## Text Description automatically generated



## Sexual Abuse Incident Review (SAIR) Report Form

## Attachment A

|  |  |  |  |
| --- | --- | --- | --- |
| Facility: | | | Investigation/Incident Report #: |
| Date of Allegation: | Date investigation complete: | | Date of SAIR: |
| Alleged Victim: | | Alleged Perpetrator: | |
| Victim inmate/detainee/resident ID#: | | | |
| Alleged perpetrator was: (check one):  Staff/Volunteer/Contractor  Inmate/Detainee/Resident | | | |
| The incident being reviewed was:  Substantiated  Unsubstantiated | | | |

1. The review team has considered whether the allegation or investigation indicates a need to change policy or practice to better prevent, detect, or respond to sexual abuse.

**CHECK ONE:**

No changes to policy or practice indicated.

Yes, change(s) to policy or practice indicated as described below.

|  |
| --- |
| Description/Recommendation: |

1. The review team has considered whether the incident or allegation was motivated by race; ethnicity; gender identity; LGBTI identification, status, or perceived status; or gang affiliation; or was motivated or otherwise caused by other group dynamics at the facility.

**CHECK ONE:**

No indication of any of the listed motivating factors.

Yes, which motivating factor(s) was/were identified and why? Describe below.

|  |
| --- |
| Description/Recommendation: |

1. The review team has examined the area in the facility where the incident allegedly occurred to assess whether physical barriers in the area may have enabled abuse.

**CHECK ONE:**

No physical barriers present that may have enabled abuse.

Yes, physical barriers may have enabled abuse as described below.

|  |
| --- |
| Description/Recommendation: |

1. The review team has assessed the adequacy of staffing levels in that area during different shifts.

**CHECK ONE:**

No indication of inadequate staffing levels.

Yes, there may be inadequate staffing levels as described below.

|  |
| --- |
| Description/Recommendation: |

1. The review team has assessed whether monitoring technology should be deployed or augmented to supplement supervision by staff.

**CHECK ONE:**

No supplemental technology necessary.

Yes, supplemental technology may be necessary as described below.

|  |
| --- |
| Description/Recommendation: |

**SAIR team members present (printed name, title, and signature)**

Attending staff members from each of the below listed areas, including other relevant staff (when appropriate).

**Upper-level management:**

|  |  |  |
| --- | --- | --- |
| **Name** | **Title** | **Signature** |
|  |  |  |
|  |  |  |
|  |  |  |

**Line supervisor(s):**

|  |  |  |
| --- | --- | --- |
| **Name** | **Title** | **Signature** |
|  |  |  |
|  |  |  |
|  |  |  |

**Investigator(s):**

|  |  |  |
| --- | --- | --- |
| **Name** | **Title** | **Signature** |
|  |  |  |
|  |  |  |
|  |  |  |

**Medical and/or mental health practitioner(s):** [Tab for additional rows]

|  |  |  |
| --- | --- | --- |
| **Name** | **Title** | **Signature** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

**PREA Compliance Manager:**

|  |  |  |
| --- | --- | --- |
| **Name** | **Title** | **Signature** |
|  |  |  |

**Other relevant staff:** [Tab for additional rows]

|  |  |  |
| --- | --- | --- |
| **Name** | **Title** | **Signature** |
|  |  |  |
|  |  |  |
|  |  |  |

**This report was completed on this date:**

|  |
| --- |
|  |

**This report was completed by:**

|  |  |  |
| --- | --- | --- |
| **Name** | **Title** | **Signature** |
|  |  |  |

**This report and recommendations were submitted to:**

|  |  |
| --- | --- |
| **PREA Compliance Manager name:** | **Date:** |
|  |  |
| **Facility head name:** | **Date:** |
|  |  |

**Are there recommendations for improvement?**

Yes  No  
 **Facility Head review of report and recommendations for improvement:**

|  |  |  |
| --- | --- | --- |
| Yes | No | Date reviewed: |

**Recommendations approved:**

N/A  Yes  No  Partially

If any recommendations are **approved**, which ones and what is the deadline for improvement to be made/implemented? A corrective action plan (CAP) must be completed by the PCM or designee for all recommended changes or improvements and must accompany this form.

|  |
| --- |
|  |

If recommendations were **not approved**, which ones and describe the reason why not: (**Corrective action plan can be attached if recommendations are approved or partially approved to track completion.**)

|  |
| --- |
|  |