilities. While they may be at significant risk of sexual assault due to having a female appearance and manners, if word spreads that they were sexually assaulted, it is likely they will be targeted even more avidly by sexual predators in the facility. Corrections officials may be prone in such cases to immediately place victims in isolation in the

⁸² A study of sexual violence reported to prison and jail authorities indicated that just 13 percent of all allegations of sexual abuse made in 2008 were substantiated (determined upon investigation to have occurred). As cited in Beck & P. Guerino, *Sexual Violence Reported by Adult Correctional Authorities, 2007-2008*, BJS Special Report.

⁸³ Based largely on Vera Institute of Justice, *Summary Memos for the Sexual Assault Forensic Protocol in Corrections Prison, Jail, and Residential Community Corrections Work Group Meetings* (Washington, D.C.: Unpublished, 2011).

⁸⁴ The following Department of Justice PREA standards set specific requirements regarding the use of protective custody and agency responsibilities to protect inmates and staff who report sexual abuse. See *National Standards to Prevent, Detect, and Respond to Prison Rape, Final Rule*, 77 Fed. Reg. 37106-37232 (June 20, 2012) (to be codified at 28 C.F.R. §§ 115.43, 115.67, 115.167, 115.7267, 115.367, 115.68, and 115.368).

⁸⁵ Abner, Browning, & Clark, *Preventing and Responding to Corrections-based Sexual Abuse* (2009), p.8.

facility as a safety precaution—an action which, while it may offer a degree of protection for victims, also reduces their access to privileges and can diminish their mental health.

Some victims may delay reporting until they no longer fear retaliation or loss of privileges or freedoms (e.g., after they are transferred to another facility or released, or their perpetrators leave their facilities).

Victims' concerns that may deter reporting:

Victims may be concerned that instead of being helped when they report sexual assault to corrections officials, they will be regarded with contempt and ridicule. Consequently, victims may choose silence over reporting in order to avoid humiliation. Such humiliation, if experienced, could feel like re-victimization, in addition to the violation of the sexual assault.

Victims may think it is useless to try to hold their perpetrators accountable, even if their reports are taken seriously by corrections staff.

Victims may blame themselves/feel too ashamed to admit they were sexually assaulted.

Victims will face many barriers to reporting that are unique to their history and the circumstances of the assault. Societal preconceived notions and stereotypes about gender roles, gender identity, and sexual orientation often play a unique role in creating barriers to reporting.

Listed below are some examples of how stereotypes can impact victim reporting:

- **Male victims** in prisons and jails, in particular, may be too ashamed to admit that they have been victimized, in an environment often ruled by machismo where physical strength means power.⁸⁶
- **Male victims**, in particular, may have concerns related to sexuality. If they are assaulted by men, they may be labeled as less masculine, gay, or bisexual. They may run the risk of becoming a “sex slave” to others if word of their victimization spreads across the facility and possibly to other facilities. They may question their own sexual orientation; for example, are they gay if they had sexual contact with other men? They may fear their sexual orientation will influence others' perceptions of the sexual contact; for example, a sexual assault of a gay man by another man may be discounted by others as consensual sex (falsely believing if a man is gay, he is interested in sex of any kind with any man).
- **Male victims** who are victimized by female corrections staff may not see the sexual contact, even nonconsensual contact, as sexual assault. If they do, they may be afraid of ridicule by others if their victimization becomes public. They might fear that corrections officials will not believe them or will lack the competency to respond to these cases. They may be concerned that staff perpetrators will turn the tables and accuse them of assault.
- **Female victims**, in particular, may believe in instances of staff sexual misconduct that there is an intimate relationship and they are “in love” with their perpetrators. For inmate-on-inmate sexual abuse, they may think that corrections officials will not take reports of female-on-female sexual assault seriously.
- **Victims may not report sexual assault because they don't see it as out of the range of normal sexual behavior.** Many in the corrections population, especially women, have histories of sexual victimization and trauma that can make it difficult for them to recognize abusive behaviors and leave them more vulnerable to and accepting of the unacceptable (e.g., they may have sex with a corrections official in exchange for protection or with an employer in order to retain their jobs).
- **Residents of community confinement facilities** may see corrections staff in the community, creating ambiguity about boundaries between residents and staff and opportunities to cross established boundaries. There may be a reluctance to report staff sexual misconduct if there is a perception that the sexual contact is part of an intimate relationship between the resident and staff person rather than an abuse of power by a staff person.

⁸⁶ Abner, Browning, & Clark, *Preventing and Responding to Corrections-based Sexual Abuse* (2009), p.7.

4. Who is Most At Risk?

While anyone can become a sexual assault victim, the most marginalized members of society also tend to be the most vulnerable in confinement settings.⁸⁷ Perpetrators tend to target those they perceive as having an attribute that can be used to their advantage. For example, the following may increase a person's risk of sexual assault.⁸⁸

- Mental or physical disability;
- Young age;
- Old age;
- Small stature or perceived physical weakness;
- First incarceration or term of confinement;
- Non-heterosexual orientation (gay, lesbian, or bisexual), as well as those who are transgender, or who are intersex;
- Gender nonconforming appearance;
- Prior sexual victimization;
- Prior institutional victimization (e.g., physical assault or extortion);
- Lack of gang affiliation;
- Patterns of complaints against those housed in the facility; and
- Other visible signs of vulnerability (e.g., low self-esteem, showing fear, loneliness, or uncertainty, or appearing ill at ease and overwhelmed).

Being female is another risk factor. BJS's institutional reports and surveys of incarcerated adults and former state prisoners indicate that females are disproportionately victimized by other inmates compared to males.⁸⁹ According to reports made to correctional authorities, females are also disproportionately victimized by staff compared to males, but inmate surveys suggest that female inmates report lower rates of staff-on-inmate sexual assault than male inmates.⁹⁰ However, more males are sexually victimized in confinement settings simply because the vast majority of individuals in prisons, jails, and community confinement settings are men.⁹¹

5. Potential Repercussions

Experiences of sexual assault have the potential to harm a person in every dimension of life—most victims report persistent, if not lifelong, repercussions.⁹² Sexual assault can be particularly damaging in correctional environments, where the power dynamics are heavily skewed against victims, the remedies available are often inadequate to meet their needs, and seeking help may pose serious risks to their safety and well-being (as previously discussed).⁹³

⁸⁷ Just Detention International, *The Basics About Sexual Abuse in U.S. Detention* (Los Angeles, CA, 2009), through http://www.justdetention.org/en/fact_sheets.aspx.

⁸⁸ Adapted from National Prison Rape Elimination Commission, *Report*, p.75; and Abner, Browning, & Clark, *Preventing and Responding to Corrections-based Sexual Abuse*, p.19. Note that this list is not inclusive of all factors that might increase a person's risk. For a more in-depth exploration, one resource is J. Warren, S. Jackson, A. Booker Loper, & M. Burnette, *Risk Markers for Sexual Predation and Victimization in Prison* (Report submitted to the U.S. Department of Justice, 2009).

⁸⁹ See Beck, Harrison, Berzofsky, Caspar, & Krebs, *Sexual Victimization in Prisons and Jails Reported by Inmates, 2008-09*; A. Beck & P. Guerino, *Sexual Violence Reported by Adult Correctional Authorities 2007-2008, BJS Special Report* (Washington, D.C.: U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics, 2011); and A. Beck & C. Johnson, *Sexual Victimization Reported by Former State Prisoners, 2008*. (Washington, D.C.: U.S. Department of Justice, Bureau of Justice Statistics, 2012).

⁹⁰ Beck, Harrison, Berzofsky, Caspar, & Krebs, *Sexual Victimization in Prisons and Jails by Inmates, 2008-09*; and A. Beck & P. Guerino, *Sexual Violence Reported by Adult Correctional Authorities 2007-2008, BJS Special Report*.

⁹¹ In 2009, 82 percent of the total correctional population was male and 18 percent was female. The female population has slowly increased since 1990 (when females were 14 percent of the total correctional population). As cited in L. Glaze, *Correctional Population in the United States, 2009* (Washington, D.C.: U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics, 2010), p.3.

⁹² Adapted from National Prison Rape Elimination Commission, *Report* (2009), p.44.

⁹³ *National Standards to Prevent, Detect, and Respond to Prison Rape, Notice of Proposed Rulemaking*, 76 Fed. Reg. 6249 (February 3, 2011); and Abner, Browning, & Clark, *Preventing and Responding to Corrections-based Sexual Abuse* (2009), p.18.

Reactions to sexual assault can vary greatly, as each victim deals with victimization in their own way. However, specific behavioral, physical, and emotional symptoms and reactions are often associated with sexual assault.

Behavioral Changes

A plethora of immediate, short-term, and long-term behavioral changes are linked with experiencing sexual assault and coping with its aftermath. Examples of these changes can include, but are not limited to:⁹⁴

- **Self-harming behaviors**—increased drug and alcohol use, self-mutilation, and suicidal thoughts and attempts;
- **Physiological changes**—sleep disturbances such as insomnia or excessive sleeping, changes in eating patterns that can lead to weight gain/loss, bulimia, and anorexia, bed wetting and incontinence, aversion to touch, and change in patterns of hygiene (e.g., feeling the need to frequently bathe or not wanting to bathe at all); and
- **Changes in social interactions/behaviors**—withdrawal or self-isolation, changes in dressing patterns (e.g., wearing many layers of clothing or dressing provocatively), aggressive or disruptive behavior, regressive behavior, sexually inappropriate behavior and sexual promiscuity, excessive attachment, and avoidance of certain individuals or places.⁹⁵

Physical Consequences

As perpetrators are often successful in using coercion, intimidation, and the threat of force to facilitate sexual assault, excessive force is generally not the norm. As a consequence, victims may have few visible physical injuries. However, some who experience sexual assault are physically injured. Male victims in correctional environments may be more prone to physical injury than females.⁹⁶ Increased physical injuries may occur when victims experience multiple sexual assaults and/or multiple perpetrators.⁹⁷ Obvious acute physical injuries require immediate medical attention.⁹⁸

Other physical consequences of sexual assault, such as pregnancy (for female victims) or exposure to HIV and other sexually transmitted infections (STIs), may not be suspected or detected until days or even weeks after the assault. Incarcerated victims of sexual assault have a heightened risk of contracting

⁹⁴ Drawn from West Virginia Sexual Assault Free Environment Partnership, *WV S.A.F.E. Training and Collaboration Toolkit: Serving Sexual Violence Victims with Disabilities* (West Virginia Foundation for Rape Information Services, Northern West Virginia Center for Independent Living, & West Virginia Department of Health and Human Resources, 2010), pp.B2.2-3.

⁹⁵ For example, following an assault, a male victim may become aggressive against his perpetrator or others, in an attempt to regain his sense of masculinity and social standing. He may “hook up” with a sexual partner in exchange for protection against others in the facility. Abner, Browning, & Clark, *Preventing and Responding to Corrections-based Sexual Abuse* (2009), p.18.

⁹⁶ A Bureau of Justice Statistics inmate survey found that among persons who reported inmate-on-inmate sexual victimization in jail, 37 percent of males reported being injured, compared to 8 percent of females. In prison, males and females were almost equally as likely to report injury (21 percent and 17 percent respectively) during sexual victimization. Among victims of staff sexual misconduct in jail, 17 percent of males and 8 percent of females reported being injured during the incident. Among victims of staff sexual misconduct in prison, 9 percent of males and 19 percent of females said they had been injured. As cited in Beck, Harrison, Berzofsky, Caspar, & Krebs, *Sexual Victimization in Prisons and Jails Reported by Inmates, 2008-09*. Another study of incarcerated men found that more than half of all sexual assaults resulted in physical injury, with those assaulted by inmates somewhat more likely than those assaulted by corrections staff to be injured physically. As cited in N. Wolff & J. Shi, Contextualization of Physical and Sexual Assault in Male Prisons: Incidents and Their Aftermath. *Journal of Correctional Health Care*, 15(1) (2009), pp.58-82.

⁹⁷ C. Struckman-Johnson, D. Struckman-Johnson, L. Rucker, K. Bumby, & S. Donaldson, Sexual Coercion Reported by Men and Women in Prison, *J. Sex Res.*, 33(1) (1996), pp.71-72. Note that results from this state prison inmate survey indicated that, on average, prisoners who said they were sexually coerced experienced nine episodes of pressured or forced sex, and more than one fourth of the male victims were forced to have intercourse with two or more perpetrators. As cited in R. Dumond, The Impact of Prisoner Sexual Violence: Challenges of Implementing Public Law 108-79—The Prison Rape Elimination Act of 2003, *Journal of Legislation*, 32 (2006), p.6.

⁹⁸ In addition to anal or vaginal tearing from forced penetration, physical injuries sustained during sexual assault have been reported to include bruises, scratches, swelling, cuts, lacerations, knife or stab wounds, black eyes, sprains, bleeding, broken bones, concussions, knocked-out teeth, internal injuries, and other minor and serious physical damage. As cited in J. Mariner, Rape scenarios, *No Escape: Male Rape in U.S. Prisons* (New York: Human Rights Watch, 2001), National Prison Rape Elimination Commission, *Report*, 129; Beck, Harrison, Berzofsky, Caspar, & Krebs, *Sexual Victimization in Prisons and Jails Reported by Inmates (2008-09)*; and A. Beck & C. Johnson, *Sexual Victimization Reported by Former State Prisoners, 2008*. (Washington, D.C.: U.S. Department of Justice, Bureau of Justice Statistics, 2012).

HIV/AIDS and other STIs. HIV/AIDS, hepatitis B and C, tuberculosis, and other communicable diseases are more prevalent among prison and jail populations than in the larger community.⁹⁹ Also, multiple sexual assaults by multiple perpetrators can increase the risk of infection.¹⁰⁰

Emotional Trauma

Victims often struggle with significant emotional trauma as a result of the sexual assault. Reactions to sexual assault can include, but are not limited to depression, shock and disorientation, spontaneous crying, self-blame, feelings of despair and hopelessness, anxiety and panic attacks, fearfulness, suicidal thoughts, feelings of being out of control, irritability, anger, emotional numbness, and withdrawal from normal routines and relationships.¹⁰¹ Victims may also experience memory lapses, especially about the assault,¹⁰² difficulty in making decisions and concentrating, hyperactivity, and impulsivity.

While sexual assault is considered to be a traumatic event, certain factors may influence the extent of emotional trauma a victim experiences in the aftermath of such an incident. Some of these factors include, but are not limited to:¹⁰³

- Severity and frequency of the victimization;
- Threat of continued violence;
- Personal history (e.g., prior victimizations, age at the time of the assault, relationship with perpetrator, etc.);
- Any added meaning the victimization may represent for an individual (e.g., a man may feel his masculinity is compromised and that others will view him as weak);
- Individual coping skills, values, and beliefs; and
- Reactions and support from family, friends, and/or professionals.

Additional symptoms are linked with severe traumatic events, including sexual violence, and are key indicators of post-traumatic stress disorder (PTSD):¹⁰⁴

- Intrusive thoughts, flashbacks, or nightmares and a sudden flood of emotions or images related to the traumatic event. Intrusive symptoms sometimes cause people to lose touch with the “here and now” and react in ways that they did when the trauma originally occurred.¹⁰⁵ Trauma can be triggered by unique circumstances, such as encountering smells, sounds, sights, or feelings that were present at the time of the initial event. Such circumstances, which the victim cannot control, can make healing difficult.
- Amnesia, avoidance of situations that resemble the initial event, detachment to avoid painful emotions and feeling overwhelmed, and an altered sense of time. Frequently, people use drugs or alcohol to avoid trauma-related feelings and memories.¹⁰⁶
- Hypervigilance, jumpiness, and an extreme sense of being “on guard”; overreactions including sudden, unprovoked anger, general anxiety, insomnia, and obsession with death.

For victims in correctional environments, recovery from sexual violence may be significantly impeded by the closed and harsh nature of the setting, their reduced autonomy, the constant threat of subsequent violence and degradation, and the social stigma associated with being identified as a victim in these settings. These conditions may exacerbate post-trauma responses.¹⁰⁷

⁹⁹ Abner, Browning, & Clark, *Preventing and Responding to Corrections-based Sexual Abuse* (2009), p.17; J. Robertson, Rape Among Incarcerated Men: Sex, Coercion, and STDs, *AIDS Patient Care and STDs*, 17(8) (2003), pp.423-430

¹⁰⁰ *Ibid.*

¹⁰¹ Drawn in part from West Virginia Sexual Assault Free Environment Partnership, *WV S.A.F.E. Training and Collaboration Toolkit* (2010), pp.B9.3.

¹⁰² Note that, therefore, a change in victims’ accounts of what happened during or surrounding a sexual assault should not immediately be perceived as lying. Instead, it should be understood in the context of the impact of trauma.

¹⁰³ Drawn from Santa Barbara Graduate Institute Center for Clinical Studies and Research and LA County Early Intervention and Identification Group, *Emotional and Psychological Trauma: Causes and Effects, Symptoms and Treatment* (Healing Resources.info, reprinted from Helpguide.org, 2005).

¹⁰⁴ Symptoms listed, except where noted, drawn from Santa Barbara Graduate Institute et al.

¹⁰⁵ Sidran Institute, *What is Post-Traumatic Stress Disorder?* (Brooklandville, MD, 2000).

¹⁰⁶ *Ibid.*

¹⁰⁷ National Prison Rape Elimination Commission, *Report* (2009), p.45.

Trauma experienced as a result of rape may be compounded for victims in correctional settings due to factors such as: (1) their lack of privacy and control over their environment (e.g., they may face continuous contact with their perpetrators, and repeated or ongoing sexual assault or threats of sexual assault); (2) disorientation after an assault, making it difficult to follow rules; (3) frequent triggers that bring back the feelings of the assault and may cause them to act out violently and/or with anger or fear; (4) a general distrust and perception that seeking help is a safety risk; (5) physical trauma connected with the assault and systemic infliction of psychological trauma (e.g., by perpetrators and others who seek to use their knowledge of the assault against them); and (6) emotional reactions to being placed in isolation for protection.¹⁰⁸

Trauma resulting from rape will manifest itself differently for each victim. Every victim will experience their own unique response and coping mechanisms to sexual abuse. For example, some victims may become more aggressive and self-destructive, and struggle with questions of sexual identity. Some victims may experience their lack of privacy in different, more painful ways. For example, they may perceive room searches and body cavity searches as replications of sexual violation.¹⁰⁹ They may be very vulnerable to abusive authority figures. When faced with potential sexual assault situations, they may not recognize that they have the right to refuse and/or they may believe that it would be dangerous to refuse.¹¹⁰

¹⁰⁸ National Prison Rape Elimination Commission, *Report* (2009), p.45.

¹⁰⁹ Note that the Department of Justice PREA Standards limit cross-gender pat downs against female inmates, but not against male inmates. See 28 CFR §§ 115.15, 115.115, 115.215, 115.315.

¹¹⁰ Adapted from National Institute of Corrections/American University, Washington College of Law, Project on Addressing Prison Rape, *Responding to Inmate on Inmate Sexual Violence* (Victimization and Mental Health Care) (2008).

II. Overview of the Sexual Assault Medical Forensic Examination for Victims in Correctional Facilities

This section provides corrections administrators with the basics on:

- Elements of an Immediate Response to Sexual Assault
- Core Responders
- Activating a Coordinated Response and Conducting an Examination
- A Protocol for Immediate Response and the Examination Process
- Usefulness of a Correctional Protocol
- Collaboration in Protocol Development and Implementation

1. Elements of an Immediate Response to Sexual Assault

When sexual assault is reported in correctional facilities, it is essential to: (1) offer timely assistance to victims in order to protect them, prevent further trauma, and help them heal; and (2) promptly intervene in a way that holds perpetrators accountable for their behaviors and stops them from committing further violence.¹¹¹ Elements of such an immediate response to sexual assault typically include:¹¹²

- Protection for victims from threats of imminent harm;
- Provision of medical care for victims (for acute injuries and other related health concerns such as HIV/AIDS, other sexually transmitted infections (STIs), and risk of pregnancy);
- Collection of forensic evidence from victims, which may aid investigations;
- Preliminary documentation and investigation (which may lead to criminal charges against suspects, prosecution, and conviction, as well as administrative findings of sexual assault, a formal disciplinary process, and/or disciplinary sanctions); and
- Support, crisis counseling, information, and referrals for victims (and their families as applicable), as well as advocacy to ensure victims receive appropriate assistance.

A sexual assault medical forensic examination specifically addresses victims' health care needs related to the assault and the collection of forensic evidence, as appropriate.¹¹³ The process of facilitating this examination for victims in correctional environments—referred to in this guide as the examination process—can involve all of the elements of an immediate response.

2. Core Responders

Professionals involved in an immediate response to a report of corrections-based sexual assault, both those internal and external to the correctional environment, should include, at a minimum (see Appendix D for a description of possible roles):

- Corrections staff (e.g., administrators, line staff such as those first responding to a report and transport officers, staff acting as victim resource specialists, medical/mental health staff, and investigators);
- Health care personnel at the examination site (e.g., those involved in intake, those providing emergency care, forensic examiners, those doing discharge and a plan for follow-up, and examination site administrators);
- Community-based sexual assault victim advocates; and
- Criminal justice agencies/professionals (e.g., law enforcement, investigators, and prosecution).¹¹⁴

¹¹¹ Adapted from Office on Violence Against Women, *A National Protocol* (2013), p.12.

¹¹² *Ibid.*

¹¹³ *Ibid.*, p.17

¹¹⁴ While prosecutors are typically not actively involved in an immediate response, they should be available to consult with first responders as needed.

The effectiveness of an immediate response largely depends on coordination among all of these responders. Many communities have formed teams of core responders—commonly known as sexual assault response teams (SARTs) and sexual assault response and resource teams (SARRTs)—which coordinate interventions during an immediate response to sexual assault (in this guide, these teams are referred to as SARTs). A team approach to sexual assault response is recognized as a best practice. To facilitate coordination during an immediate response, corrections administrators should consider forming a correctional facility/system-based SART or participating in an already existing SART in their community.

3. Activating a Coordinated Response and Conducting an Examination

In any correctional setting, a report of a recent sexual assault should activate the coordinated interventions of core responders (SART immediate response).¹¹⁵ Their interventions will facilitate the medical forensic examination process. SART response and the examination process can also be triggered in cases when the report of sexual assault is delayed. Note, however, that the passage of time since the incident may influence victims' need for protection, medical care, and emotional support, as well as whether there might be forensic value in conducting an examination.¹¹⁶

Activating a SART response and the examination process does not necessarily equate to a full or even partial examination being performed in every case of reported sexual assault. Instead, it sets the stage for responders to collaboratively consider the most effective immediate response, given the specific circumstances of each case, the victim's self-identified needs and wishes, and the relevant policies of responding agencies. Responders should be encouraged to rely on each other for input whenever there is a question of the value of an examination to a specific case. Several important related points to keep in mind include:

- The medical forensic examination addresses the full spectrum of sexual assault rather than only attempted/completed sexual penetration. (See the explanation of the term sexual assault in the Introduction to the Guide.)
- The medical forensic examination addresses victims' medical and evidentiary needs. Some of these needs are addressed by conducting a prompt examination, providing support, crisis intervention and advocacy, obtaining a history of the assault, documenting examination findings, evaluating and treating injuries, properly collecting, handling and preserving forensic specimens, providing prophylaxis against STIs and HIV/AIDS, and assessing a female victim for pregnancy, and providing, as needed, emergency contraception. Depending on the circumstances of the case and victim's needs and wishes, a full or partial examination may be conducted.
- A primary reason that victims seek help is concern about their health. The medical forensic examination is intended in part to speak to the specialized health care needs of individuals who have been sexually assaulted.
- Forensic evidence in these cases includes not only biological and trace evidence (perpetrators' saliva, hair, or blood, debris on clothing/body, etc.), but also documentation of physical findings on victims' bodies (bruises, wounds, lacerations, etc.) and information gathered for a medical forensic history. The history and physical findings can help guide forensic examiners on if and where they look on a victim's body for evidence. The history and documentation of findings in and of themselves can be invaluable to an investigation. Many jurisdictions have developed sexual assault evidence collection kits to guide evidence collection from victims.¹¹⁷
- It is conceivable that evidence exists even if the time since the assault occurred is beyond the

¹¹⁵ The definition of a recent sexual assault is usually based on jurisdictional policies regarding a standard cut-off time to collect biological and/or trace evidence on victims' bodies and clothing, using the jurisdiction's designated evidence collection kit. The reason for the cut-off is that after a certain period of time, such evidence often is lost or damaged. However, most jurisdictions allow some flexibility in their cut-off times in acknowledgement of the fact that it is conceivable under some circumstances that evidence may still be available even after their cut-off times. Delayed reporting of a sexual assault thus refers to reports made after the jurisdiction's cut-off time.

¹¹⁶ In terms of whether delayed complaints will be investigated, jurisdictions vary in their statutes of limitations for different sex offenses. Correctional facilities also may have reporting and investigative policies on delayed complaints.

¹¹⁷ See Office on Violence Against Women, *A National Protocol* (2013), pp.71-72.

standard cut-off time for evidence collection in that jurisdiction.¹¹⁸ The potential for evidence will depend on factors such as its location (e.g., sperm in the cervix), type (e.g., traces of certain drugs), whether victims washed since the assault, and whether there are visible signs of trauma from the assault.¹¹⁹

- Delays in conducting an examination due to responder uncertainty or assumptions about the legitimacy of a complaint or availability of evidence can lead to the loss of evidence. There is forensic value in conducting an examination if there is any possibility that forensic evidence exists.
- If an examination is appropriate in a specific case, victims should be able to have the examination conducted even if they have not decided whether they will cooperate with a criminal investigation. One example is when incarcerated victims report to corrections staff that they have been sexually assaulted, but they do not name the perpetrator. Another example is when a resident of a community confinement facility seeks out an examination on their own after being sexually assaulted by a corrections staff member or another resident, but is undecided about reporting the assault to local law enforcement (if that option exists) and/or corrections staff at the time of the examination. Most jurisdictions permit evidence to be stored after a medical forensic examination (with jurisdictional policies defining the specific time period for storage) to allow victims time to make a reporting decision. The rationale is that even if victims are not ready to report at the time of the examination, the best way to preserve their option for criminal investigation/prosecution is to have examinations performed as soon after the assault as possible.
- The victim shall not have to assume the financial cost related to evidence collection (testing/prophylaxis for STIs and pregnancy are covered).¹²⁰
- An examination should never be conducted against the will of the victim. While victims in confinement settings may lack full autonomy, they should never be forced to undergo any part of the medical forensic examination.¹²¹

A medical forensic examination is not always appropriate. It is only warranted if a complaint includes nonconsensual sexual contact or sexual contact where the victim does not have the capacity to give consent. When a medical forensic examination is not conducted, victims should continue to be offered protection, medical care, mental health services, support, and/or legal remedies, as per facility policies and jurisdictional laws related to the offense, and as appropriate to the circumstances of the case.

4. A Protocol for Immediate Response and the Examination Process

A correctional protocol for an immediate response to sexual assault should include the integrated policies and procedures of all responders. It can also include plans to address implementation and institutionalization. It should be influenced by factors such as the U.S. Department of Justice's PREA standards; applicable state laws and reporting requirements; who has criminal jurisdiction for sex offenses; what resources are available; and existing policies and procedures of the facility and other responding agencies (e.g., the examination site and law enforcement agencies).

A correctional protocol for an immediate response to sexual assault, specifically during the medical forensic examination process, should include:

- A protocol purpose statement.
- Information on applicable laws and the Department of Justice's PREA standards.

¹¹⁸ As indicated earlier, jurisdictions typically have a standard cut-off time to collect biological and/or trace evidence on victims' bodies and clothing, using their designated evidence collection kit. Most jurisdictions allow some flexibility in cut-off times given it is conceivable under some circumstances that evidence may still be available even beyond the cut-off times.

¹¹⁹ See Office on Violence Against Women, *A National Protocol* (2013), pp.73-74.

¹²⁰ Under the Department of Justice PREA standards, the victim cannot be charged for forensic examinations or emergency medical costs related to sexual assault. *National Standards to Prevent, Detect, and Respond to Prison Rape, Final Rule*, 77 Fed. Reg. 37106-37232 (June 20, 2012) (to be codified at 28 C.F.R. §§ 115.21, 115.121, 115.221, 115.321, 115.82, 115.182, 115.282 and 115.382). See also 42 USC 3796gg-4, which provides that, as a condition for certain federal grant funds, all states and territories must certify that the state or another governmental entity bears the full out-of-pocket costs for sexual assault medical forensic examinations. Each state has a different process for payment for these exams. To learn about the process, facilities should reach out to the administrator of the grant funds for its state. A list of the administrators is available at <http://www.ovv.usdoj.gov/stop-contactlist.htm>. Also see Office on Violence Against Women, *A National Protocol* (2013), p.55.

¹²¹ See Office on Violence Against Women, *A National Protocol* (2013), pp.43-44.

- Information on who has criminal jurisdiction for sex offenses.
- Identification of those involved in response to victims, internal/external to the facility.
- Guidance on each topical area related to the examination process (e.g., policies, procedures, handouts, forms, background information, and variations in response).
- Delineation of responder roles in sexual assault cases for all involved responders. Checklists of duties of each involved responder and flow charts of response may be useful in this section. (See Appendix D for a description of potential roles.)
- A plan for implementing and institutionalizing the protocol. The plan might include: (1) strategies for building the facility's capacity to support a coordinated response; (2) procedures for informing inmates/residents on how the facility responds to reports and the resources available to victims; (3) training requirements for staff and other responders; and (4) timeframes for periodic protocol reviews for compliance, effectiveness, and revision, as needed.

5. Usefulness of a Correctional Protocol

A correctional protocol for an immediate response to sexual assault, specifically during the medical forensic examination process, can be a vehicle for correctional facilities to:

- Address their unique needs and challenges in responding to sexual assault victims in their facilities;
- Maximize use of internal and external resources for this purpose; and
- Establish consistent policies and procedures to support effective response.

Such a protocol can increase the capacity of all responders to carry out their duties, as it publicizes policies and procedures that delineate roles and requires training that provides responders with guidance on these roles.

Developing a correctional protocol based on this guide and the [National Protocol](#) will not only help correctional facilities achieve compliance with several of the Department of Justice's PREA standards, it may lead to the institutionalization of best practices in an immediate response to sexual assault. Implementation of these best practices will likely result in improved care for victims, a greater likelihood of holding perpetrators accountable for their behaviors, and a better coordinated response to sexual assault.

Victims in confinement settings are more likely to seek assistance when they perceive that responders will work together to ensure that they are safe, informed of their options for assistance, and aided in obtaining help. In addition, they are likely more willing to report when they perceive that disclosures of corrections-based sexual assault are taken seriously by all responders, when they will not be penalized for reporting, when their care is made a priority, when evidence of the assault is preserved and collected in a timely manner, and when investigations are objective and frequently lead to prosecution and/or disciplinary actions against their perpetrators.¹²²

6. Collaboration in Protocol Development and Implementation

While this guide is written primarily with corrections administrators in mind, an immediate response to sexual assault, specifically during the medical forensic examination process, is by definition a collaborative effort. Collaboration occurs when involved professionals commit to share resources, refer victims for services, respond to sexual violence as a team, and monitor and evaluate interagency responses.¹²³

Forging partnerships with these goals in mind will require time, energy, and commitment. Many correctional facilities have little to no relationships or channels to communicate with outside agencies and professionals that should be involved in responding to sexual assault, or if they do, it is not necessarily for that purpose. Some correctional facilities are located in rural areas without specialized resources, such

¹²² Drawn from Vera Institute of Justice, *Summary Memos for the Sexual Assault Forensic Protocol in Corrections Prison, Jail, and Residential Community Corrections Work Group Meetings* (Washington, D.C.: Unpublished, 2011).

¹²³ Office for Victims of Crime, *SART Toolkit* (2011), Develop a SART.

as rape crisis centers or specially educated and clinically prepared forensic examiners. Also, correctional facilities may have few internal resources to dedicate to planning, implementing, and monitoring a coordinated response in sexual assault cases.

Corrections administrators can move incrementally towards the goal of achieving collaboration. As they make progress in working together with other responding agencies, the rewards can be significant. An examination protocol for a correctional facility that is developed and implemented through a collaborative effort can engender trust among corrections staff and responders from the community. Ideally, it acknowledges the legitimacy and importance of all responder roles, and facilitates communication and partnerships among responders to address issues that arise in specific cases. For this reason, this guide strongly encourages that correctional facilities build collaborative relationships with external agencies and professionals who should be involved in an immediate response to sexual assault reported in their facilities.

III. Recommendations: Prisons, Jails, and Community Confinement Facilities

This section provides recommendations for corrections administrators on topical areas that should be addressed in protocols for an immediate response to sexual assault for prisons, jails, and community confinement facilities.

The recommendations are organized into two categories:

- Recommendations for Victim-Centered Care
- Recommendations for Promoting a Coordinated Team Approach

Note:

- A victim-centered care recommendation is denoted with a “V,” while “C” denotes a coordination recommendation;
- Prisons, jails, and community confinement facilities may differ somewhat in how they respond to sexual assault. Therefore, recommendations, either in whole or part, specific to a particular type of confinement are referenced by underlining the type of setting.
- These recommendations customize sections of the [National Protocol](#) related to victim-centered care and coordinated response. Refer to the *National Protocol* for guidance on incorporating other aspects of an immediate response specific to the examination process into facility protocols, as only areas that present unique challenges in confinement settings are covered in this guide.

1. Recommendations for Victim-Centered Care

V1. Ensure that victims in correctional facilities have access to the full range of specialized services they may need in the aftermath of a report of sexual assault.

Victims of sexual assault have specialized needs—physical protection, medical and mental health care, forensic evidence collection, emotional support and advocacy, information, legal remedies, etc.—that are best addressed by trained professionals who have the experience and skills to provide those services. Victims who report a sexual assault after the jurisdiction’s cut-off time for forensic evidence collection may not require medical forensic examinations, but they should still have access to other specialized services. (See V8 for more detail regarding when a medical forensic exam is appropriate.) Despite their assets, correctional facilities often lack the full range of specialized services that these victims may need. Correctional facilities should partner with service providers in the community—community-based sexual assault victim advocacy programs (e.g., local rape crisis centers), hospitals, health care facilities, or other facilities that conduct medical forensic examinations, forensic examiners, mental health providers, law enforcement, prosecution, etc.—to fill any gaps.

Community confinement facilities likely have an even greater need for this collaboration than prisons and jails, because part of their function is to help residents re-integrate into the community and connect with services from which they could benefit.

V2. Maximize victim safety.

- In cases of sexual assault by perpetrators housed in the correctional facility, immediately separate victims and perpetrators. In facilities where victims and perpetrators are both sent out for medical forensic examinations, do not transport them together or have them arrive or wait at the examination site simultaneously.
- If victims report staff sexual misconduct and name their perpetrators, those perpetrators should not be involved as responders in any aspect of the facility’s response. For example, a staff perpetrator should not escort the victim for medical care or a medical forensic examination.
- Following an examination, continue to keep victims separated from their perpetrators, whether the

perpetrators are corrections staff or other individuals housed in the facility.¹²⁴ (Also see V3.)

V3. Balance victims' needs with the safety and security needs of the correctional facility.

The need for this balance is clear for prisons and jails, but it is also an important issue for community confinement facilities. Corrections administrators must be diligent and creative in figuring out how to maximize everyone's safety in their facilities without automatically sacrificing the needs of sexual assault victims or their privileges or freedoms whenever there is a question of facility security. This is a delicate and difficult balance for corrections staff to maintain.

- Protect victims without taking measures that they may perceive as punitive, to the extent possible. On an individual case basis, consult with security staff and talk to victims about their safety concerns and possible precautions. Thoughtfully consider ways to avoid curtailing victim privileges and freedoms, while protecting them from additional violence and/or retaliation.
 - Do not send victims in community confinement facilities back to prison or jail as a safety precaution. Also, make every effort not to move them to another facility where they might be geographically separated from family.
 - Explore alternatives to automatically placing sexual assault victims in prisons and jails into isolating conditions (e.g., administrative segregation or protective custody) as a default form of protection. Segregation should be a last resort and, when used, victims should spend the shortest possible time there until other arrangements can be made.¹²⁵ Additionally, avoid automatically transferring victims to another facility if they cannot be safely housed anywhere other than a segregation unit, as a transfer may disrupt an investigation, service provision, or victim access to personal support persons.
- Consider ways for victims to seek protection and services as confidentially as possible.¹²⁶ For example, publicize contact information for the internal victim resource specialist and ensure that locked drop boxes are accessible for submitting a report of sexual assault. Corrections administrators need to make sure that any staff concerns about frivolous or strategic claims of sexual abuse do not create unnecessary barriers to reporting. (Also see V11.)
 - Residents in community confinement facilities should know whether they have the option to report sexual assault directly to law enforcement, in addition to, or instead of, facility staff. They should know if they can seek out a medical forensic examination on their own or if they need the assistance of corrections staff. They should understand that community-based victim advocates, if available, can help them deal with the emotional aftermath of sexual assault and assist with safety planning and recovery issues. (Also see V5 and C4.)
- Strictly limit who within the correctional facility needs to know about a report of sexual assault.¹²⁷ Restricting access to information may help keep an individual's victim status from becoming known throughout the facility and help them avoid further violence by others who view sexual assault victims as vulnerable for further sexual and non-sexual attacks. (Also see V4 and V11.)

V4. Offer victims privacy at the correctional facility, to the extent possible, in the aftermath of a report of sexual assault.

- Exercise discretion in ways appropriate to the confinement setting to avoid the victims' embarrassment of being identified by others in the correctional facility as a victim, and to increase their safety and comfort in seeking help.
 - Following a report of a sexual assault in a prison or jail, escort victims to a private area in the facility (e.g., an examination room in the medical unit), where they can receive necessary immediate services (e.g., acute medical care and crisis intervention), get information about what happens in the facility after a report has been made, and their options (to have a medical forensic examination, receive support from a victim advocate, etc.). Accessing a private room, supervised by corrections staff, may be more easily accomplished for prisons and large- to medium-sized jails. The location of private areas for sexual assault victims should be identified ahead of time in

¹²⁴ *National Standards to Prevent, Detect, and Respond to Prison Rape, Final Rule*, 77 Fed. Reg. 37106-37232 (June 20, 2012) (to be codified at 28 C.F.R. §§ 115.67, 115.167, 115.267, and 115.367).

¹²⁵ National Prison Rape Elimination Commission, *Report* (2009), pp.78-80 and 28 C.F.R. §§ 115.342, 115.43, 115.68, 115.368.

¹²⁶ 28 C.F.R. §§ 115.51, 115.151, 115.251, and 115.351.

¹²⁷ 28 C.F.R. §§ 115.61, 115.161, 115.261, and 115.361.

small jails, recognizing their space limitations and that they may not have a specific medical or mental health unit.

- o Following a medical forensic examination, allow victims in prisons and jails to shower as privately as the facility allows. If private shower areas are not normally available, facilities should consider whether there are ways that victims can be offered privacy while they shower after the exam. For example, are there secure and private showers in other parts of the facility that the victim could use? Are there ways to temporarily limit access to the shower while the victim washes up?
- o Afford privacy, to the extent feasible, to victims in prisons and jails for phone calls with personal support persons (family, friends, religious counselors, etc.) after the medical forensic examination (or, if they do not have the examination, after all immediate interventions occur). Calls should be made from the correctional facility, not the examination site. If the facility monitors these calls, inform victims of the extent to which the calls will be monitored before calls are placed. Note that for the purposes of this guide, community-based victim advocates are not considered personal support persons and that these advocates are permitted to have contact with victims at the examination site.¹²⁸ (Also see V5 and V10.)
- Consider the extent of victim information that each responder requires to appropriately intervene. Avoid sharing victim information unless it is critical to response. For example, facility and/or jurisdictional policies might require specific corrections medical and/or mental health staff and/or security and management staff to be informed about certain information in the report in order to develop treatment plans or make housing, bed, work, education, and/or program assignments.¹²⁹ By contrast, examiners and victim advocates don't necessarily need access to the corrections report, as victims can choose the extent of information they will share with them. (Also see V3 and V11.)
- Ensure that the area where community-based victim advocates talk to victims is as private and safe as possible for both advocates and victims. Creativity and planning are critical to making this happen, particularly in small facilities with limited physical space. Another possibility for community confinement facilities to maintain privacy is to send victims out for community-based victim advocacy services. (Also see V5.)

For guidance on facilitating victim privacy while at the examination site, refer to the [National Protocol](#).¹³⁰ Note, however, that victims from prisons and jails will likely be required to be accompanied by at least one security staff member, who will either have to remain in the room or maintain visual contact depending upon the victim's security level. Also, while personal support persons such as family and friends may not be permitted at the examination site, victims can be offered a community-based victim advocate or a corrections staff member they trust (whenever possible). (Also see V5 and V10.)

V5. Make every reasonable effort to include community-based sexual assault victim advocates in an immediate response to victims in confinement settings.¹³¹

Many correctional facilities employ or contract with qualified mental health professionals to provide counseling and other services to incarcerated individuals. Internal mental health practitioners play a vital role in any correctional setting and should play a significant role in a facility's sexual assault response protocol. (Also see V6.) They understand the correctional environment and culture often have regular contact with those housed in the facility, and, particularly in large facilities, are easily accessible for appointments. While they can and should treat victims following an assault, they should not substitute for community-based sexual assault advocates unless all efforts to establish a relationship with a community-based advocacy program have failed. Provision of community-based victim advocacy is the best practice for support for sexual assault victims. Because of their specific training and expertise on sexual assault, community-based victim advocates may be in a better position to support victims. Victims in correctional facilities may also be more willing to trust a community-based advocate than someone employed by the facility, particularly if their abuser is an employee. With victims' permission, advocates can accompany and support victims through the medical forensic examination and investigatory processes and beyond,

¹²⁸ If your facility/local community-based advocacy program does consider victim advocates as personal support persons, advocates should be permitted to accompany victims at the examination site.

¹²⁹ 28 C.F.R. §§ 115.81 and 115.381.

¹³⁰ Office on Violence Against Women, *A National Protocol* (2013), p.29.

¹³¹ 28 C.F.R. §§ 115.21, 115.121, 115.221, 115.321, 115.53, 115.253, and 115.353.

providing emotional support, crisis intervention, advocacy, information, and referrals.

- Identify local community-based victim advocacy programs (often referred to as rape crisis centers). State sexual assault coalitions can help connect corrections administrators with local rape crisis centers.¹³² Go to the National Sexual Assault Resource Center at www.nsvrc.org/organizations/state-and-territory-coalitions and click on a specific coalition to access information about rape crisis centers in that state or territory (or call the coalition if rape crisis center information is not available). Another resource to identify victim advocacy programs is Just Detention International's *Resource Guide for Survivors of Sexual Abuse Behind Bars*, available at <http://justdetention.org/en/resourceguides.aspx>. The National Sexual Assault Hotline at 1-800-656-HOPE (4673) can also connect callers with a rape crisis center in their area. In addition, the local phone directory sometimes lists rape crisis centers with emergency numbers. If there is no local rape crisis center, seek ideas on ways to access advocates from the state sexual assault coalition. One suggestion is to partner with a center in a neighboring jurisdiction.

Only substitute in-house trained staff for community-based victim advocates if: (1) efforts to develop a working relationship with a community-based victim advocacy program are unsuccessful; or (2) if there is no such program in the area or region. If initial efforts fail to secure a community-based victim advocate, create a plan to work incrementally towards that goal. Another option is to use advocates from other community organizations, such as social services- or health-related programs if sexual assault specific programs are not available.

- Facilitate discussions between corrections staff and representatives of the community-based victim advocacy program on how to provide advocacy services to sexual assault victims housed in the correctional facility.
 - Offer a facility tour to help advocates understand the correctional environment.
 - Discuss the interest of the correctional facility in partnering with advocates to offer a range of supportive services to victims. Seek their support of this partnership.
 - Discuss the supportive services that would be most useful for victims housed in the facility and the procedures needed to facilitate service provision. Corrections staff may request a tour of the advocacy program to understand their scope of services.
 - Discuss the scope of confidentiality permitted for victim/advocate communications—what will be kept confidential and what community-based victim advocates are required to report to the facility and/or the state.¹³³ Having the option for confidential communication with community-based victim advocates may make victims more inclined to seek support to heal and more inclined to work with investigators and prosecutors.¹³⁴ (Also see V3 and V11.) Victims should be informed of the scope and limits of victim/advocate confidentiality before speaking with an advocate.¹³⁵ Corrections staff should also understand the scope and limitations of victim/advocate communications, as well as the fact that corrections staff's interactions with victims are not confidential and they can be required to testify in judicial proceedings related to a sexual assault case.

To be successful, advocates working with incarcerated victims must work collaboratively with their corrections partners and negotiate agreements on confidentiality that protect victims without compromising the safety and security of the facility. In the community, the extent of victim-advocate

¹³² State sexual assault coalitions serve as membership associations for local service providers, mainly from rape crisis centers, and also often advocate for improvements in laws, services, and resources for survivors of sexual violence and service providers. As cited at Resource Sharing Project at <http://www.resourcesharingproject.org/>.

¹³³ For more on confidentiality, see Office on Violence Against Women, *A National Protocol* (2013), pp.47-49 and 28 C.F.R. §§ 115.53, 115.253, and 115.353.

¹³⁴ In her testimony before the National Prison Rape Elimination Commission, former California Department of Corrections and Rehabilitation Assistant Director Wendy Still testified that California's Paths to Recovery project (a joint program of Just Detention International and the California Department of Corrections and Rehabilitation where advocates are allowed into facilities to provide confidential counseling to incarcerated individuals) had resulted in "[a]n increased capacity to fulfill our rehabilitation mission and create an environment that is more conducive to reporting incidents of sexual abuse." *Special Topics in Preventing and Responding to Prison Rape: Medical and Mental Health Care, Community Corrections Settings, and Oversight*, National Prison Rape Elimination Commission Public Testimony (2007), Testimony of Wendy Still, p.5. Available electronically at <http://www.justdetention.org/en/reaching.aspx>.

¹³⁵ 28 C.F.R. §§ 115.53, 115.253, and 115.353.

confidentiality can vary, depending on jurisdictional statutes. In general, community-based advocacy programs do not release victim information unless (1) they have the victim's permission, (2) the victim discloses information that an advocate is required to report as per state statute, such as abuse or neglect of a child or vulnerable adult or an emergency situation involving imminent risk of serious harm (e.g., the victim is attempting suicide), or (3) the information has been successfully subpoenaed in court. Communications between advocates and incarcerated victims should closely follow jurisdictional statutes. However, there may be cases where advocates are required to disclose security risks that may not rise to the community standard of imminent risk of serious harm. For example, advocates may be required to report credible plans to escape or disclose information they learn about unsafe areas of the facility. In the latter case, if an incarcerated victim reveals that he or she was assaulted in a blind spot area of the facility and tells the advocate that assaults in that area are common, advocates can protect the victim without jeopardizing security by reporting concerns about the blind spot without identifying the victim.

- o Decide who specifically from the community-based victim advocacy program will provide services to victims in the correctional facility. Advocates should have training to work with victims from confinement settings and be committed to the continuity of services for this population. Advocates may be required to obtain a security clearance to enter the facility. For these reasons, having advocacy program staff versus volunteer advocates may make more sense operationally. Yet such a requirement should not be mandatory as many advocacy programs have minimal paid staff and necessarily rely on volunteer staff for direct service provision.
- o As applicable, discuss compensation for advocacy services. Corrections administrators are encouraged to dialogue with community-based advocacy program directors about ways the correctional facility can support them in being able to respond to this population.¹³⁶ The need and extent of compensation may depend on factors such as the scope of services and travel time/costs (particularly if the facility is a considerable distance from the advocacy program). Some examples of being supportive include providing reimbursement for related travel or fee-for-services, sharing resources and expertise, and jointly applying for grant funds to build the capacity of the advocacy program to do this work.
- Facilitate cross-training for corrections staff and victim advocates. Corrections staff could benefit from training from victim advocates on: (1) the dynamics of sexual assault victimization, (2) the importance of trauma-informed care, (3) services of the advocacy program, (4) the scope and limits of victim/advocate confidentiality, and (5) an overview of other relevant community resources. Victim advocates could benefit from training from corrections staff on: (1) the correctional environment (policies, layout, culture, information on the corrections population in the facility, etc.), (2) the dynamics of sexual assault in the correctional setting, (3) facility policies related to the examination process and longer-term service provision for victims, and (4) whether a security clearance is required to enter the facility and how advocates should obtain this clearance, if needed.
 - o For community confinement facilities, advocates could also benefit from training from corrections staff on: facility policies that impact victims' interaction with them, including if residents' conditions of release require them to inform the correctional facility of their whereabouts and to secure permission from the facility before meeting an advocate off-site; and financial responsibilities of the facility, jurisdiction, and residents for medical care associated with the sexual assault and the medical forensic examination.
- Delineate the relationship between the correctional facility and community-based victim advocacy program in a written memorandum of understanding (MOU). Clarify:
 - o Contact persons at the correctional facility and victim advocacy program;
 - o How a victim advocate will be notified/activated;

¹³⁶ Some victim advocacy programs may initially be hesitant to provide services to victims in correctional environments due to stipulations of some of their funders. For example, many of these programs receive Victims of Crime Act (VOCA) funding, which cannot currently be used to serve victims in correctional environments. However, VOCA funded organizations are not prohibited from providing services for victims in corrections through other, non-VOCA funding streams. DOJ will soon publish a proposed rule that would revise the VOCA Victim Assistance Program Guidelines to allow services for incarcerated victims. Likewise, STOP Formula Grants under VAWA must generally focus on women, although recipients are required to serve similarly situated men in need who call for assistance. After October 1, 2013, STOP funds will be allowed to support programs addressing sexual assault against men, women, and youth in correctional and detention settings. Funds from other sources, including, but not limited to compensation from a correctional agency, can be used to serve both men and women in confinement settings.

- o How a victim advocate will enter/exit the correctional facility (both for secure and non-secure settings), if applicable;
- o Where meetings with victims will take place and how these meetings will be facilitated, keeping the need for victim privacy and safety at the forefront;
- o Scope of services a victim advocate can provide, direct services and otherwise (e.g., case reviews, consultation, etc.);
- o Reporting requirements for a victim advocate and any issues related to the scope and limits of victim/advocate confidentiality;
- o The victim advocacy program's commitment to serve all victims in the facility, regardless of sex, gender identity, or sexual orientation;
- o Required training for corrections staff and victim advocates related to responding to sexual assault in the correctional environment (also see C3); and
- o Arrangements to compensate the advocacy program for services, as applicable.

V6. Train at least one staff person (either security or non-security) in the correctional facility to serve as an internal victim resource specialist to provide general information and guidance to victims during the immediate response and beyond.

- Clarify this position's role in the correctional facility. It would be ideal for corrections administrators to discuss with the community-based victim advocacy program how this position can dovetail with and complement the role of the community-based victim advocate. During an immediate response, an internal victim resource specialist can help ensure that victims receive the following information in a timely and compassionate manner:
 - o What happens once a report of sexual assault is made within the facility (e.g., explain how it will be responded to, including who will respond, and what victims should expect during any resulting investigation, prosecution, and/or administrative hearing);
 - o Victims' options for protection, emotional support/victim advocacy, medical/mental health care, evidence collection, and criminal justice involvement; and
 - o The importance of preserving forensic evidence on victims' clothing and bodies prior to a medical forensic examination.

Also, the corrections administrator could assign an internal victim resource specialist the responsibility of contacting internal and external responders to alert them of the possible need for their services, and/or coordinating internal follow-up care and external services to promote victim healing and investigative processes.

- Recognize that the internal victim resource specialist is not intended to be a substitute for a community-based victim advocate. However, if a community-based victim advocate is not available to provide services, then this position could be temporarily expanded to include additional duties, with the proper training and supervision. In this case, efforts should continue to involve a victim advocate and if successful, relieve this staff person of these additional duties. (Also see V5.)
- Decide who within the correctional facility is eligible to fill this position. Corrections staff applying for this position should have regular contact with individuals housed in the correctional facility. They should have interest in doing this kind of work—therefore, staff members should be encouraged to volunteer for this position rather than being assigned by management. A qualified internal mental health practitioner might be a good candidate for this position. When possible, corrections administrators should collaborate with community-based victim advocates to screen and train candidates (both to ensure a good fit for the position and prepare volunteers for their role).¹³⁷ In smaller facilities, it may be necessary to train two or three staff members to take turns being on-call. Larger facilities might consider having one trained staff person per shift. In terms of training, the internal victim specialist could benefit from knowledge/skill building on topics including, but not limited to: the scope and limitations of this role, relevant policies and laws, what is entailed in an immediate response to a report of sexual assault, dynamics of sexual assault in correctional environments, common victim reactions and needs, listening and crisis intervention skills, what victims can expect

¹³⁷ When screening, one issue to consider is if candidates have histories of sexual victimization. If so, it is critical to assess if they have sufficiently healed from this trauma in order to be able to (1) separate their own feelings about sexual victimization from those of victims they might work with in this position, and (2) effectively cope with secondary trauma they might experience.

once a report is made, victim options and rights, the basics of communicating with other responders, and self-care.

V7. Ensure that victims have access to sexual assault forensic examiners to perform the medical forensic examination.¹³⁸

These examiners should have specialized education and clinical preparation in the collection of forensic evidence and treatment of sexual assault patients. With such training, they can competently and efficiently conduct a medical forensic examination, address the specialized needs of sexual assault victims, and testify in related judicial proceedings as needed.

- When possible, consider utilizing independent forensic examiners, meaning those not employed by the correctional facility or under contract with the correctional agency. Using independent forensic examiners can be beneficial in several ways. It helps avoid the possibility that a victim will be examined by someone who sexually assaulted them. It can also help avoid a potential conflict of interest or the appearance of a conflict of interest for correctional facilities investigating a sexual assault.
- Identify local or regional forensic examiners/forensic examiner programs. Sexual assault nurse examiner (SANE) programs are available in many communities. One resource for locating a SANE or other forensic examiner programs in a particular area is through the Sexual Assault Forensic Examiner Technical Assistance website at <http://www.safeta.org/>. Clicking “Find a Program” takes you to the International Association of Forensic Nurses’ Clinical Forensic Program Registry.
 - Prison and jail administrators are urged to identify and coordinate with sexual assault forensic examiners to conduct this examination, either at a local/regional examination site (e.g., a hospital or other facility that has a forensic examiner/forensic examiner program) or the medical unit of the prison or jail.¹³⁹ Jails without a medical unit should either consider sending victims out to have the examination or ensure they select a location in their facilities that provides the necessary privacy, space, equipment, and supplies. (Also see C5.)
 - Community confinement administrators should identify local or regional examination sites that use specially educated and clinically prepared sexual assault forensic examiners to conduct the examination and ensure that residents who report sexual assault to staff are sent to those sites if they require a medical forensic examination. (Also see C4.)
- Facilitate dialogue among corrections staff, forensic examiners, and other examination site staff as applicable on how to coordinate the examination.
 - Offer a correctional facility tour to help forensic examiners and examination site staff understand the correctional environment—in turn, corrections staff could request an examination site tour, particularly if it is external to the correctional facility, to understand what happens during the examination;
 - Identify issues that need to be discussed or clarified related to conducting a medical forensic examination for sexual assault victims from the correctional facility (regarding communications needed between corrections staff/examination site staff before and after the examination, security issues for the examination site and the examiner when victims are from prisons or jails, scope of information/record sharing between the facility and the examination site/examiner, etc.).
 - If administrators from prisons or jails are considering the possibility of having a forensic examiner conduct examinations at the correctional facility, discuss the advantages/disadvantages of this arrangement and logistics involved in facilitating all aspects of the examination process. (Also see C5.)
- Facilitate cross-training for corrections staff and sexual assault forensic examiners and other examination site staff. Corrections staff could benefit from training from forensic examiners on: (1) the purposes and steps of the medical forensic examination, (2) jurisdictional policies related to the examination and sexual assault evidence collection kit (if such policies exist), (3) the role of the

¹³⁸ 28 C.F.R. §§ 115.21, 115.121, 115.221, and 115.321.

¹³⁹ See Office on Violence Against Women, *A National Protocol* (2013), pp.63-65, for a general discussion regarding facilities where the examination is conducted. Regardless of the location, the examination should be conducted by a specially educated and clinically prepared sexual assault forensic examiner. See *A National Protocol* (2013), pp.59-61, for further information on forensic examiners.

forensic examiner, (4) follow-up activities of the forensic examiner, and (5) areas and tasks where coordination between the forensic examiner and corrections staff is necessary.

- Forensic examiners and other examination site staff could benefit from training from corrections staff on: (1) the correctional environment (policies, culture, information on the corrections population at the facility, etc.); (2) the dynamics of sexual assault in this environment; (3) facility policies on the examination process; and (4) if applicable, whether a security clearance is required to enter the facility.
 - To be prepared to respond to victims from prisons and jails, forensic examiners and other examination site staff could benefit from training from corrections staff on: (1) correctional facility rules governing professional boundaries, including prohibitions on developing personal relationships or providing favors or items that are considered contraband; (2) procedures to maintain safety and security at the examination site, including why and under what circumstances a security presence is necessary (and where they should stand to minimize intrusiveness), safeguarding medical instruments, and arranging the room so that non-security personnel can exit if necessary; (3) where a victim will wait at the examination site to maximize both safety and victim comfort; (4) if incarcerated victims are shackled/restrained during the examination, how to make sure they are as comfortable as possible and able to participate in examination activities; and (5) how to work with corrections personnel regarding victim care. (Also see V9 and C5.)
 - To be prepared to respond to victims from community confinement facilities, forensic examiners and other examination site staff could also benefit from training on: (1) correctional facility policies that might impact victims' interaction with them, including if residents' conditions of release require them to inform the correctional facility of their whereabouts; and (2) financial responsibilities of the residents, correctional facility, and the jurisdiction for medical care associated with the medical forensic examination. (Also see C4.)
- Delineate the relationship between the correctional facility and the forensic examiner/examination site in a written MOU. Clarify:
 - For prisons and jails: whether victims will go to an examination site or the forensic examiner will go to the correctional facility to perform the examination (also see C5);
 - For community confinement facilities and prisons and jails: who will send victims to an examination site for the examination, what procedures will be used by the correctional facility to notify staff at the examination site when an incarcerated individual will be coming in for an examination and, when possible, an estimated time of arrival (also see C4);
 - If victims from prisons or jails are sent to an external examination site: how they will be transported to/from the examination site, what security will be provided in transit and on site, and if corrections staff will bring additional clothing for victims in case the clothes they have on are taken for evidence (also see C5);
 - If examinations are conducted at a prison or jail: how the correctional facility will notify/activate the forensic examiner to come to the facility to conduct an examination, what response time has been agreed upon between the correctional facility and examiner (e.g., the examiner will arrive at the facility within a 60-minute time period after notification), how the forensic examiner will enter/exit the correctional facility, what security clearance is needed, if any, where specifically in the facility the examination will be conducted, and whether that location provides the privacy, physical space, equipment, and supplies necessary to facilitate the examination (also see C5);
 - For victims from both community confinement facilities and prisons and jails: what is involved in the medical forensic examination and the examiner's role during and after the examination (e.g., communicate with staff at the correctional facility to provide follow-up instructions, testify in related judicial hearings, provide consultation, and participate in case reviews); and
 - The required training for corrections staff from both community confinement facilities and prisons and jails, as well as for forensic examiners and other examination site staff related to the examination process (also see C3, C4, and C5).

V8. Offer a medical forensic examination to sexual assault victims whenever it is appropriate.¹⁴⁰
(See Section II for further details.)

¹⁴⁰ 28 C.F.R. §§ 115.21, 115.121, 115.221, and 115.321.

- Recognize that this examination addresses the full spectrum of sexual assault, not only attempted and/or completed sexual penetration.
- Understand that this examination speaks to victims' medical and evidentiary needs. Depending on the circumstances of the case and victim needs and wishes, a full or partial examination can be conducted.
- Recognize that one of the primary reasons victims seek help is concern about their physical health. The medical forensic examination addresses the specialized health care needs of individuals who have been sexually assaulted.
- To determine whether this examination is appropriate in a specific case, consider:
 - the victim's health needs and concerns;
 - the jurisdiction-accepted timeframe for evidence collection (e.g., as per policies for use of the jurisdiction's sexual assault evidence collection kit); and
 - the specific circumstances of the assault.¹⁴¹ If there is a question as to the appropriateness of an examination, seek the input of a forensic examiner, in conjunction with an investigator, if one is involved in the case.
- If there is a question of whether evidence might exist, err on the side of caution and refer victims for this examination.
- The victim shall not assume the financial cost related to evidence collection.¹⁴²
- The victim must have the option of having the examination even if they are undecided about cooperating with a criminal investigation.
 - Victims in community confinement facilities will often be able to seek an examination without disclosing to/getting the assistance of corrections staff. If they do not disclose to corrections staff and have the option of reporting the sexual assault to law enforcement, they must be able to have this examination even if they are undecided about reporting.
 - Victims in prisons and jails who report a sexual assault to corrections staff should be able to have this examination even without naming their perpetrators.¹⁴³
- Never force a victim to undergo this examination.¹⁴⁴
- If a forensic examination is not conducted, discuss with victims their needs and options and help them access services they want, to the extent possible, as per facility policies and as appropriate to the circumstances of the case.

V9. If, for security purposes, victims from prisons and jails must be shackled or otherwise restrained, ensure the level of shackling/restraint correlates with their security status. However, shackle or restrain only if necessary for security.

When needed, victims should be restrained and shackled as comfortably and respectfully as possible, and in a way that allows them to participate in the examination activities.

V10. Facilitate victims' access to personal support persons, if requested.

In this guide, personal support persons refer to victims' family, friends or others that they may informally seek emotional support from in the aftermath of a sexual assault, such as religious counselors. It does not refer to community-based victim advocates. (Also see V5.)

- Be aware that when and how victims are able to access personal support persons can differ based on the type of correctional setting. Access is typically more limited in prisons and jails than in community confinement due to security reasons.
 - Refer to the *National Protocol* for guidance on accommodating requests by victims housed in

¹⁴¹ See Office on Violence Against Women, *A National Protocol* (2013), pp.71-72, for more information on these kits. As noted earlier, jurisdictions typically have a standard cut-off time to collect evidence on victims' bodies and clothing, using their designated evidence collection kit. Most jurisdictions allow some flexibility in cut-off times given it is conceivable under some circumstances that evidence may still be available even beyond the cut-off times. See *A National Protocol* (2013), pp.73-74, for more on timing considerations for collecting evidence.

¹⁴² See Office on Violence Against Women, *A National Protocol* (2013), p.55 and 28 C.F.R. §§ 115.21, 115.121, 115.221 and 115.321.

¹⁴³ The Department of Justice's PREA standards indicate that the victim can receive emergency medical care without having to name the abuser. See 28 C.F.R. §§ 115.82, 115.182, 115.282, and 115.382. See Office on Violence Against Women, *A National Protocol* (2013), pp.51-54.

¹⁴⁴ See Office on Violence Against Women, *A National Protocol* (2013), pp.43-45.

- o community confinement facilities for personal support persons.¹⁴⁵
- o Permit victims in prisons and jails to call personal support persons if they wish following a medical forensic examination. If the examination is conducted off-site, such calls will likely have to wait until the victim returns to the facility. Due to security concerns while off-site from the facility, allowing incarcerated victims to make phone calls or receive in-person visits from personal support persons before, during, or immediately after the forensic medical examination is not feasible. (Also see V4.)

V11. Devise correctional facility practices that address, to the extent possible, victims' concerns related to reporting.¹⁴⁶ (See Section I for reporting concerns.)

- Educate all corrections staff, external agencies and professionals who interact with individuals housed in the correctional facility, and other relevant entities (e.g., employers of residents in community confinement) of the facility's zero tolerance policy towards sexual assault.¹⁴⁷ They should be informed specifically about what zero tolerance entails including, but not limited to, what activities are considered sexual assault, how those housed in the facility learn about this policy, options and procedures for victims to report sexual assault, what will happen if a report of sexual assault is made, and what resources are available to victims and how they can access them.
- Upon intake to the correctional facility, provide individuals with information about sexual assault, including, but not limited to:¹⁴⁸ general information and facts about sexual assault; their right to be free from sexual assault and retaliation; the facility's zero tolerance policy toward sexual assault; how to report crimes, including sexual assault, and potential benefits of reporting; limits to confidentiality when disclosing sexual assault;¹⁴⁹ and protection and support services available to sexual assault victims. Peer education programs may be useful in disseminating the above information. Facilities should also make this information readily available throughout the facility on posters or other print materials.
 - o For residents of community confinement facilities, also explain that they may bear some responsibility for health care costs related to the sexual assault—while the medical forensic examination, including STI and pregnancy testing/prophylaxis, is typically covered, they may be responsible for other costs (e.g., initial and follow-up treatment for injuries sustained during the assault or for mental health counseling).
 - o Inform residents in community confinement facilities if they have the option of reporting crimes, including sexual assault, directly to law enforcement, in addition to or instead of reporting to the correctional facility. If they do have this option, they should also be aware of reasons to report to the correctional facility, in addition to or instead of reporting to law enforcement, such as: (1) in the case of staff sexual misconduct, so perpetrators can be removed from duty pending an investigation, as per facility policy; and (2) in the case of sexual assault committed by another resident, so the correctional facility can immediately separate perpetrators from victims and potentially impose sanctions against perpetrators to prevent further violence. (Also see C4.)
- Make accommodations as needed to ensure access to this information for all individuals housed in the facility, including those who have limited English proficiency, are low literate or illiterate, are deaf, or have a disability that might impact their vision or ability to process information.¹⁵⁰
- Make facility policies on reporting as easy, private, and secure as possible.
- Ensure there is at least one way for victims in correctional facilities to report sexual assault to an outside public or private entity or office that is not part of the agency.¹⁵¹ This outside entity should be

¹⁴⁵ Office on Violence Against Women, *A National Protocol* (2013), p.41.

¹⁴⁶ 28 C.F.R. §§ 115.51, 115.151, 115.251, and 115.351.

¹⁴⁷ 28 C.F.R. §§ 115.31, 115.131, 115.231, 115.331, 115.32, 115.132, 115.232, and 115.332.

¹⁴⁸ This lists builds upon the Office on Violence Against Women, *National Protocol* (2013) p. 42; 28 C.F.R. §§ 115.33, 115.233, and 115.333; and National Prison Rape Elimination Commission, *Standards for the Prevention, Detection, Response, and Monitoring of Sexual Abuse in Adult Prisons and Jails* (2009).

¹⁴⁹ Corrections staff are typically obligated to report, according to their facilities' policies (and under state law in many instances), any knowledge or suspicion of sexual assault involving individuals in prison, jail, and community confinement. However, they do not have the duty to report sexual victimization that occurred outside a correctional setting/custodial relationship, unless it is required under mandatory reporting laws of the jurisdiction (e.g., if the victims is a minor or considered a vulnerable adult). See 28 C.F.R. §§ 115.33, 115.233, and 115.333.

¹⁵⁰ 28 C.F.R. §§ 115.16, 115.116, 115.216, and 115.316.

¹⁵¹ 28 C.F.R. §§ 115.51, 115.151, 115.251, and 115.351.

prepared to provide this service and have specially trained staff available to receive reports. Training should include a primer on a victim-centered response and procedures for forwarding reports to officials at the correctional facility.

- o Residents in community confinement facilities will often have the option of reporting directly to law enforcement, in addition to or instead of reporting to the correctional facility. As described earlier in this recommendation, the facility should inform residents upon intake whether they have this option. If so, the facility should also provide reasons for considering reporting to the correctional facility, in addition to or instead of reporting to law enforcement. Corrections staff should cooperate with law enforcement personnel if the report is made to law enforcement; if the report is made to both entities, they should coordinate the immediate response and subsequent investigation as appropriate to the case. (Also see C4.)
- o Victims in prisons and jails should be allowed to report a sexual assault to corrections staff or outside entities without naming their perpetrators. Reporting in this manner should allow them to receive medical treatment, a medical forensic examination, counseling, and support. Corrections staff may be able to help them address their general safety concerns. However, if perpetrators are not named, the facility cannot pursue disciplinary action against them or offer specific protection for victims from them.
- Ensure that corrections staff and external agencies consistently respond to sexual assault in a manner that demonstrates to those housed in the correctional facility that they take reports of sexual assault seriously and will strive to help victims and hold perpetrators accountable for their behaviors. When incarcerated individuals and residents see trained staff and responders from external agencies working collaboratively and quickly to respond to victims' needs and investigate reports of sexual assaults, they will likely be more willing to report if they become victims of sexual assault during their incarceration.
- Use case-by-case assessment, including consulting with security staff and talking to victims about their safety concerns and possible precautions, to reduce the use of protective actions that victims could perceive as punitive.¹⁵² (Also see V3.)
- Whenever possible, provide victims with access to community-based victim advocates for confidential emotional support and counseling related to healing from sexual assault.¹⁵³ (Also see V5.)
- Strictly limit who within the correctional facility and external agencies can access information about a report of sexual assault.¹⁵⁴ (Also see V3 and V4.)

V12. Offer victims information following their sexual assault.

- Develop written information on sexual assault topics that can be offered to victims. Note that written information can be provided through the correctional facility and/or other sources (e.g., the community-based victim advocacy program and at the examination site). Information on the following topics may be helpful:¹⁵⁵
 - o Normal reactions to sexual assault (stressing that it is never the victim's fault) and signs and symptoms of traumatic response;
 - o The medical forensic examination, including how findings potentially will be used;
 - o Available victim support and advocacy services;
 - o Available mental health counseling options;
 - o Where applicable for female victims, information about related pregnancy risks and all pregnancy-related medical services that are lawful in the community;
 - o Information about related risks of sexually transmitted infections and prophylaxis;
 - o Victims' expectations and rights, including the right to be free from retaliation;
 - o Medical discharge and follow-up instructions/care needed;
 - o Planning for their safety and healing;

¹⁵² 28 C.F.R. §§ 115.41, 115.141, 115.241, 115.341, 115.42, 115.242, 115.342, 115.43, 115.68, and 115.368.

¹⁵³ See 28 C.F.R. §§ 115.53, 115.253, and 115.353. California's Paths to Recovery project (a joint program of Just Detention International and the California Department of Corrections and Rehabilitation) is one example. See <http://www.justdetention.org/en/reaching.aspx> for more information on the program.

¹⁵⁴ 28 C.F.R. §§ 115.82, 115.282, and 115.382.

¹⁵⁵ Adapted from Office on Violence Against Women, *A National Protocol* (2013) p.42 and 28 C.F.R. §§ 115.82, 115.282, and 115.382.

- o Steps and options in the criminal justice process;
- o Civil remedies that may be available to sexual assault victims;
- o Procedures to access related medical records or investigative reports; and
- o Resources for support for victims' families and friends.
- Where possible and practical, use a three-tiered system to deliver the information: corrections staff members (whether an internal victim resource specialist, medical/mental health staff, or corrections officer) to provide information about what will happen at the correctional facility in response to the report; forensic examiners to provide information on medical and forensic issues; and community-based victim advocates to provide information on what symptoms/reactions they might experience in the aftermath of the assault, emotional support, recovery options, and the criminal justice response to a sexual assault.
- Make accommodations as needed to ensure access to this information for victims who have limited English proficiency, are low literate or illiterate, are deaf, or have a disability that might impact their vision or ability to process information.¹⁵⁶

2. Recommendations for Promoting a Coordinated Team Approach¹⁵⁷

C1. Form a planning committee to facilitate the development/revision of a correctional protocol for an immediate response to sexual assault. This committee can also periodically review the protocol for effectiveness and revise as needed.

The planning committee should be comprised of core responders involved in the immediate response to sexual assault for a specific correctional facility and those from responding agencies who are able to make decisions on behalf of their agencies or designee. Possible committee members could include:

- Corrections administrators
- The agency's PREA coordinator (as applicable)
- Community-based victim advocate program director and staff
- Corrections staff acting as internal victim resource specialists
- Corrections medical director and staff (as applicable to the facility)
- Corrections mental health director and staff (as applicable to the facility)
- Corrections staff who transport victims to/from the examination site and provide security (as applicable to the facility)
- Forensic examiners
- Administrators from the examination site (if applicable)
- Corrections investigators
- Correctional facility classification and training staff
- Law enforcement personnel
- Sex crimes investigators
- Prosecutors
- Forensic scientists.¹⁵⁸

If a correctional facility is part of a larger correctional system, it may make sense to plan an immediate response protocol for all facilities in the system rather than for one facility at a time.

- Assess the current immediate response when individuals housed in the correctional facility report sexual assault to learn what works and where gaps exist. (See Appendices D and E.)
- Map out a strategic plan for an ideal immediate response that builds upon strengths in the current response and addresses gaps. Create the policies and procedures necessary to implement that vision. Include policies and procedures that facilitate coordinated actions of all core responders to a sexual assault reported in the correctional facility. To strengthen the effectiveness of such policies and procedures, develop MOUs with external agencies to solidify working relationships and clarify actions needed on each responder's part. (See Appendices D and E.)

¹⁵⁶ 28 C.F.R. §§ 115.16, 115.116, 115.216, and 115.316.

¹⁵⁷ 28 C.F.R. §§ 115.65, 115.165, 115.265, and 115.365.

¹⁵⁸ If a forensic scientist (e.g., from the jurisdiction's crime lab) is not available, it is useful to at least identify a forensic scientist the planning committee can consult if forensic input is needed.

C2. Consider participating in a community-based sexual assault response team (SART), if one exists, or forming a SART for the correctional facility. A SART is a vehicle used to facilitate coordination among core responders to reports of sexual assault. Core responders are those professionals involved in an immediate response to a report of corrections-based sexual assault, both those internal and external to the correctional environment.

- If a community SART exists, consider hosting a SART meeting at the correctional facility to learn more about how the local SART functions, as well as to provide a tour of the facility, educate SART members regarding needs of victims in confinement settings, and get input on whether the local SART or a corrections-based SART would be most appropriate for victims in the correctional facility. Hosting a SART meeting may also help the correctional facility gain support for a formal partnership with prosecutors. Formal relationships with prosecutors may help increase and improve communications regarding criminal cases of corrections-based sexual assault, which in turn could improve prosecution and conviction rates for these assaults.
- Consider the logistical tasks and challenges related to developing a SART specific to the correctional facility:
 - How will the SART (and each member of the SART) be activated when a sexual assault is reported in the correctional facility and during the examination process?
 - What are the roles of each member of the SART in responding to a report of corrections-based sexual assault? What roles do they have, if any, following an immediate response/the examination process? (See Appendix D for potential core responder roles.)
 - How will the SART be tailored to address the specific circumstances that may face sexual assault victims housed in the correctional facility?
 - What are potential challenges and issues that might arise when responding to a report of corrections-based sexual assault and what are possible solutions to these challenges and issues for the SART?
- Based on resources and corrections-specific issues, decide whether to become active in the local SART or form a facility-based SART. Some correctional facilities may already be involved in their community SARTs; if not, getting involved might be a relatively easy task.
 - For example, one representative from a community confinement facility or a small jail could participate on the local SART, attending periodic team meetings. That representative could then lead internal facility coordination efforts and activate coordination with external agencies and professionals as needed.
 - Or a jail might be administered by a sheriff's office that already participates on the local SART. In that case, the sheriff and the jail administrator could work together with other SART members to ensure that a report of sexual assault at the jail activates the local SART response. In places where the jail is not run by a sheriff, jail administrators could connect with the local SART directly. Similarly, law enforcement staff who supervise lockups could also be involved in the SART, either directly or in conjunction with other staff from their agency (a jail administrator, investigators, or the sheriff/chief), to ensure that a sexual assault that occurs in the lockup activates the local SART response.
 - A prison administrator or a staff person designated by the administrator could initially represent the correctional facility on the SART and then determine which additional prison staff should also participate on the local SART.

If a corrections administrator chooses to form a facility-based SART, it can be done in increments rather than all at once. For example, in facilities with an existing support/crisis response team, this team could be expanded in scope and in members to be able to take on SART functions. Smaller facilities may want to explore the possibility of collaborating with other nearby correctional facilities of the same type to establish a joint SART.

- Partner with the local SART (if one exists) to maximize communications across SARTs and resource sharing, and to receive guidance, even if a facility-based SART is formed.

C3. Ensure core responders are appropriately trained.¹⁵⁹ (Also see V5, V6, V7, V11, C4, and C5.)

¹⁵⁹ 28 C.F.R. §§ 115.31, 115.131, 115.231, 115.331, 115.32, 115.132, 115.232, and 115.332.

- Provide training to core responders, both internal and external to the correctional facility, to promote zero-tolerance of corrections-based sexual assault. The stigma connected with being a convicted criminal can influence responders' perceptions of sexual assault in confinement settings. They may find it hard to view individuals housed in correctional facilities who are sexually assaulted as victims who are worthy of help, justice, and healing. Others may see sexual assault as an unfortunate, but inevitable reality facing individuals in the correctional environment. It stands to reason that responders with these attitudes may not be invested in providing victim-centered care or in coordinating with others to improve interventions in these cases. It likely is not worthwhile to victims to report a sexual assault to staff or other external responders with these attitudes. (Also see V11.) Ultimately, increasing responders' understanding of the importance of providing victim-centered care and using a coordinated team approach when responding to sexual assault can promote zero tolerance for corrections-based sexual assault and raise the commitment to proactively intervene when it does occur. Specifically, responders should be trained on: (1) the dynamics of sexual victimization in confinement settings; (2) issues facing specific corrections populations who are at high risk for sexual assault such as young males, first-time offenders, females, and gay, lesbian, bisexual, transgender, and intersex individuals; (3) the necessity and benefits of helping victims in these settings stay safe and heal; and (4) the usefulness of a coordinated team approach to corrections-based sexual assault.
- Ensure that all core responders are trained on the specifics of how to intervene in a sexual assault reported in the correctional facility. Core responders should be educated on: (1) their facility-/agency- and position-specific roles in an immediate response to a report of sexual assault, as well as applicable facility/agency policies and procedures; (2) the roles of other responders; (3) their responsibilities for coordinating with other responders according to applicable policies and procedures; and (4) what makes an immediate response effective (e.g., the response addresses the victim's needs, provides information about his/her options, focuses on maintaining his/her safety and well-being, and supports his/her participation in an investigation). Training—whether it is facility-/agency-specific or multi-agency/multidisciplinary—should emphasize a team approach to response. Consider developing checklists to assist responders in fulfilling their roles. (See Appendix D for potential core responder roles.)
- Conduct both initial and refresher trainings, given the potential for staff turnover in all agencies and the fact that staff might not get a chance to “practice” their response if there are few reports of sexual assault.¹⁶⁰

C4. Sexual assault reported in community confinement facilities should, to the extent possible, be handled like a sexual assault in the community, as per the [National Protocol](#), with the exceptions noted in this guide's recommendations.

- Victims reporting sexual assault to corrections staff should be informed of whether they also have the option of reporting to law enforcement. Corrections staff and other responders should understand if victims have this option. In instances where a report is made to law enforcement as well as to the correctional facility, corrections staff and local law enforcement should coordinate their immediate response and subsequent investigations as appropriate. Planning such cooperation and coordination ahead of time (e.g., by crafting an MOU between agencies) can make the response in specific cases more streamlined and effective. (Also see V11.)
- Staff at community confinement facilities should contact 9-1-1 for resident victims with acute medical needs (if victims cannot make the call for themselves) or when there are life threatening/serious safety issues that cannot be addressed by staff at the facility (e.g., the perpetrator is present and threatening the victim or others). Many community confinement facilities do not have medical staff. However, if there is medical staff trained in assessing/treating acute injuries, they should be involved in an immediate response.
- Victims with non-acute medical needs and concerns should be encouraged to seek medical attention, either prior to and during the medical forensic examination or from another medical professional.

¹⁶⁰ See Office on Violence Against Women, *A National Protocol* (2013), p.134. For further recommendations on education for core responders, as well as applicable training and education requirements for individuals who have contact with persons housed in correctional environments see also 28 C.F.R. §§ 115.31, 115.131, 115.231, 115.331, 115.32, 115.132, 115.232, 115.332, 115.34, 115.134, 115.234, 115.334, 115.35, 115.235, and 115.335.

- Victims should be directed to the nearest facility that provides sexual assault medical forensic examinations by trained forensic examiners. Staff at the examination site should activate the examiner and victim advocate.
- Victims should be encouraged to explore transportation options to get to/from the examination site with law enforcement, victim advocates, and/or corrections staff. Law enforcement often will transport victims to the examination site.
- Ensure that core responders are trained to understand that victims' conditions of release may require notification to the community confinement facility of their travels/whereabouts. Core responders should understand their role, if any, in facilitating this notification. Core responders may be asked by a victim who has this travel requirement to notify the community confinement facility of his/her current location (e.g., at the examination site, a law enforcement office, or community-based advocacy program) and anticipated time of return to the facility. In these instances, core responders should allow the victim to call his/her facility to provide this information and/or verify this information themselves with corrections staff. If the resident indicates that they have not reported the sexual assault to the community confinement facility, core responders should not disclose the reason for the visit.

C5. Facilitate examination site readiness for victims from prisons and jails.

- Determine whether examinations will be conducted at the correctional facility or a local examination site (e.g., a hospital or other facility that has specially educated and clinically prepared forensic examiners conducting the medical forensic examination). Corrections administrators should discuss the advantages, disadvantages, and logistics of such an arrangement with forensic examiners/other examination site staff. (Also see V7.)
 - o If the medical forensic examination is to occur at a local examination site, establish an agreement with the site, delineating operational procedures related to this examination and coordination needed. (Also see V7.)
 - o If examinations are to be done at the correctional facility, delineate operational procedures and coordination needed. (Also see V7.)
- Facilitate training for non-corrections-based health care providers who interact with sexual assault victims on issues specific to conducting the examination with sexual assault victims from prisons or jails. (See V7 for possible training topics.)

C6. Ensure that policies are in place for reporting sexual assault occurring in other correctional facilities.¹⁶¹

Victims in correctional facilities may delay reporting of a sexual assault until they are released or transferred to another facility and no longer fear retaliation or loss of privileges or freedoms. Coordination among correctional facilities to report the assault is critical to ensure that these delayed reports are taken seriously and investigated promptly. Prisons, jails, lockups, and community confinement facilities should work together to improve cross-communication among and between the different settings on this matter. Residents of community confinement facilities who remained silent about sexual victimization while incarcerated may disclose those experiences while in community settings. In addition to less fear of retaliation from perpetrators, they may be somewhat more trusting of corrections staff, particularly given their social worker/counselor functions.

- If an individual housed in a correctional facility reports being sexually assaulted while housed at another correctional facility, the facility that received the report has a duty to notify the institution where the assault occurred, regardless of the amount of time that has lapsed from the incident to the reporting of the sexual assault.
- The institution currently housing the victim should obtain/receive information about investigation findings from the institution where the assault occurred.¹⁶²

¹⁶¹ 28 C.F.R. §§ 115.63, 115.163, 115.263, and 115.363.

¹⁶² The Department of Justice PREA standards require notifying an individual housed in a correctional facility about the findings of an investigation (if another agency conducts the investigation, the correctional facility should request the relevant information from the investigative agency in order to inform the individual). Under the PREA standards, facilities housing individuals are not required to inform individuals of investigation findings from assaults that occurred in other facilities. However, this guide recommends that facilities do so as a best practice. See 28 C.F.R. §§ 115.73, 115.273, 115.373.

- Victims reporting sexual assault that occurred at another confinement facility should have access to the same coordinated response as other sexual assault victims, including advocacy services and support (although length of time since the assault may lessen the likelihood of forensic evidence, the need for acute medical care, or a victim's interest in advocacy/support).

C7. Initiate regular clinical reviews of the facility's response to sexual assaults and responder performance to determine strengths, weaknesses, gaps, and areas where additional training or revisions to policy are indicated.¹⁶³

- In addition to corrections staff, involve outside community-based victim advocates and/or SART members in these reviews whenever possible for perspective and guidance.¹⁶⁴

¹⁶³ 28 C.F.R. §§ 115.86, 115.186, 115.286, and 115.386.

¹⁶⁴ Note that the Pennsylvania Coalition Against Rape may be a resource for states and counties on this practice. Contact information available through <http://www.pcar.org/>.

Appendix A. Bibliography¹⁶⁵

In addition to this guide, the following three publications provide a foundation for corrections administrators as they draft or revise their protocols for an immediate response to sexual assault, specifically during the medical forensic examination process:

National Prison Rape Elimination Commission (June 2009). *National Prison Rape Elimination Commission Report*. Washington, DC: National Prison Rape Elimination Commission. Available electronically at <http://www.ncjrs.gov/pdffiles1/226680.pdf>.

"National Standards to Prevent, Detect, and Respond to Prison Rape, Final Rule." *Federal Register* 77:119 (June 20, 2012) pp.37106-37232.

Office on Violence Against Women (2013). *A National Protocol for Sexual Assault Medical Forensic Examinations, Adults/Adolescents, 2d*. Washington, D.C.: U.S. Department of Justice. Available electronically at <https://www.ncjrs.gov/pdffiles1/ovw/241903.pdf>. For resources related to the *National Protocol* and the medical forensic examination, go to <http://www.safeta.org>, call the SAFEta Helpline: 1-877-819-SART, or e-mail info@safeta.org.

Additional reference tools:

Abner, C., Browning J., & Clark, J. (December 2009). *Preventing and Responding to Corrections-Based Sexual Abuse: A Guide for Community Corrections Professionals*. Lexington, KY.: American Probation and Parole Association, with International Community Corrections Association (Silver Spring, MD), & Pretrial Justice Institute (Washington, D.C.). Available electronically at <http://nicic.gov/Library/024176>.

National Prison Rape Elimination Commission (2009). *Standards for the Prevention, Detection, Response, and Monitoring of Sexual Abuse in Community Corrections*. Washington, D.C.: National Prison Rape Elimination Commission. Available electronically at <http://www.ncjrs.gov/pdffiles1/226683.pdf>.

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Additional documents referenced in this guide:

Beck, A., Harrison, P., Berzofsky, M., Caspar, R., & Krebs, C. (2010). *Sexual Victimization in Prisons and Jails Reported by Inmates, 2008-09. National Inmate Survey, 2008-09*. Washington, D.C.: U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics. Available electronically through <http://bjs.ojp.usdoj.gov/>.

Beck, A., Harrison, P., & Guerino, P. (2010). *Sexual Victimization in Juvenile Facilities Reported by Youth, 2008-09*. Washington, D.C.: U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics. Available electronically through <http://bjs.ojp.usdoj.gov/>.

¹⁶⁵ Note that the online resources listed in this bibliography were available at the time of this guide's publishing; however, they may be moved or be removed at any time. If you are experiencing difficulty accessing an online resource listed here, you might try to find it by doing a title search through your web browser.

- Beck, A. & Guerino, P. (2011). *Sexual Violence Reported by Adult Correctional Authorities 2007-2008*. Washington, D.C.: U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics. Available electronically through <http://bjs.ojp.usdoj.gov/>.
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- Glaze, L. (2010). *Correctional Population in the United States, 2009*. Washington, D.C.: U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics. Available electronically through <http://bjs.ojp.usdoj.gov/>.
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- National Institute of Corrections/American University, Washington College of Law, Project on Addressing Prison Rape (2010). *Curriculum: Investigating Allegations of Staff Sexual Misconduct with Offenders*. Washington, D.C. Available electronically through <http://www.wcl.american.edu/nic/>.
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- Sidran Institute (2000). *What is Post-Traumatic Stress Disorder?* Brooklandville, MD. Available electronically through <http://www.sidran.org>.
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Appendix B. Issues and Recommendations for Lockups¹⁶⁶

Many lockups are situated in law enforcement agencies that are experienced in responding to sexual assaults that occur in the community. Those agencies should review the U.S. Department of Justice's Office of Violence Against Women publication, *National Protocol for Sexual Assault Medical Forensic Examinations: Adults/Adolescents, 2d.*¹⁶⁷ (referred to in this guide as the *National Protocol*) and apply its principles to the fullest extent possible to sexual assaults that occur in their lockups. Appendix B provides an overview of lockups and sexual assault and offers administrators who operate lockups a few targeted recommendations for improving the immediate response to sexual assault occurring or reported in their facilities, using victim-centered care and coordination as the guiding principles.

1. Lockups and Sexual Assault

In the U.S. Department of Justice's final standards on the Prison Rape Elimination Act (PREA),¹⁶⁸ a lockup is defined as a facility that contains holding cells, cell blocks, or other secure enclosures that are:

- Under the control of a law enforcement, court, or custodial officer; and
- Primarily used for the temporary confinement of individuals who have recently been arrested, detained, or are being transferred to or from a court, jail, prison, or other agency.

Notably, people usually spend hours, not days,¹⁶⁹ in lockups before being transferred to another facility or released. Despite the short period of time detainees spend in lockups, Congress recognized the opportunity for sexual assault to occur in these settings by including "police lockup" under the definition of "prison" in the PREA statute.¹⁷⁰

While lockups are included under PREA, little is known about the actual incidence and prevalence of sexual assault in lockups. Still, despite the lack of empirical data, the National Prison Rape Elimination Commission (the Commission) heard testimonial evidence that sexual assault can and does occur in these settings.¹⁷¹ Its standards and the final standards promulgated by the U.S. Department of Justice address sexual abuse in lockups.

2. Recommendations for Lockups

By design, lockups are intended to hold individuals in custody for short periods of time. They employ few staff members and may not be equipped with medical or mental health facilities or staff. Despite these limitations, there are several important steps that officers who supervise lockups can take when a sexual assault occurs. (Note that the lockup recommendations below are denoted with a "L.")

L1. If a recent sexual assault is discovered or reported, ensure that the victim's immediate medical needs are tended to and that they are transported out immediately for a medical forensic examination, according to facility and jurisdictional policies.¹⁷²

Prophylactic treatment for sexually transmitted infections and pregnancy should occur as soon after a sexual assault as possible. Because forensic evidence degrades quickly, it should be collected and

¹⁶⁶ For an explanation of terms used in this appendix, see the *Introduction to the Guide*.

¹⁶⁷ Office on Violence Against Women, *A National Protocol for Sexual Assault Medical Forensic Examinations, Adults/Adolescents, 2d.* (Washington, D.C.: U.S. Department of Justice, 2013).

¹⁶⁸ *National Standards to Prevent, Detect, and Respond to Prison Rape, Final Rule*, 77 Fed. Reg. 37106-37232 (June 20, 2012) (to be codified at 28 C.F.R. § 115.5).

¹⁶⁹ Note that there are exceptions. For example, if someone is arrested on a Friday night of a holiday weekend, they could spend multiple days in a temporary holding facility before a first court appearance.

¹⁷⁰ Prison Rape Elimination Act of 2003, 42 U.S.C. §15606 (e)(2)(M).

¹⁷¹ *Lockups, Native American Detention Facilities, and Conditions in Texas Penal and Youth Institutions*, National Prison Rape Elimination Commission Public Testimony (2007), Testimony of Erica Hejnar. Available electronically at www.justdetention.org/en/NPREC/ericahejnar.aspx.

¹⁷² 28 C.F.R. § 115.182.

documented as soon as possible after a sexual assault. A victim should never be transferred out of a lockup to a jail or other confinement facility before the completion of a medical forensic examination. If a victim is slated for release back into the community, they should be released directly from the examination site following the examination. If the facility has not yet completed the release process at the time the assault is reported, the victim should be returned to the agency's custody only for as long as it takes for the release process to be completed. Victims slated for release should be given a report of the incident with a complaint number they can reference when seeking services or updates on the investigation.

L2. Train custodial staff responsible for supervising and transporting detainees on the importance of community-based sexual assault advocacy services and the right of detainees to use advocacy services.

When a detainee is brought in for a sexual assault medical forensic examination, staff at the examination site should follow the same protocol they use for notifying community-based sexual assault advocates when any sexual assault victim presents at that facility. Agencies should make sure that corrections officers and other responders understand the examination site's protocol and that, despite their status as detainees, victims of sexual assault in lockups have a right to accept crisis counseling and other services offered by community-based sexual assault advocates.

L3. Following the completion of the medical forensic examination, release or transfer the victim to another facility as quickly as possible so that they can connect with long-term medical and mental health providers.

Because lockups are not staffed with on-site medical or mental health providers who can provide care to sexual assault victims, agencies should make sure that victims have access to necessary follow-up health services as soon as possible following the medical forensic examination.

L4. If a detainee reports a sexual assault that occurred at another facility, a supervisor at the lockup should notify the facility where the assault was reported to have occurred.¹⁷³

Consistent with C6 in Section III of this guide, all confinement facilities, including lockups, should strive to improve communication and information sharing when incidents of sexual assault are reported.

¹⁷³ 28 C.F.R. § 115.163.

Appendix C. Issues and Recommendations for Juvenile Detention Facilities¹⁷⁴

In 2006, approximately 90,000 juveniles were confined in juvenile detention facilities in the United States, with more than half (55,978) under the age of 16.¹⁷⁵ Unfortunately, this population is not immune to experiencing sexual victimization during confinement. A 2010 Bureau of Justice Statistics special report showed that an estimated 12 percent of youth in state juvenile facilities and large non-state facilities self-reported experiencing one or more incidents of sexual victimization by another youth or facility staff in the prior 12 months.¹⁷⁶ Included in the final PREA standards,¹⁷⁷ the U.S. Department of Justice issued standards tailored to prevent, detect, and respond to sexual assault occurring in juvenile detention facilities.

The scope of this guide is limited to adults and adolescents in prisons, jails, and community confinement facilities, and does not include youth held in juvenile detention facilities.¹⁷⁸ However, several broad-based recommendations are offered below that may assist administrators of juvenile detention facilities in drafting or revising facility protocols for an immediate response to sexual assault, specifically during the medical forensic examination.

Recommendations for Juvenile Detention Administrators

(Note that the juvenile detention recommendations below are denoted with a “J.”)

J1. Develop a protocol that applies the concepts of victim-centered care and a coordinated response to all reports of sexual assault.¹⁷⁹

Juvenile detention administrators are encouraged to use the principles included in this guide as a framework for developing a protocol that is responsive to the needs of victims in their facilities.

J2. In the absence of the guidance of a national protocol, form a working group that includes community-based sexual assault victim advocates to assist in developing a facility protocol.

This guide, along with the U.S. Department of Justice’s Office of Violence Against Women publication, [National Protocol for Sexual Assault Medical Forensic Examinations: Adults/Adolescents, 2.d](#) (referred to in this guide as the *National Protocol*), and the PREA standards can be used as a starting point for discussions.

J3. Address the following issues in the facility protocol and provide related training for facility staff:

- Adolescent sexual development, including normative and sexually aggressive/dangerous behaviors, and the ways in which sexual victimization can affect healthy sexual development;
- The difference between sexual assault and consensual sexual contact between residents;
- Gender specific responses to trauma, including how past abuse (including sexual assault) may impact behaviors, suicidal thoughts and attempts, emotional outbursts, oppositional behavior, or failure to follow directions;

¹⁷⁴ For an explanation of terms used in this appendix, see the *Introduction to the Guide*.

¹⁷⁵ National Center for Juvenile Justice, *Easy Access to the Census of Juveniles in Residential Placement* (Washington, D.C.: U.S. Department of Justice, Office of Juvenile Justice and Delinquency Programs, Office of Juvenile Justice and Delinquency Prevention, 2008), available electronically at: <http://ojjdp.ncjrs.gov/ojstatbb/ezacjrp>.

¹⁷⁶ A. Beck, P. Harrison, & P. Guerino, *Sexual Victimization in Juvenile Facilities Reported by Youth, 2008-2009* (Washington, D.C.: U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics, January 2010), available electronically through <http://bjs.ojp.usdoj.gov/>.

¹⁷⁷ *National Standards to Prevent, Detect, and Respond to Prison Rape, Final Rule*, 77 Fed. Reg. 37106-37232 (June 20, 2012) (to be codified at 28 C.F.R. §115).

¹⁷⁸ See the *Introduction to the Guide* for an explanation of the limitations of the guide’s scope. Also see Office on Violence Against Women, *A National Protocol for Sexual Assault Medical Forensic Examinations, Adults/Adolescents*, 2d. (Washington, D.C.: U.S. Department of Justice, 2013), p.1.

¹⁷⁹ 28 C.F.R. § 115.365.

- Age of consent laws, including consent to medical treatment and evidence collection without parental or guardian involvement;
- How to communicate effectively and professionally with all residents, regardless of sexual orientation;
- Limits to confidentiality for minors;
- Mandatory reporting laws and requirements; and
- Appropriate methods for handling disclosures of past abuse (including sexual assault).¹⁸⁰

¹⁸⁰ Beck, Harrison, & Guerino, *Sexual Victimization in Juvenile Facilities Reported by Youth, 2008-2009* (2010).

Appendix D. Possible Roles of Core Responders¹⁸¹

Corrections administrators can refer to this outlined description of possible core responder roles when developing or modifying their facility protocols for an immediate response to sexual assault, specifically during the medical forensic examination process. They can make changes to roles as appropriate to conform to jurisdictional and institutional specifications. This outline can also be a basis from which a SART delineates responders' responsibilities in corrections-based sexual assault cases.

Note:

- Core responders are the professionals involved in an immediate response to a report of sexual assault, both those internal and external to the correctional environment.
- Roles in this outline are generally organized for each responder in the order that they might occur. However, victims' points of entry into the response system, when responders get involved in a case, and the sequence and scope of their interventions can vary widely. Whether a report is made immediately after an assault or delayed also can affect responder actions.
- This outline focuses on an immediate response to reports of sexual assault but also indicates potential longer-term functions of responders.
- All responders are encouraged to provide victim-centered interventions using a coordinated team approach. Victim-centered interventions are systemically and deliberately focused on the physical, mental, and emotional needs of each victim. When responders coordinate their interventions, it can afford victims protection, access to immediate care, and help to minimize trauma, while simultaneously facilitating an investigation. Corrections staff should coordinate their actions in sexual assault cases and work in a coordinated manner with responders external to their facility.
- For all responders, assess the age, abilities, communication modality, and health condition of victims and tailor responses as appropriate.

Actual roles may depend on factors such as organization, staffing, policies, and practices of a facility or agency. In addition, jurisdictional issues, accessibility of services, and the existing level of partnerships among responders may influence interventions. Of course, responders' interventions in a corrections-based sexual assault case will also depend on the specifics of that case, may or may not require all of the responder activities listed below, and may require modification of roles or additional activities.

Corrections Staff

First responding corrections line staff—roles may include, but not be limited to:

- Acknowledging disclosures of sexual assault and obtaining basic information from victims (but not starting an investigation);
- Assessing immediate victim safety needs, separating victims and perpetrators to prevent further harm/injury, and in prisons and jails, considering the need to lock down other incarcerated individuals on the unit for security and/or investigative purposes;
- Calling for emergency medical assistance if needed;
- Sealing/preserving any crime scenes;
- Requesting victims not to take any actions that could destroy physical evidence (including washing, brushing their teeth, changing their clothes, urinating, defecating, smoking, drinking, or eating);
- Reporting incidents (which triggers interventions by other responders);
- Writing a comprehensive report of each incident; and
- Communicating with other corrections staff as necessary to ensure optimal coordination and confidentiality of interventions and address issues in specific cases.

¹⁸¹ For an explanation of terms used in this appendix, see the *Introduction to the Guide*. Also see *National Standards to Prevent, Detect, and Respond to Prison Rape, Final Rule*, 77 Fed. Reg. 37106-37232 (June 20, 2012) (to be codified at 28 C.F.R. §§ 115.64, 115.164, 115.264, 115.364, 115.65, 115.165, 115.265, and 155.365).

First responding line staff who are not security personnel: If safety of victims/other individuals or security of the evidence is an issue, they should promptly notify security staff. For small community confinement facilities with no security staff, promptly notify local law enforcement.

Corrections medical/mental health staff (some facilities, such as small jails and community confinement facilities, may provide only first aid and crisis intervention while others, such as larger jails and prisons, may have the capacity to provide comprehensive health care, as well as follow-up care after a medical forensic examination)—roles may include, but not be limited to:

- Assessing acute medical/mental health needs and coordinating care;
- If acute care is provided at the correctional facility, preserving forensic evidence to the extent possible prior to a medical forensic examination (e.g., if the victim's clothing needs to be removed to provide care, ensure that the clothing is packaged, labeled, sealed, and then included with other forensic evidence, in a way that maintains the chain of custody of evidence);
- If the victim is going from a prison or jail to a local examination site, work with other corrections staff to arrange transport for the victim to/from the site and security to/from the site and during the examination;
- Communicating with other responders as necessary to ensure optimal coordination of interventions (e.g., confer with the forensic examiner and corrections investigator if there is a question as to whether a medical forensic examination is appropriate in a particular case, and communicating with the forensic examiner regarding follow-up medical instructions) and address issues in specific cases;
- Providing/coordinating follow-up health care (longer-term function); and
- Participating in case reviews and SART meetings, if one exists (longer-term function).

For prisons and jails that use external examination sites, facility administrators may assign their medical staff a role in communicating with staff at the examination site regarding the imminent arrival of the victim from their facility, as well as with the forensic examiner/health care provider regarding follow-up instructions.

Prison/Jail staff providing transportation for victims to/from the local examination site as well as security while in transport and during the examination—roles can include, but not be limited to:

- Coordinating with corrections staff as necessary to arrange transportation and security;
- Communicating with external responders as necessary to ensure optimal coordination of interventions and address issues in specific cases;
- Bringing an extra set of clothing for victims to the examination site in case their clothes are taken as evidence; and
- Ensuring victims are transported and secured in a way that maintains:
 - Their safety (e.g., do not transport victims with their perpetrators);
 - The security of the correctional facility and examination site (e.g., do not have victims wait in public waiting areas of the examination site, and check the exam room in conjunction with examination site staff for items that might function as weapons and remove/rearrange them so that victims do not have access to them);
 - Their privacy to the extent possible (e.g., consider how victims will exit/enter the correctional facility, and be as unintrusive during the examination as possible); and
 - Potential evidence (e.g., requesting that victims not eat or drink during transport to the examination site or while waiting for an examination).

If, for security purposes, incarcerated victims are shackled or otherwise restrained, corrections security staff should ensure the level of shackling/restraint correlates with their security status. They should be restrained and shackled as comfortably as possible and in a way that allows them to participate in examination activities.

Role of community confinement facility staff in transporting their residents to/from the medical forensic examination site—staff of community confinement facilities may or may not provide resident victims with transportation to the examination site, but they can help coordinate that transportation. If law enforcement is involved, a law enforcement representative may be able to transport resident victims.

Local emergency medical services (EMS) may be called to provide emergency medical care and transport them. Personal support persons may also be able to provide transport or the community-based victim advocacy program may help resident victims identify transportation options. Note that use of EMS may result in resident victims being billed for this service. Security while in transport or at the examination site is typically not necessary for resident victims from community confinement facilities.

Corrections staff acting as victim resource specialists (Many facilities would need to create this position; volunteers could be sought among corrections staff who interact with victims in the facility)—roles can include, but not be limited to:

- Providing basic information to victims about what happens once a report of sexual assault is made within the facility (e.g., how it will be responded to, and what to expect during any resulting investigation, administrative hearings, and/or prosecution), how to preserve forensic evidence prior to a medical forensic examination, and their options for medical/mental health care, evidence collection, emotional support/victim advocacy, and criminal justice involvement;
- Encouraging victims who agree to a medical forensic examination to bring extra clothing to the examination site as the clothes they have on may be taken for evidence;
- Communicating with other responders as necessary to ensure optimal coordination of interventions and address issues in specific cases; and
- Participating in case reviews and SART meetings, if one exists (longer-term function).

Facility administrators may also assign this staff member some responsibility for contacting internal/external responders to alert them of the possible need for their services, and coordinating internal follow-up care and external services to promote victim healing and investigative processes.

Corrections administrators (the administrator may take on these roles or designate them to the PREA coordinator or other staff person with decision-making authority)—roles can include, but not be limited to:

- Receiving reports of sexual assault disclosed in their facilities;
- Ensuring that investigations occur in a timely manner;
- If victims report staff sexual misconduct and name their perpetrators, ensuring that those perpetrators are not involved in any aspect of the facility's response;
- If the examination will be done outside of the correctional facility, ensuring that procedures are in place to facilitate alerting the examination site that a victim from the correctional facility will be arriving within a specific time period for an examination;
- If the examination will be done at the prison or jail, ensuring that procedures are in place to notify the forensic examiner that they are needed to conduct an examination;
- Ensuring an appropriate staff person (e.g., medical staff, if applicable) communicates with the forensic examiner regarding follow-up instructions after the examination;
- Following the examination, ensuring procedures are in place to allow victims the opportunity to discuss with security personnel their safety concerns and possible precautions (e.g., addressing their desire to be kept separate from perpetrators);
- If victims opt not to have the examination but do want advocacy services, ensure that a process is in place to activate a community-based victim advocate (whenever possible);
- Ensuring procedures are in place to allow victims access to personal support persons if requested, with restrictions as necessary for the security of the facility;
- Strictly limiting who within the correctional facility needs to know about a report of sexual assault;
- Staying abreast of related investigations, administrative hearings, and prosecutions;
- Ensuring procedures are in place to relay reports of sexual assaults that occurred in other correctional facilities to those facility administrators;
- Ensuring procedures are in place to facilitate communication among corrections staff and external agencies and professionals as needed to coordinate interventions; and
- Participating in case reviews and SART meetings, if one exists (longer-term function).

Corrections investigators—roles can include, but not be limited to:

- Promptly gathering direct and circumstantial evidence and ensuring that all evidence collection, preservation, and storage follows the chain of custody;

- If not already done, requesting that victims not take any actions that could destroy physical evidence until either after the examination is conducted or they decide not to have evidence collected;
- If there is a question as to whether a medical forensic examination is appropriate in a specific case of sexual assault, seeking the input of a forensic examiner;
- Coordinating with forensic examiners to facilitate collection, documentation, preservation, and storage of forensic evidence on the victim, while maintaining the chain of custody;
- Obtaining preliminary statements from victims, witnesses, and suspects;
- Communicating with other responders as necessary to ensure optimal coordination of interventions and address issues in specific cases;
- Interviewing suspects and witnesses (longer-term function);
- Requesting crime lab analysis (longer-term function);
- Reviewing medical and lab reports (longer-term function);
- Writing investigative reports (longer-term function);
- Communicating with prosecuting authorities in potential criminal cases for guidance regarding what evidence/statements are essential (longer-term function);
- Informing the victim of the progress and outcome of the investigation (longer-term function);
- Presenting cases to facility officials for administrative hearing purposes (longer-term function);
- Referring cases for prosecution whenever evidence and documentation indicates a criminal offense occurred (longer-term function); and
- Participating in case reviews and SART meetings, if one exists (longer-term function).

Many prisons and jails and some community confinement facilities have investigators who investigate reports of crimes within their facilities. However, local law enforcement agencies may conduct investigations of crimes occurring in a correctional facility, particularly in cases involving criminal allegations against staff. Also, in community confinement facilities, residents who are sexually assaulted may have the option of reporting to law enforcement, either in addition to or instead of the correctional facility.

Responders External to Corrections

Community-based sexual assault victim advocates—roles include, but are not limited to:

- Responding promptly to requests either from staff at the examination site to provide on-site victim advocacy during the medical forensic examination, or from corrections staff to provide victim advocacy to individuals housed in their facilities;
- Accompanying victims during the actual examination (with their permission);
- Ensuring that victims have access at the examination site to extra clothing in case the clothes they have on are taken for evidence;
- Providing victims with emotional support, crisis intervention, information, and referrals as needed, whether or not they decide to have a medical forensic examination;
- In community confinement facilities, offering to help victims who wish to have the examination identify transportation options to/from the examination site;
- Helping ensure that victims' self-identified needs are addressed to the extent possible during an immediate response;
- Communicating with other responders as necessary to ensure optimal coordination of interventions and address issues in specific cases;
- Providing victims a range of supportive follow-up services (longer-term function); and
- Participating in case reviews and SART meetings, if one exists (longer-term function).

Health care personnel providing triage and intake at the examination site—roles can include, but not be limited to:

- Conducting intake to assess victim immediate medical needs;
- Providing care for acute injuries, and in the process, preserving forensic evidence to the extent possible prior to a medical forensic examination;
- If not already been done, activating a forensic examiner to perform the medical forensic examination;

- If not already been done, activating a community-based victim advocate to offer on-site support for victims during the medical forensic examination; and
- Communicating with any other responders to ensure optimal coordination of interventions (e.g., with corrections and examination site staff to address security concerns) and address issues in specific cases.

Forensic examiners—roles can include, but not be limited to:

- Responding promptly to requests for a medical forensic examination;
- Performing the medical forensic examination—taking the medical forensic history, doing a physical evaluation, collecting forensic evidence, and documenting all findings;
- Creating discharge and a follow-up plan with the victim;
- Communicating with corrections staff regarding follow-up instructions as appropriate (as well as to inform community confinement administrators, at a resident's request, that that resident has come in for an examination and when they are expected to return to the community confinement facility);
- Communicating with any other responders to ensure optimal coordination of interventions (e.g., with corrections and examination site staff to determine if a medical forensic examination is appropriate in a specific case or to address security concerns) and address issues in specific cases;
- Being prepared to testify in related judicial proceedings (longer-term function); and
- Participating in case reviews and SART meetings, if one exists (longer-term function).

Law enforcement representatives (e.g., 9-1-1 dispatchers, patrol officers, officers who process crime scene evidence, and investigators) may be called by corrections staff to respond to sexual assaults occurring/reported in correctional facilities. This may occur particularly if the correctional facility/system does not have in-house investigators, if the report names a corrections staff member as the perpetrator, and/or if the assault occurs in a community confinement facility. Victims in community confinement facilities may have the option of reporting to law enforcement, either in addition to or instead of the community confinement facility. Roles include, but are not limited to:

- Responding promptly to initial complaints;
- Addressing victim safety to the extent necessary;
- Ensuring victims are provided with emergency medical assistance as needed;
- Securing any crime scenes if not already done;
- Emphasizing to victims the need for medical evaluation to address health concerns related to sexual assault and for forensic evidence collection;
- Advising victims not to take any actions that could destroy physical evidence;
- Explaining to victims their reporting options, and that evidence collection is not typically dependent on reporting (evidence can typically be stored for a period of time until victims make a decision about reporting or the time expires);
- Arranging for victims' transportation to and from the examination site, as needed;
- Coordinating evidence collection (including with forensic examiners to facilitate collection, documentation, preservation, and storage of forensic evidence on the victim while maintaining the chain of custody of evidence) and delivery of evidence to designated labs or law enforcement property facilities;
- Taking preliminary statements from victims, witnesses, and suspects;
- Communicating and collaborating with any other responders to ensure optimal coordination of interventions and to address issues in specific cases;
- Interviewing suspects and witnesses (longer term function);
- Requesting crime lab analysis (longer term function);
- Reviewing medical and lab reports (longer term function);
- Preparing and executing search warrants (longer term function);
- Writing investigative reports (longer term function);
- Presenting cases to prosecutors (longer term function); and
- As applicable, participating in case reviews and SART meetings, if one exists (longer-term function).

Prosecutors—roles include, but are not limited to (all but the first are longer-term functions):

- Consulting with core responders as requested to help guide the investigation;
- Determining if there is sufficient evidence for prosecution and, if so, prosecuting the case; or, if there is not sufficient evidence, promptly notifying the correctional facility that the case has been declined and why;
- To reduce case closures and declinations due to lack of compelling evidence: educate other responders about prosecutorial policies and practices, provide legal definitions and explanations, assist in developing and implementing strategies to enhance prosecution, assist with case reviews, and provide updates on case dispositions.¹⁸²
- Communicating with other responders to ensure optimal coordination of interventions and address issues in specific cases; and
- Participating in SART meetings, if one exists.

Additional professionals or agencies may be involved in immediate interventions in a specific correctional facility. For example, particularly in community confinement facilities, EMS might provide urgent medical aid and transportation to the examination site. Or forensic lab personnel may be asked to educate the SART, particularly forensic examiners and investigators, about ways to maximize evidence quality.

Differences in the type of correctional facility likely will impact who is sought out from the community to be involved, especially for longer-term response. Prisons and jails, for example, usually have in-house staff who provide mental health treatment, whereas community confinement facilities may or may not have mental health staff and may need to refer residents to local providers for mental health treatment. The location of the correctional facility may also impact what external resources are available. For example, a correctional facility in a rural or remote community may need to travel to a regional examination site because the local hospital does not have a forensic examiner program.

¹⁸² Adapted from Office for Victims of Crime, *SART Toolkit* (2011), Develop a SART.

Appendix E. An Assessment Tool for Corrections Administrators Drafting/Revising Protocols for an Immediate Response to Sexual Assault¹⁸³

Part 1: Initial Information Gathering

Identify characteristics of your corrections population.

- Classification information, age, cultural/ethnic breakdown, language preferences, education levels, etc.
- What characteristics stand out as those that increase risk for sexual victimization for persons housed in your facility?

What currently happens when a sexual assault is reported to corrections staff in your facility?

- Have corrections staff been trained on what to do if an individual housed in the facility reports being sexually assaulted? Are they informed of their role? If so, how?
- Which facility administrator/staff member should corrections staff inform upon receiving a report of sexual assault? Is a written report of the incidence required? Is there a specific form for this report?
- What happens to the report once it is received by that facility administrator/staff member? What immediate response does it trigger?
- What happens to victims, both in cases of recent sexual assault and delayed reports, immediately following a report?
- What happens to suspects, both inmate/resident suspects and staff suspects, following a report? Describe the internal disciplinary process.
- What should victims expect during any resulting investigation, administrative hearings, and/or prosecution?
- What support services are available to sexual assault victims internal and external to the correctional facility? How can they access these services? How are victims' safety concerns addressed?

Who has criminal jurisdiction over sexual assaults committed in your facility?

- Describe the current relationship between the correctional facility and the jurisdiction's criminal justice agencies in handling sexual assault cases.

Which corrections staff and external agencies and professionals are currently involved in an immediate response to sexual assault in your facility, specifically during the medical forensic examination process?

- What corrections staff members are involved at the correctional facility?
- What agencies and/or professionals from the local/regional community are involved?

What is the incidence of sexual assault in your facility?

- How many sexual assaults were reported to corrections authorities in the past year? What was the breakdown for different types of sex crimes and staff sexual misconduct? How many were delayed reports? What were the outcomes of investigations of reported sexual assaults? How many resulted in disciplinary hearings/sanctions for perpetrators?
- Have there been anonymous/confidential surveys of persons housed in your facility that might shed light on actual incidences of sexual assault? If yes, explain.

¹⁸³ This tool is adapted with permission from K. Littel, J. Archambault, & K. Lonsway, SARRT assessment tool for rural and remote communities/regions, in *SARRT: A Guide for Rural and Remote Communities* by the same authors (Addy, WA: Ending Violence Against Women International, 2008). Some of the material in this tool was adapted from J. Archambault, *Community SART Assessment Tool for Universities and Colleges* (Addy, WA: Sexual Assault Training and Investigations, Inc.); Office on Violence Against Women, *A National Protocol for Sexual Assault Medical Forensic Examination, Adults/Adolescents, 2d.* (Washington, D.C.: U.S. Department of Justice, 2013); and *Developing a SART: A Resource Guide for Kentucky Communities* (Frankfort, KY: KY Association of Sexual Assault Programs, 2002).

- How many sexual assaults from your facility did prosecution offices review in the last year? In how many cases did they file/issue charges? What was the breakdown of case dispositions?

Are persons housed in your facility aware of what to do if a sexual assault occurs?

- If yes, how are they made aware?

What are the barriers to getting and providing immediate help?

- What barriers do persons housed in your facility face when seeking protective measures, health care, emotional support and advocacy, and criminal justice assistance in the aftermath of a sexual assault?
 - What might cause victims to be reluctant to report to corrections authorities?
 - If applicable, what might cause victims to be reluctant to report to law enforcement or to be involved in the prosecution of their perpetrators?
 - What might cause victims to be reluctant to seek out health care, a medical forensic examination, emotional support, and advocacy?
- What challenges do responders face in providing prompt and victim-centered assistance to victims?
- Are there other challenges, problems, or concerns specific to your corrections population or facility that might negatively influence the effectiveness of an immediate response to sexual assault victims?

Part 2: Individual Responders and Coordination Information

What is involved in the current immediate response of corrections staff and external agencies and professionals to corrections-based sexual assault, specifically during the medical forensic examination process?

Consider the following responders:

Corrections Staff

- First responding corrections line staff
- Corrections medical/mental health staff (if applicable)
- Prison/jail staff providing transportation for victims to/from the examination site as well as security while in transport and during the examination (if applicable)
- Corrections staff acting as victim resource specialists (if existing)
- Corrections administrators
- Corrections investigators

Responders External to Corrections

- Community-based sexual assault victim advocates
- Health care personnel providing triage and intake
- Forensic examiners
- Law enforcement representatives
- Prosecutors
- Forensic crime lab personnel
- Other professionals or agencies (e.g., emergency medical services)

For each responder, consider:

- How specifically are they involved in an immediate response to sexual assault in your facility? Explain current roles.
- Are they also involved in a longer-term response? If yes, how specifically?
- Are there policies in place that delineate their immediate interventions in sexual assault cases reported in the facility? Their longer-term response?
- In terms of an immediate response, what are the challenges for this responder in effectively intervening in sexual assault cases reported in the facility?
- What are the challenges for this responder in coordinating with other responders to streamline an immediate response and address problems that arise in each case?

- What are the challenges for this responder in coordinating with other responders to provide interventions that address victim-identified needs?
- Are there other responders who should be involved in an immediate response?

What formal coordination occurs during an immediate response, both within the correctional facility and across agencies?

- Are there procedures agreed upon among facilities/agencies regarding a coordinated immediate response to sexual assault reported in your facility? Are they documented in agency policies, interagency agreements, and/or in a protocol? If yes, describe.
- Do those individuals who typically provide an immediate response in sexual assault cases in your facility receive related multidisciplinary training? If yes, describe.

Part 3: Strengths and Areas for Improvement Identified

Define and evaluate the success of the current immediate response, specifically during the medical forensic examination process.

Based on the information you gathered through this assessment:

- What are the strengths of your facility's immediate response to sexual assault, specifically during the exam process?
- What are the areas needing improvement? What are the facility/agency barriers, position-specific barriers, and coordination barriers to an effective immediate response to sexual assault, specifically during the medical forensic examination process?