Prison Rape Elimination Act (PREA) Audit Report
Community Confinement Facilities

☐ **Interim** ☒ **Final**

Date of Report September 15, 2018

Auditor Information

Name: Bernard McKie	**Email:** dollmckie@aol.com
Company Name: Correctional Management and Communications Group	
Mailing Address: 979 Koon Road	**City, State, Zip:** Irmo, SC 29063
Telephone: 803-422-2851	**Date of Facility Visit:** August 20, 2018

Agency Information

Name of Agency: Alston Wilkes Society		**Governing Authority or Parent Agency** *(If Applicable)*: N/A	
Physical Address: 3519 Medical Drive		**City, State, Zip:** Columbia, SC 29203	
Mailing Address: N/A		**City, State, Zip:** N/A	
Telephone: N/A		**Is Agency accredited by any organization?** ☒ Yes ☐ No	
The Agency Is:	☐ Military	☐ Private for Profit	☒ Private not for Profit
☐ Municipal	☐ County	☐ State	☐ Federal
Agency mission: Rebuilding Lives for a Safer Community			
Agency Website with PREA Information: www.alstonwilkessociety.org			

Agency Chief Executive Officer

Name: S. Anne Walker	**Title:** Executive Director
Email: annewalker@aws1962.org	**Telephone:** 803-799-2490

Agency-Wide PREA Coordinator

Name: Jacorie Slater	**Title:** Compliance Manager/PREA Coordinator
Email: jslater@aws1962.org	**Telephone:** 803-799-2490
PREA Coordinator Reports to: Toi Reid Worley	**Number of Compliance Managers who report to the PREA Coordinator** 0 (Serves as both)

Facility Information

Name of Facility: Columbia Residential Reentry Center (CRRC)			
Physical Address: 1218 Bull Street Columbia, SC 29201			
Mailing Address (if different than above): N/A			
Telephone Number: 803-765-1394			
The Facility Is:	☐ Military	☐ Private for Profit	☒ Private not for Profit
☐ Municipal	☐ County	☐ State	☐ Federal

Facility Type:	☐ Community treatment center	☐ Halfway house	☐ Restitution center
	☐ Mental health facility	☐ Alcohol or drug rehabilitation center	
	☒ Other community correctional facility		

Facility Mission: Rebuilding Lives for a Safer Community	
Facility Website with PREA Information: www.alstonwilkessociety.org	
Have there been any internal or external audits of and/or accreditations by any other organization?	☒ Yes ☐ No

Director

Name: Latonda McMullin	**Title:** Facility Director
Email: LMcMullin@aws1962.org	**Telephone:** 803-765-1394

Facility PREA Compliance Manager

Name: Jacorie Slater	**Title:** Compliance Manager/PREA Coordinator
Email: jslater@aws1962.org	**Telephone:** 803-799-2490

Facility Health Service Administrator

Name: N/A	**Title:** N/A
Email: N/A	**Telephone:** N/A

Facility Characteristics

Designated Facility Capacity: 56	**Current Population of Facility:** 33
Number of residents admitted to facility during the past 12 months	216
Number of residents admitted to facility during the past 12 months who were transferred from a different community confinement facility:	4

Number of residents admitted to facility during the past 12 months whose length of stay in the facility was for 30 days or more:	216
Number of residents admitted to facility during the past 12 months whose length of stay in the facility was for 72 hours or more:	216
Number of residents on date of audit who were admitted to facility prior to August 20, 2012:	0

Age Range of Population:	☒ Adults 18 and over	☐ Juveniles Click or tap here to enter text.	☐ Youthful residents Click or tap here to enter text.

Average length of stay or time under supervision:	4 months
Facility Security Level:	Community
Resident Custody Levels:	Minimum
Number of staff currently employed by the facility who may have contact with residents:	19
Number of staff hired by the facility during the past 12 months who may have contact with residents:	4
Number of contracts in the past 12 months for services with contractors who may have contact with residents:	0

Physical Plant

Number of Buildings: 1	**Number of Single Cell Housing Units:** 0
Number of Multiple Occupancy Cell Housing Units:	11
Number of Open Bay/Dorm Housing Units:	0

Description of any video or electronic monitoring technology (including any relevant information about where cameras are placed, where the control room is, retention of video, etc.):

The camera monitoring system is located in the central control room which is located at the front entrance of the facility. The system is constantly monitored by a direct care staff member. There are eleven (11) interior and seven (7) exterior cameras located strategically throughout the facility including indoor/outdoor recreation areas, dayrooms, visiting areas, kitchen, hallways and administrative areas the system records all movement and has the capability to maintain recordings for thirty (30) days. No cameras are located in bathroom/shower areas.

Medical

Type of Medical Facility:	N/A
Forensic sexual assault medical exams are conducted at:	Palmetto Richland Memorial Hospital (PRMH)

Other

Number of volunteers and individual contractors, who may have contact with residents, currently authorized to enter the facility:	1
Number of investigators the agency currently employs to investigate allegations of sexual abuse:	0

Audit Findings

Audit Narrative

The Alston Wilkes Columbia Residential Reentry Center (CRRC) is located in Columbia, SC and serves male/female residents. The onsite audit phase of the Prison Rape Elimination Act (PREA) audit was conducted on August 20, 2018 by Bernard McKie, a certified United States Department of Justice Certified PREA Auditor. The facility's initial PREA audit was completed with a written report in August 2015. The current audit was attained and assigned to the Auditor by Correctional Management and Communications Group, LLC (CMCG) located in Minneola, Florida. The facility is accredited by the American Correctional Association.

The CRRC is a 56-bed secure facility and houses residents18 years and older. The Bureau of Prisons (BOP) refers residents to the facility for residential reentry. There are no known existing conflicts of interest with the Auditors and the facility and there were no barriers in completing any phase of the audit.

Audit Methodology

Pre-Onset Audit Phase

The CRRC Compliance Manager/PREA Coordinator and the Auditor had discussions concerning access to the facility and staff, the audit process, logistics for the onsite phase of the audit, and goals and expectations prior to the site visit. The PREA Auditor was in communication with the Compliance Manager/PREA Coordinator prior to the audit. The Compliance manager/PREA Coordinator serves as the facility's PREA Coordinator. The Compliance Coordinator and the Director of the facility were very receptive to the audit process and were well informed of the role of the Auditor and the expectations during each stage of the PREA audit.

The audit notice was posted July 14, 2018, at least six weeks prior to the onsite audit. The pictures of the posted notices were taken with the locations identified and emailed to the Auditor. The audit notice was posted on brightly colored paper using print that was easy to see and read. The notices were strategically placed throughout the facility, accessible to residents, staff, visitors, contractors, and volunteers. The notices were posted at eye levels easy for a person to see either sitting or standing. The audit notices were placed in the lobby, hallways, living units, recreation and common areas. The posted audit notices contained the Auditor's contact information and included information regarding confidentiality. No correspondence was received during any phase of the audit. Further verification of notice placement was made through observations during the site review. The original notice was provided to the facility by the Compliance Manager/PREA Coordinator and had previously been provided by CMCG.

The completed PREA Pre-Audit Questionnaire, policies and procedures, and supporting documentation were uploaded to a flash drive and mailed to the Auditor. This flash drive was received by the Auditor on July 19, 2018, well over a month before the site visit. An initial

assessment was conducted of the information provided and it was determined the information was provided in detail on the flash drive. The documentation on the flash drive was well organized by each standard, including the identified provisions of each standard. Additional information requested during the site visit was provided or explained by the Compliance Manager/PREA Coordinator.

The PREA Administrator was provided a document titled, "Information Requested to Determine Staff and Residents to be interviewed during the On-Site PREA Audit." The document was forwarded to the facility's PREA Coordinator who completed and returned the document to the Auditor. The document requested the identification of the staff members who served and performed in specific PREA related specialized roles within the facility, including volunteers and contractors who have contact with residents. The document requested a list of direct care staff and their shift assignments and a resident population roster. Additionally, the request included information regarding residents who may be in vulnerable categories such as disabled; limited English proficient; intersex, gay, lesbian, bisexual and/or transgender residents; and residents housed in isolation.

The Auditor communicated with the PREA Coordinator and the Facility Director to confirm schedules and to clarify specialized PREA roles. A current resident/staff roster was also provided to the Auditor. As a result of the information received, the Auditor developed an interview schedule of specialized and random staff and residents, including targeted resident interviews.

The facility provided the lists and information before or during the site visit that assisted with the following determinations and interview selections:

Lists/Information	Comments
Complete Resident Roster	An up-to-date roster was provided prior to the site visit.
Residents with disabilities	Two were identified.
Residents who are Limited English Proficient	None were identified.
LGBTI Residents	None were identified.
Residents in segregated housing	There is no segregated housing.
Residents in Isolation	There is no isolation area.
Residents who reported sexual abuse	None were identified.
Residents who reported sexual victimization during risk screening.	None were identified
Staff roster for the time of the site visit.	The roster was provided during the pre-onsite phase of the audit.
Specialized Staff	Specialized staff was identified on interview document sent to the facility.
Contractors who have contact with the residents	No contractors had contact with residents. Food Service delivered food and left with staff at the entrance of the facility.
Volunteer who has contact with the residents	One was interviewed.
All grievances/allegations made in the 12 months preceding the audit	None. Facility does not have grievance process.

All allegations of sexual abuse and sexual harassment reported for investigation in the 12 months preceding the audit	None noted in past 12 months preceding the audit.
Hotline calls made during the 12 months preceding the audit	None noted in past 12 months preceding the audit.
Detailed list of number of sexual abuse and sexual harassment allegations in the 12 months preceding the audit	The facility reported there were no allegations of sexual abuse or sexual harassment in the 12 months preceding the audit.

The Auditor reviewed the lists/documents provided and conferred with the PREA Coordinator and Facility Director in development of the interview schedule for staff/residents.

Internet research of the facility revealed no indication of litigation, U. S. Department of Justice involvement, or federal consent decrees. General and specific information about the facility and the programs and services provided are detailed on the facility's website. The facility's website also contains PREA information including but not limited to the zero-tolerance and coordinated response policies. The PREA audit report for the initial audit in 2015 is located on the website and it also contains the third-party reporting form.

Onsite Audit Phase

The Auditors, accompanied by the CRRC PREA Coordinator, arrived onsite during the early morning hours in order to interview some staff members on the overnight shift and observe early morning operations. Random staff members working the overnight shift were interviewed immediately upon the Auditors' arrival to the facility to reduce the accrual of overtime hours. Once the interviews were completed, an entrance conference was conducted. In addition to the Auditor and the CRRC PREA Coordinator, the entrance conference included the Facility Director. Formal introductions were made and a review of the audit process, site visit activities and the itinerary were reviewed.

Upon completion of the entrance conference, a comprehensive site review of the facility was conducted and led by the Facility Director and the Compliance Manager/PREA Coordinator. The tour included all areas of the facility. The staff was observed providing direct supervision and interacting with the residents.

During the pre-audit phase, the Auditor was provided a diagram of the physical plant which provided familiarity with the layout of the facility. The program is housed in one building which includes eleven (11) housing units; kitchen, recreation area, basement storage, outside areas; offices; and storage rooms. Resident files were observed to be maintained securely in locked file cabinets in offices which are kept locked when unoccupied. The file cabinets have limited and identified key access. The resident population on the day of the onsite audit was 33.

During the comprehensive site review, the printed notifications of the PREA site visit were observed posted in the areas previously identified in the pictures sent to the Auditor, such as living units, lobby and common areas for residents and staff. The notices contained large enough print to make them accessible and easy to see and read. Posted signs were observed regarding

general PREA information including emergency and non-emergency 800 numbers for assistance.

The posted information includes instructions on accessing the 24/7 hotline for reporting allegations and requesting advocacy services from National Sexual Assault Hotline and Sexual Trauma Services of the Midlands (rape crisis centers). to receive allegations of sexual abuse and sexual harassment and for the provision of advocacy services upon request. The representative from the hotline was interviewed by phone and confirmed the advocacy services to be provided in accordance with the MOU.

Documentation and interviews with Administrative staff confirmed forensic medical examinations will be performed at Palmetto Richland Memorial Hospital (PRMH) also located in Columbia, SC. The hospital's Sexual Assault Policy provides that a Sexual Assault Nurse Examiner (SANE) will conduct the examinations. According to the Hospital's written Policy, when a SANE is not available, the Emergency Department Physician and Emergency Department Nurse will assume care of the patient and follow the protocols outlined in the Policy. PRMH was contacted and a MOU was used to verify compliance.

Questions were answered by staff during informal interviews regarding resident activities and program services as the site review progressed throughout the facility. The site visit also included the outside grounds. During the comprehensive site review, the intake process was described, and the daily scheduled activities and staff supervision were discussed by the Director and the Compliance Manager/PREA Coordinator. There were no new admissions during the site visit. Staff readily explained activities as different facility areas were visited.

Residents were observed in the dayrooms preparing for the daily programming. In addition to direct care staff members providing direct supervision to residents, another staff member was monitoring the camera system in the central control area/staff workstation. Telephones were observed in the lobby area for reporting allegations of sexual abuse and sexual harassment. The telephones were in working order. The reporting process was discussed during the site review. Directions for accessing the crisis hotline are posted and include the limitations of confidentiality.

Female/male staff knocked on room doors and announced to alert the residents that a female/male is entering the unit. All residents interviewed stated the female/male staff members knocked and announced prior to entering the living unit. This practice was experienced and observed during the comprehensive site review.

Visibility is enhanced with the strategic use of cameras. There were four (4) blind spots detected during the onsite visit and a date of September 19, 2018 was set to have them installed. There are no cameras in bathrooms and privacy is provided to residents when they use the toilet, change clothes and shower. The doors to closets and storage rooms are kept locked with a keyed lock not allowing the door to be looked from the inside.

Interviews

Nineteen (19) staff members are currently employed at the facility that may have contact with residents. A total of 33 residents were in the facility during the site visit. Twelve (12) residents

were interviewed after randomly selecting the names from the facility population report. A previous inquiry was made regarding vulnerable categories within the resident population related to the selection of targeted interviews. The random selections were made from the population roster, considering each housing unit and information regarding the make-up of the population. Two (2) targeted resident interviews were conducted due to physical disabilities.

Seven (7) random staff members were interviewed that covered all shifts and twelve (12) individual specialized staff members were interviewed based on their job duties and PREA roles. Also, one volunteer was interviewed by telephone. The Facility Director and the Compliance Manager/PREA Coordinator were interviewed however they are not counted as specialized staff. The specialized interviews conducted totaled twelve (12) due to staff members in this category serving in more than one PREA related specialized role.

The volunteer interviewed conducts mental health services at the facility. A contractor provides food services, but staff receives the food upon entry to the facility and contractors do not come in contact with residents. The interviews with residents, staff and volunteer indicated their receipt of PREA training which was also verified by a review of documentation, including training materials. Staff and resident interviews were conducted, and the interviews conducted onsite were done in privacy.

The Auditors conducted 12 resident interviews in the following categories during the onsite phase of the audit:

Category of Residents	**Number of Interviews**
Random Residents	10
Residents with Physical Disability	2

The Auditors conducted the following number of specialized staff interviews during the onsite phase of the audit:

Category of Staff	**Number of Interviews**
Administrative (Human Resources) Staff	1
Intermediate or Higher-level Facility Staff (unannounced rounds)	1
Volunteers who have Contact with Residents	1
Staff who Perform Screening for Risk of Victimization and Abusiveness	2
Staff on the Incident Review Team	2
Designated Staff Member Charged with Monitoring Retaliation	1
Non-Security Staff First Responders	2
Intake Staff	2
Number of Specialized Staff Interviews	11
Number of Random Staff Interviews	7
Total Random and Specialized Interviews	18

Total Interviews plus PREA Coordinator and Director	20

Onsite Documentation Review
The Auditor received many examples of documentation from resident and staff files as part of the Pre-Onsite Audit Phase. During the Pre-Onsite Audit Phase and the Onsite Audit Phase the auditor reviewed a sample of personnel files of the staff selected to be interviewed, including documentation of criminal background checks occurring. The PREA Pre-Audit Questionnaire and facility policies, procedures and supporting documentation were reviewed prior to the site visit and while onsite for interviewees and persons not interviewed. The secondary documentation reviewed included but was not limited to PREA education and training acknowledgement forms; training records; checklists; sexual abuse coordinated response plan; annual staffing plan assessment; staff schedules; unannounced rounds reports; retaliation monitoring form; organization chart; and other documentation. The facility reports there were no allegations of sexual abuse or sexual harassment in the past twelve (12) months.

After the completion of the site visit process, an exit briefing was held in the conference room. The attendees were the Facility Director; Compliance Manager/PREA Coordinator and Human Resources Manager. The exit briefing served to review the onsite process and review program strengths. The facility and CRRC staff members were given the opportunity to ask additional questions about the activities of the day and the shared information. The timelines for the submission of PREA reports were reviewed.

Post Onsite Audit Phase
The Auditor contacted the Compliance Manager/PREA Coordinator regarding clarity of information. The final report was concluded on the posted date. The Auditor determined the information and documentation received and reviewed and the results of the site visit confirmed all the standards were met.

Facility Characteristics

The Alston Wilkes Society was founded in 1962 as the South Carolina Therapeutic Association by the Reverend Eli Alston Wilkes. The original mission was to provide rehabilitative services to adults released from correctional facilities in South Carolina. Over the years, The Alston Wilkes Society expanded its focus to include emotionally disadvantaged youth, the homeless, offenders, homeless veterans and their families. The agency's mission is "rebuilding lives for a safer community"; the vision statement is "to provide offenders, former offenders, the homeless, at risk youth, Veterans and their families the tools they need to become productive citizens; and the value statement is "our primary responsibility is to those we serve. The success of the Alston Wilkes Society is measured by how we meet our responsibilities to clients, volunteers, investors, other agencies and each other. We operate in the spirit of doing unto others as we would have them do unto us". The AWS has been operating residential programs for offenders through

contacts with the Federal Bureau of Prisons (FBOP) since 1971. Columbia Residential Reentry Program (CRRC) has been operation in this capacity since 1985.

The Alston Wilkes Society Columbia Residential Reentry Center (CRRC) is a two-story brick facility with a basement and rear paved parking lot located near a residential/business area at 1218 Bull Street, Columbia, SC 29201.The building was constructed in 1939 as a form of boarding house. In 1985 Alston Wilkes acquired the property and converted it into a residential reentry center. The main entrance and exit door to the building is controlled by a staff post positioned at the front door. Cameras are positioned within the interior common areas and exterior doors of the building. The facility is well situated in terms of access to public transportation and services. It is a branch of the Alston Wilkes Society, which is a private, not for profit community-based organization.

The facility only houses adults, males/females over 18 years of age from the FBOP. Residents are transferred from the FBOP in accordance with a reentry contract agreement between the two agencies. The residents are assigned to various rooms, with two to four residents to a room, with adjoining restroom and showers in the middle of two rooms. A separate female only room with restroom and shower is located on the main floor near the staff post. Residents with disabilities are housed on the main floor as well. There are three common use areas utilized for meals, programs, recreation and visitation. The facility is an American Disabilities Act (ADA) accessible building and complies with local ordinances. The facility houses 56 residents at capacity and on the day of the audit 33 residents were housed. During the past twelve months, 216 residents were housed at the facility with an average length of stay of 4 months. The facility has a total of 19 staff assigned with at least three (3) staff members, two (2) males, one female on each shift with watch duty 24 hours daily.

Summary of Audit Findings

The Auditor was on site for one day, August 20, 2018. The audit began at 6:30AM to allow for viewing of third shift operations and interviewing of the residents and staff before third shift ended at 8:00AM. The remainder of the day until 6:30PM was spent touring the facility, observing operations/security protocol, viewing files and interviewing residents/staff. A follow-up visit was conducted on September 19, 2018 to verify installation/operation of the requested cameras to eliminate the four (4) blind spots. During the past twelve (12) months, there were no reported PREA allegations. The corrective action of the camera installation was completed. CRRC was found to be in compliance with 41 applicable PREA standards.

Number of Standards Exceeded: 0

Number of Standards Met: 41

Number of Standards Not Met: 0

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Summary of Corrective Action (if any)

PREVENTION PLANNING

Standard 115.211: Zero tolerance of sexual abuse and sexual harassment; PREA coordinator

All Yes/No Questions Must Be Answered by The Auditor to Complete the Report

115.211 (a)

- Does the agency have a written policy mandating zero tolerance toward all forms of sexual abuse and sexual harassment? ☒ Yes ☐ No
- Does the written policy outline the agency's approach to preventing, detecting, and responding to sexual abuse and sexual harassment? ☒ Yes ☐ No

115.211 (b)

- Has the agency employed or designated an agency-wide PREA Coordinator? ☒ Yes ☐ No
- Is the PREA Coordinator position in the upper-level of the agency hierarchy? ☒ Yes ☐ No
- Does the PREA Coordinator have sufficient time and authority to develop, implement, and oversee agency efforts to comply with the PREA standards in all of its facilities? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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

CRRC Policy 3.4 states the facility mandates zero tolerance toward all forms of sexual abuse and sexual harassment and outlines the agency's approach to preventing, detecting and responding to such conduct. The agency has one upper-level, agency-wide PREA Compliance Coordinator with sufficient time and authority to develop, implement and oversee agency efforts to comply with the PREA standards in all of its facilities. The facility being audited has one PREA Compliance Manager with sufficient time and authority to coordinate the facility's efforts to comply with PREA standards. Based on interviews with the PREA Coordinator/ Compliance Manager, they have the knowledge, background, authority and time to perform their duties. PREA Coordinator/Compliance Manager is listed on the agency and facility organizational charts. Based on a review of policy, procedure and practice to include staff, residents and outside agency interview, the agency and facility is in compliance with this PREA standard.

Documentation Reviewed:
PREA Pre-Audit Questionnaire
Facility Policy 3.4, Prison Rape Elimination (PREA) Policy
Organizational Chart
PREA Coordinator's Job Description
2015 Annual Report

Interviews:
PREA Coordinator
Random Staff
Residents

Conclusion:
Based upon the review and analysis of the available documentation, the Auditor has determined the facility is compliant with this standard requiring a zero-tolerance policy toward sexual abuse and sexual harassment and the designation of a PREA Coordinator.

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

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.212 (a)

- If this agency is public and it contracts for the confinement of its residents with private agencies or other entities including other government agencies, has the agency included the entity's obligation to comply with the PREA standards in any new contract or contract renewal signed on or after August 20, 2012? (N/A if the agency does not contract with private agencies or other entities for the confinement of residents.) ☐ Yes ☐ No ☒ NA

115.212 (b)

- Does any new contract or contract renewal signed on or after August 20, 2012 provide for agency contract monitoring to ensure that the contractor is complying with the PREA standards? (N/A if the agency does not contract with private agencies or other entities for the confinement of residents OR the response to 115.212(a)-1 is "NO".) ☐ Yes ☐ No ☒ NA

115.212 (c)

- If the agency has entered into a contract with an entity that fails to comply with the PREA standards, did the agency do so only in emergency circumstances after making all reasonable attempts to find a PREA compliant private agency or other entity to confine residents? (N/A if the agency has not entered into a contract with an entity that fails to comply with the PREA standards.) ☐ Yes ☐ No ☒ NA

- In such a case, does the agency document its unsuccessful attempts to find an entity in compliance with the standards? (N/A if the agency has not entered into a contract with an entity that fails to comply with the PREA standards.) ☐ Yes ☐ No ☒ NA

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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

Documents Reviewed:
PREA Pre-Audit Questionnaire
Facility Policy 3.4

Interviews:
Facility Director

Conclusion:
CRRC only houses federal residents as a result of a contractual agreement with the FBOP for federal resident reentry services. The residents are under the authority of the FBOP and any form of resident transfer or other confinement is coordinated and directed by the FBOP. The CRRC does not contract with other entities for the confinement of residents.

Standard 115.213: Supervision and monitoring

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.213 (a)

- Does the agency develop for each facility a staffing plan that provides for adequate levels of staffing and, where applicable, video monitoring, to protect residents against sexual abuse? ☒ Yes ☐ No

- Does the agency document for each facility a staffing plan that provides for adequate levels of staffing and, where applicable, video monitoring, to protect residents against sexual abuse? ☒ Yes ☐ No

- Does the agency ensure that each facility's staffing plan takes into consideration the physical layout of each facility in calculating adequate staffing levels and determining the need for video monitoring? ☒ Yes ☐ No

- Does the agency ensure that each facility's staffing plan takes into consideration the composition of the resident population in calculating adequate staffing levels and determining the need for video monitoring? ☒ Yes ☐ No

- Does the agency ensure that each facility's staffing plan takes into consideration the prevalence of substantiated and unsubstantiated incidents of sexual abuse in calculating adequate staffing levels and determining the need for video monitoring? ☒ Yes ☐ No

- Does the agency ensure that each facility's staffing plan takes into consideration any other relevant factors in calculating adequate staffing levels and determining the need for video monitoring? ☒ Yes ☐ No

115.213 (b)

- In circumstances where the staffing plan is not complied with, does the facility document and justify all deviations from the plan? (N/A if no deviations from staffing plan.) ☒ Yes ☐ No ☐ NA

115.213 (c)

- In the past 12 months, has the facility assessed, determined, and documented whether adjustments are needed to the staffing plan established pursuant to paragraph (a) of this section? ☒ Yes ☐ No

- In the past 12 months, has the facility assessed, determined, and documented whether adjustments are needed to prevailing staffing patterns? ☒ Yes ☐ No

- In the past 12 months, has the facility assessed, determined, and documented whether adjustments are needed to the facility's deployment of video monitoring systems and other monitoring technologies? ☒ Yes ☐ No

- In the past 12 months, has the facility assessed, determined, and documented whether adjustments are needed to the resources the facility has available to commit to ensure adequate staffing levels? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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

CRRC Policy H1303 governs this section. The facility has a capacity of 56 residents. Auditor identified four (4) blind spots and cameras were recommended to be installed to correct these deficiencies. Cameras were installed and verified by this Auditor. Blind spots were taken care of and facility has complete visual of these areas for security purposes. The staffing plan consists of assigning two male and one female staff to each shift especially during evening hours. Case Managers augment this scheduling by working alternate schedules to ensure coverage. Current facility policy is to check living areas at least hourly at night. To ensure checks, male staff check male areas and female staff check female areas. The agency and facility staffing plan takes the following into consideration:

1. The physical layout of each facility.
2. The composition of the resident population.
3. The prevalence of substantiated ad unsubstantiated incidents of sexual abuse.
4. Any other relevant facts.

In circumstance where the staffing plan is not complied with, the facility documents and justify all deviations from the plan. Whenever necessary, but no less frequently than once each year, the facility access, determine ad document whether adjustments are needed to:

1. The staffing plan established pursuant to the standard.
2. Prevailing staff patterns.
3. The facility's deployment of video monitoring and other monitoring technologies.

4. The resources the facility has available to commit to ensure adequate staffing levels.

The agency and facility are in compliance with this PREA standard.

Documents Reviewed:
Facility Policy H1303 Supervision and Monitoring
Staffing Plan
Staffing Plan Assessment
Monthly Schedule
Resident Daily Rosters
PREA Pre-Audit Questionnaire

Interviews:
Facility Director
Compliance Manager/PREA Coordinator

Conclusion:
Based upon the review and analysis of the available evidence, the Auditor has determined the facility is in compliance with this standard regarding supervision and monitoring.

Standard 115.215: Limits to cross-gender viewing and searches

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.215 (a)

- Does the facility always refrain from conducting any cross-gender strip or cross-gender visual body cavity searches, except in exigent circumstances or by medical practitioners?
  ☒ Yes ☐ No

115.215 (b)

- Does the facility always refrain from conducting cross-gender pat-down searches of female residents, except in exigent circumstances? (N/A if less than 50 residents) ☒ Yes ☐ No ☐ NA

- Does the facility always refrain from restricting female residents' access to regularly available programming or other outside opportunities in order to comply with this provision? (N/A if less than 50 residents) ☒ Yes ☐ No ☐ NA

115.215 (c)

- Does the facility document all cross-gender strip searches and cross-gender visual body cavity searches? ☒ Yes ☐ No

- Does the facility document all cross-gender pat-down searches of female residents? ☒ Yes ☐ No

115.215 (d)

- Does the facility implement policies and procedures that enable residents to shower, perform bodily functions, and change clothing without nonmedical staff of the opposite gender viewing their breasts, buttocks, or genitalia, except in exigent circumstances or when such viewing is incidental to routine cell checks? ☒ Yes ☐ No

- Does the facility require staff of the opposite gender to announce their presence when entering an area where residents are likely to be showering, performing bodily functions, or changing clothing? ☒ Yes ☐ No

115.215 (e)

- Does the facility always refrain from searching or physically examining transgender or intersex residents for the sole purpose of determining the resident's genital status? ☒ Yes ☐ No

- If a resident's genital status is unknown, does the facility determine genital status during conversations with the resident, by reviewing medical records, or, if necessary, by learning that information as part of a broader medical examination conducted in private by a medical practitioner? ☒ Yes ☐ No

115.215 (f)

- Does the facility/agency train security staff in how to conduct cross-gender pat down searches in a professional and respectful manner, and in the least intrusive manner possible, consistent with security needs? ☒ Yes ☐ No

- Does the facility/agency train security staff in how to conduct searches of transgender and intersex residents in a professional and respectful manner, and in the least intrusive manner possible, consistent with security needs? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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

CRRC Policy H1402 states the facility has a rated capacity of 56 residents and does not conduct cross gender strip searches or cross gender visual cavity searches. Staff interviewed were familiar with the policy and stated they did not perform cross gender searches. This was also verified by residents of the facility. Staff shall not search or physically examine a transgender or intersex resident for the sole purpose of determining resident genital status. Showers are taken by residents one at a time and doors are on showers entrance. Staff of the opposite gender announce their presence when entering living areas. This was witnessed by Auditor during tour and verified with staff and resident interviews. Staff training records/interviews verify staff receiving training on cross gender pat searches and searches on transgender and intersex residents.

Documents Reviewed:
Facility Policy H1402
PREA Pre-Audit Questionnaire
Training Records
Training Sign-in Sheet
Resident Handbook
Posted signs

Interviews:
Random staff
Residents

Conclusion:
Based upon the review and analysis of the available evidence, the Auditor has determined the facility is in compliance with this standard.

Standard 115.216: Residents with disabilities and residents who are limited English proficient

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.216 (a)

- Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Residents who are deaf or hard of hearing? ☒ Yes ☐ No

- Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Residents who are blind or have low vision? ☒ Yes ☐ No

- Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Residents who have intellectual disabilities? ☒ Yes ☐ No

- Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Residents who have psychiatric disabilities? ☒ Yes ☐ No

- Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Residents who have speech disabilities? ☒ Yes ☐ No

- Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Other? (if "other," please explain in overall determination notes.) ☒ Yes ☐ No

- Do such steps include, when necessary, ensuring effective communication with residents who are deaf or hard of hearing? ☒ Yes ☐ No

- Do such steps include, when necessary, providing access to interpreters who can interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary? ☒ Yes ☐ No

- Does the agency ensure that written materials are provided in formats or through methods that ensure effective communication with residents with disabilities including residents who: Have intellectual disabilities? ☒ Yes ☐ No

- Does the agency ensure that written materials are provided in formats or through methods that ensure effective communication with residents with disabilities including residents who: Have limited reading skills? ☒ Yes ☐ No

- Does the agency ensure that written materials are provided in formats or through methods that ensure effective communication with residents with disabilities including residents who: Are blind or have low vision? ☒ Yes ☐ No

115.216 (b)

- Does the agency take reasonable steps to ensure meaningful access to all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment to residents who are limited English proficient? ☒ Yes ☐ No

- Do these steps include providing interpreters who can interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary? ☒ Yes ☐ No

115.216 (c)

- Does the agency always refrain from relying on resident interpreters, resident readers, or other types of resident assistants except in limited circumstances where an extended delay in obtaining an effective interpreter could compromise the resident's safety, the performance of first-response duties under §115.264, or the investigation of the resident's allegations? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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

CRRC Policy H1301 states the facility has a verified contract with an outside organization called, Palmetto Interpreters to service any and all residents who are limited English proficient. Facility Director, Staff and resident interviews verify the standard is practiced at the facility. There were two (2) residents with physical disabilities housed at the facility during this audit and they stated they had no problem accessing all areas of the facility. The facility states that residents are housed in accessible areas for residents with disabilities. The facility is American Disabilities Act (ADA) accessible. The agency does not rely on resident interpreters, resident readers, or other types of resident assistants except in limited circumstances where an extended delay in obtaining an effective interpreter could compromise the resident's safety. The facility has not used any resident interpreters in the past twelve (12) months.

Documents Reviewed:
Facility Policy H1301

Memorandum of Understanding (MOU), Palmetto Interpreters
Admission Referral Form
Resident Handbook in English

Interviews:
Targeted Residents (2)
Random Staff
Compliance Manager/PREA Coordinator

Conclusion:
Based upon the review and analysis of the available evidence, the Auditor has determined the facility is in compliance with this standard regarding residents with disabilities and residents who are limited English Proficient. Residents with disabilities and who are limited English Proficient are provided equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment.

Standard 115.217: Hiring and promotion decisions

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.217 (a)

- Does the agency prohibit the hiring or promotion of anyone who may have contact with residents who: Has engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility, or other institution (as defined in 42 U.S.C. 1997)? ☒ Yes ☐ No

- Does the agency prohibit the hiring or promotion of anyone who may have contact with residents who: Has been convicted of engaging or attempting to engage in sexual activity in the community facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse? ☒ Yes ☐ No

- Does the agency prohibit the hiring or promotion of anyone who may have contact with residents who: Has been civilly or administratively adjudicated to have engaged in the activity described in the question immediately above? ☒ Yes ☐ No

- Does the agency prohibit the enlistment of services of any contractor who may have contact with residents who: Has engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility, or other institution (as defined in 42 U.S.C. 1997)? ☒ Yes ☐ No

- Does the agency prohibit the enlistment of services of any contractor who may have contact with residents who: Has been convicted of engaging or attempting to engage in sexual activity in the community facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse? ☒ Yes ☐ No

- Does the agency prohibit the enlistment of services of any contractor who may have contact with residents who: Has been civilly or administratively adjudicated to have engaged in the activity described in the question immediately above? ☒ Yes ☐ No

115.217 (b)

- Does the agency consider any incidents of sexual harassment in determining whether to hire or promote anyone, or to enlist the services of any contractor, who may have contact with residents? ☒ Yes ☐ No

115.217 (c)

- Before hiring new employees, who may have contact with residents, does the agency: Perform a criminal background records check? ☒ Yes ☐ No

- Before hiring new employees, who may have contact with residents, does the agency: Consistent with Federal, State, and local law, make its best efforts to contact all prior institutional employers for information on substantiated allegations of sexual abuse or any resignation during a pending investigation of an allegation of sexual abuse? ☒ Yes ☐ No

115.217 (d)

- Does the agency perform a criminal background records check before enlisting the services of any contractor who may have contact with residents? ☒ Yes ☐ No

115.217 (e)

- Does the agency either conduct criminal background records checks at least every five years of current employees and contractors who may have contact with residents or have in place a system for otherwise capturing such information for current employees? ☒ Yes ☐ No

115.217 (f)

- Does the agency ask all applicants and employees who may have contact with residents directly about previous misconduct described in paragraph (a) of this section in written applications or interviews for hiring or promotions? ☒ Yes ☐ No

- Does the agency ask all applicants and employees who may have contact with residents directly about previous misconduct described in paragraph (a) of this section in any interviews or written self-evaluations conducted as part of reviews of current employees? ☒ Yes ☐ No

- Does the agency impose upon employees a continuing affirmative duty to disclose any such misconduct? ☒ Yes ☐ No

115.217 (g)

- Does the agency consider material omissions regarding such misconduct, or the provision of materially false information, grounds for termination? ☒ Yes ☐ No

115.217 (h)

- Unless prohibited by law, does the agency provide information on substantiated allegations of sexual abuse or sexual harassment involving a former employee upon receiving a request from an institutional employer for whom such employee has applied to work? (N/A if providing information on substantiated allegations of sexual abuse or sexual harassment involving a former employee is prohibited by law.) ☒ Yes ☐ No ☐ NA

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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

CRRC Policy 4.3 procedures and practice along with staff and Director of Human Resources interviews, confirm the agency does not hire or promote anyone who may have contact with residents and does not enlist the services of any contractor who may have contact with residents, who have engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility or other institution, or who has been convicted of engaging or attempting to engage in sexual activity in the community facilitated by force, overt or implied threats of force, or coercion or if the victim did not consent or was unable to consent or refuse; or has been civilly or administratively adjudicated to have engaged in the activity described. Material omissions regarding such misconduct, or the provision of materially false information may be grounds for termination.

The agency considers any incidents of sexual harassment in determining whether to hire or promote anyone, or to enlist the services of any contractor, who may have contact with residents. The agency performs a criminal background records check in coordination with the FBOP before enlisting the services of any contractor who may have contact with residents. A process is in place for criminal background checks at least every five years for current staff and contractors who may have contact with residents.

Documents Reviewed:
Facility Policy 4.3
Personnel Files

Interviews:

Administrative (Human Resources) Director
Random Staff

Conclusion:
Based upon the review and analysis of the available evidence, the Auditor has determined the facility is in compliance with this standard.

Standard 115.218: Upgrades to facilities and technologies

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.218 (a)

- If the agency designed or acquired any new facility or planned any substantial expansion or modification of existing facilities, did the agency consider the effect of the design, acquisition, expansion, or modification upon the agency's ability to protect residents from sexual abuse? (N/A if agency/facility has not acquired a new facility or made a substantial expansion to existing facilities since August 20, 2012, or since the last PREA audit, whichever is later.)
  ☐ Yes ☐ No ☒ NA

115.218 (b)

- If the agency installed or updated a video monitoring system, electronic surveillance system, or other monitoring technology, did the agency consider how such technology may enhance the agency's ability to protect residents from sexual abuse? (N/A if agency/facility has not installed or updated a video monitoring system, electronic surveillance system, or other monitoring technology since August 20, 2012, or since the last PREA audit, whichever is later.)
  ☒ Yes ☐ No ☐ NA

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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

CRRC Policy H701 governs this section. Auditor recommended the installation of four (4) cameras to alleviate blind spots. The Facility Director placed a work order for camera installations immediately. Cameras were installed and alleviated the blind spots. The agency considers technology an asset to enhance the agency's ability to protect residents against sexual abuse and sexual harassment.

Documents Reviewed:
Verification that cameras were installed September 8, 2018

Interviews:
Facility Director
Compliance Manager/PREA Coordinator

Conclusion:
Based upon the review and analysis of the available evidence, the Auditor has determined the facility is in compliance with this standard.

RESPONSIVE PLANNING

Standard 115.221: Evidence protocol and forensic medical examinations

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.221 (a)

- If the agency is responsible for investigating allegations of sexual abuse, does the agency follow a uniform evidence protocol that maximizes the potential for obtaining usable physical evidence for administrative proceedings and criminal prosecutions? (N/A if the agency/facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations.) ☐ Yes ☐ No ☒ NA

115.221 (b)

- Is this protocol developmentally appropriate for youth where applicable? (N/A if the agency/facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations.) ☐ Yes ☐ No ☒ NA

- Is this protocol, as appropriate, adapted from or otherwise based on the most recent edition of the U.S. Department of Justice's Office on Violence Against Women publication, "A National Protocol for Sexual Assault Medical Forensic Examinations, Adults/Adolescents," or similarly comprehensive and authoritative protocols developed after 2011? (N/A if the agency/facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations.) ☐ Yes ☐ No ☒ NA

115.221 (c)

- Does the agency offer all residents who experience sexual abuse access to forensic medical examinations, whether on-site or at an outside facility, without financial cost, where evidentiarily or medically appropriate? ☒ Yes ☐ No

- Are such examinations performed by Sexual Assault Forensic Examiners (SAFEs) or Sexual Assault Nurse Examiners (SANEs) where possible? ☒ Yes ☐ No

- If SAFEs or SANEs cannot be made available, is the examination performed by other qualified medical practitioners (they must have been specifically trained to conduct sexual assault forensic exams)? ☒ Yes ☐ No

- Has the agency documented its efforts to provide SAFEs or SANEs? ☒ Yes ☐ No

115.221 (d)

- Does the agency attempt to make available to the victim a victim advocate from a rape crisis center? ☒ Yes ☐ No

- If a rape crisis center is not available to provide victim advocate services, does the agency make available to provide these services a qualified staff member from a community-based organization, or a qualified agency staff member? ☒ Yes ☐ No

- Has the agency documented its efforts to secure services from rape crisis centers? ☒ Yes ☐ No

115.221 (e)

- As requested by the victim, does the victim advocate, qualified agency staff member, or qualified community-based organization staff member accompany and support the victim through the forensic medical examination process and investigatory interviews? ☒ Yes ☐ No

- As requested by the victim, does this person provide emotional support, crisis intervention, information, and referrals? ☒ Yes ☐ No

115.221 (f)

- If the agency itself is not responsible for investigating allegations of sexual abuse, has the agency requested that the investigating entity follow the requirements of paragraphs (a) through (e) of this section? (N/A if the agency/facility is responsible for conducting criminal AND administrative sexual abuse investigations.) ☒ Yes ☐ No ☐ NA

115.221 (g)

- Auditor is not required to audit this provision.

115.221 (h)

- If the agency uses a qualified agency staff member or a qualified community-based staff member for the purposes of this section, has the individual been screened for appropriateness to serve in this role and received education concerning sexual assault and forensic examination issues in general? (Check N/A if agency attempts to make a victim advocate from a rape crisis center available to victims per 115.221(d) above.) ☐ Yes ☐ No ☒ NA

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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

CRRC Policy H809 states, procedures and practice along with staff interviews, to the extent the agency is responsible for investigating allegations of sexual abuse, the agency follows a uniform evidence protocol that maximizes the potential for obtaining usable physical evidence for administrative proceedings and criminal prosecutions. The agency does not conduct criminal investigations. The agency only performs administrative investigations involving any staff on resident sexual misconduct. Any investigations will require consultation with the FBOP per agreed upon contract. The FBOP has ultimate authority over all of the federal residents at the facility. The facility only houses federal residents at the Columbia facility from the FBOP.

The agency offers all victims of sexual abuse access to forensic medical examinations at an outside facility, without financial cost, where evidentiary or medical appropriate in accordance with the standard. Such examinations shall be performed by Sexual Assault Forensic Examiners or Sexual Assault Nurse Examiners where possible. Palmetto Richland Memorial Hospital (PRMH) Columbia, South Carolina, Palmetto Baptist Hospital (PBH) signed a memorandum of agreement with the agency concerning emergency medical services including forensic examinations. The agency also has a Memorandum of Agreement (MOA) with the National Sexual Assault Hotline and Sexual Trauma Services of the Midlands (rape crisis centers) available to the victim. The facility makes available staff to accompany the resident throughout the forensic medical examination process and investigatory interviews and shall provide emotional support, crisis intervention, information and referrals. There have been no reports of sexual abuse within the past twelve (12) months.

Documents Reviewed:

Facility Policy 809
Memorandum of Understanding (MOU), Palmetto Richland Memorial Hospital (PRMH)
Memorandum of Understanding (MOU), Columbia Police Department
Memorandum of Understanding (MOU), Richland County Sheriff Department
Resident Handbook

Interviews:
Telephone interview with Federal Bureau of Prisons (FBOP) Administrator responsible for the facility
Telephone interview with PRMH
Facility Director
Compliance Manager/PREA Coordinator
Telephone interview with National Assault Hotline
Telephone interview with Sexual Trauma Services of the Midlands

Conclusion:
Based upon the review and analysis of the available evidence, the Auditor has determined the facility is in compliance with this standard.

Standard 115.222: Policies to ensure referrals of allegations for investigations

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.222 (a)

- Does the agency ensure an administrative or criminal investigation is completed for all allegations of sexual abuse? ☒ Yes ☐ No

- Does the agency ensure an administrative or criminal investigation is completed for all allegations of sexual harassment? ☒ Yes ☐ No

115.222 (b)

- Does the agency have a policy and practice in place to ensure that allegations of sexual abuse or sexual harassment are referred for investigation to an agency with the legal authority to conduct criminal investigations, unless the allegation does not involve potentially criminal behavior? ☒ Yes ☐ No

- Has the agency published such policy on its website or, if it does not have one, made the policy available through other means? ☒ Yes ☐ No

- Does the agency document all such referrals? ☒ Yes ☐ No

115.222 (c)

- If a separate entity is responsible for conducting criminal investigations, does such publication describe the responsibilities of both the agency and the investigating entity? [N/A if the agency/facility is responsible for conducting criminal investigations. See 115.221(a).]
  ☒ Yes ☐ No ☐ NA

115.222 (d)

- Auditor is not required to audit this provision.

115.222 (e)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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

There have been no reports of sexual abuse/sexual harassment within the past CRRC Policy 3.4 states the facility ensures an administrative or criminal investigation is completed for all allegations of sexual abuse and sexual harassment. The agency has a policy that ensures allegations of sexual abuse and sexual harassment are referred for investigation to an agency with the legal authority to conduct criminal investigations unless the allegation does not involve potentially criminal behavior. The agency shall publish such policy on its website, or if it does not have one, make the policy available through other means. The agency documents such referrals. Auditor verified there were no reported allegations on the agency website the past twelve (12) months.

Documents Reviewed:
Facility Policy 3.4
MOU, Columbia Police Department
PREA Pre-Audit Questionnaire
MOU, Richland County Sheriff Department

Interviews:

Random staff
Investigative Staff, BOP
Facility Director
Compliance Manager/PREA Coordinator

Conclusion:
Based upon the review and analysis of the available evidence, the Auditor has determined the facility is compliant with this standard regarding policies to ensure referrals of allegations for investigations.

TRAINING AND EDUCATION

Standard 115.231: Employee training

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.231 (a)

- Does the agency train all employees who may have contact with residents on: Its zero-tolerance policy for sexual abuse and sexual harassment? ☒ Yes ☐ No
- Does the agency train all employees who may have contact with residents on: How to fulfill their responsibilities under agency sexual abuse and sexual harassment prevention, detection, reporting, and response policies and procedures? ☒ Yes ☐ No
- Does the agency train all employees who may have contact with residents on: Residents' right to be free from sexual abuse and sexual harassment ☒ Yes ☐ No
- Does the agency train all employees who may have contact with residents on: The right of residents and employees to be free from retaliation for reporting sexual abuse and sexual harassment? ☒ Yes ☐ No
- Does the agency train all employees who may have contact with residents on: The dynamics of sexual abuse and sexual harassment in confinement? ☒ Yes ☐ No
- Does the agency train all employees who may have contact with residents on: The common reactions of sexual abuse and sexual harassment victims? ☒ Yes ☐ No
- Does the agency train all employees who may have contact with residents on: How to detect and respond to signs of threatened and actual sexual abuse? ☒ Yes ☐ No
- Does the agency train all employees who may have contact with residents on: How to avoid inappropriate relationships with residents? ☒ Yes ☐ No

- Does the agency train all employees who may have contact with residents on: How to communicate effectively and professionally with residents, including lesbian, gay, bisexual, transgender, intersex, or gender nonconforming residents? ☒ Yes ☐ No

- Does the agency train all employees who may have contact with residents on: How to comply with relevant laws related to mandatory reporting of sexual abuse to outside authorities? ☒ Yes ☐ No

115.231 (b)

- Is such training tailored to the gender of the residents at the employee's facility? ☒ Yes ☐ No

- Have employees received additional training if reassigned from a facility that houses only male residents to a facility that houses only female residents, or vice versa? ☒ Yes ☐ No

115.231 (c)

- Have all current employees who may have contact with residents received such training? ☒ Yes ☐ No

- Does the agency provide each employee with refresher training every two years to ensure that all employees know the agency's current sexual abuse and sexual harassment policies and procedures? ☒ Yes ☐ No

- In years in which an employee does not receive refresher training, does the agency provide refresher information on current sexual abuse and sexual harassment policies? ☒ Yes ☐ No

115.231 (d)

- Does the agency document, through employee signature or electronic verification, that employees understand the training they have received? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does

not meet the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The agency trains all employees who have contact with residents on:

1) Its zero-tolerance policy for sexual abuse and sexual harassment;
2) How to fulfill their responsibilities under agency sexual abuse and sexual harassment; prevention, detection, reporting and response policies and procedures;
3) Resident's right to be free from sexual abuse and sexual harassment;
4) The right of residents and employees to be free from retaliation for reporting sexual abuse and sexual harassment;
5) The dynamics of sexual abuse and sexual harassment in confinement;
6) The common reactions of sexual abuse and sexual harassment victims;
7) How to detect and respond to signs of threatened and actual sexual abuse;
8) How to avoid inappropriate relationships with residents;
9) How to communicate effectively and professionally with residents, including lesbian, gay bisexual, transgender, intersex or gender nonconforming residents; and
10) How to comply with relevant laws related to mandatory reporting of sexual abuse to outside authorities.

CRRC Policy 3.4 states facility staff should receive training on PREA. Training curriculum, staff training records and staff interviews revealed staff received PREA training during initial training and annually during refresher training. All staff received training to maintain consistency. PREA training is geared to cover male and female inmates. Staff, contractors and volunteers receive the same PREA training module. A review of staff training rosters and staff interviews revealed rosters are signed verifying comprehension of PREA training.

Documents Reviewed:
Facility Policy 3.4
Training Attendance Record (Sign-in Sheets
Training Acknowledgement Statements

Interviews:
Random Staff
Compliance Manager/PREA Coordinator

Conclusion:
Based upon the review and analysis of the available evidence, the Auditor has determined the facility is in compliance with this standard.

Standard 115.232: Volunteer and contractor training

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.232 (a)

- Has the agency ensured that all volunteers and contractors who have contact with residents have been trained on their responsibilities under the agency's sexual abuse and sexual harassment prevention, detection, and response policies and procedures? ☒ Yes ☐ No

115.232 (b)

- Have all volunteers and contractors who have contact with residents been notified of the agency's zero-tolerance policy regarding sexual abuse and sexual harassment and informed how to report such incidents (the level and type of training provided to volunteers and contractors shall be based on the services they provide and level of contact they have with residents)? ☒ Yes ☐ No

115.232 (c)

- Does the agency maintain documentation confirming that volunteers and contractors understand the training they have received? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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

CRRC Policy 4.27 requires volunteers and contractors who have contact with inmates to receive PREA training. Training is provided by facility staff trainers. Signed training rosters and interviews with volunteers revealed they are knowledgeable concerning their responsibilities relative to PREA and the agency's zero tolerance policy regarding sexual abuse and sexual harassment. Volunteers and contractors sign documentation acknowledging that they understand the training received. They receive the same training as staff and are sometimes in the same training class. The agency created a volunteer handbook and a PREA related educational training brochure that are user friendly.

Documents Reviewed:
Facility Policy 4.27

Volunteer Training Records

Interviews:
Volunteer

Conclusion:
Based upon the review and analysis of the available evidence, the Auditor has determined the facility is in compliance with this standard.

Standard 115.233: Resident education

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.233 (a)

- During intake, do residents receive information explaining: The agency's zero-tolerance policy regarding sexual abuse and sexual harassment? ☒ Yes ☐ No
- During intake, do residents receive information explaining: How to report incidents or suspicions of sexual abuse or sexual harassment? ☒ Yes ☐ No
- During intake, do residents receive information explaining: Their rights to be free from sexual abuse and sexual harassment? ☒ Yes ☐ No
- During intake, do residents receive information explaining: Their rights to be free from retaliation for reporting such incidents? ☐ Yes ☐ No
- During intake, do residents receive information regarding agency policies and procedures for responding to such incidents? ☒ Yes ☐ No

115.233 (b)

- Does the agency provide refresher information whenever a resident is transferred to a different facility? ☒ Yes ☐ No

115.233 (c)

- Does the agency provide resident education in formats accessible to all residents, including those who: Are limited English proficient? ☒ Yes ☐ No
- Does the agency provide resident education in formats accessible to all residents, including those who: Are deaf? ☒ Yes ☐ No
- Does the agency provide resident education in formats accessible to all residents, including those who: Are visually impaired? ☒ Yes ☐ No

- Does the agency provide resident education in formats accessible to all residents, including those who: Are otherwise disabled? ☒ Yes ☐ No

- Does the agency provide resident education in formats accessible to all residents, including those who: Have limited reading skills? ☒ Yes ☐ No

115.233 (d)

- Does the agency maintain documentation of resident participation in these education sessions? ☒ Yes ☐ No

115.233 (e)

- In addition to providing such education, does the agency ensure that key information is continuously and readily available or visible to residents through posters, resident handbooks, or other written formats? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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

CRRC Policy H1202 states residents receive one-on-one individualized orientation during the intake process within 24 to 48 hours of arrival. Auditor interviewed the Case Manager who conducts the intake process. Residents receive PREA information during orientation process. PREA education is provided in person. Resident signatures acknowledging orientation were reviewed by the Auditor. Also, resident interviews verified this practice at the facility. The individualized approach is accessible to residents who are limited English proficient, deaf, visually impaired, otherwise disabled as well as residents who have limited reading skills. Additionally, residents interviewed stated they received PREA information while assigned to the FBOP as well.

Documents Reviewed:
Facility Policy H1202

PREA Education and Training Log
Acknowledgement Statements
Resident Handbook
Posters Observed

Interviews:
Random Residents
Intake Staff

Conclusion:
Based upon the review and analysis of the available evidence, the Auditor has determined the facility is in compliance with this standard

Standard 115.234: Specialized training: Investigations

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.234 (a)

- In addition to the general training provided to all employees pursuant to §115.231, does the agency ensure that, to the extent the agency itself conducts sexual abuse investigations, its investigators have received training in conducting such investigations in confinement settings? [N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.221(a).] ☐ Yes ☐ No ☒ NA

115.234 (b)

- Does this specialized training include: Techniques for interviewing sexual abuse victims? [N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.221(a).] ☐ Yes ☐ No ☒ NA

- Does this specialized training include: Proper use of Miranda and Garrity warnings? [N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.221(a).] ☐ Yes ☐ No ☒ NA

- Does this specialized training include: Sexual abuse evidence collection in confinement settings? [N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.221(a).] ☐ Yes ☐ No ☒ NA

- Does this specialized training include: The criteria and evidence required to substantiate a case for administrative action or prosecution referral? [N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.221(a).] ☐ Yes ☐ No ☒ NA

115.234 (c)

- Does the agency maintain documentation that agency investigators have completed the required specialized training in conducting sexual abuse investigations? [N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.221(a).] ☐ Yes ☐ No ☒ NA

115.234 (d)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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

CRRC Policy 4.13states the agency does not conduct criminal investigations or administrative investigation involving residents. The agency does conduct administrative investigations concerning agency staff sexual misconduct.

Specialized training shall include techniques for interviewing sexual abuse victims, proper use of Miranda and Garrity warnings, sexual abuse evidence collection in confinement settings, and the criteria and evidence required to substantiate a case for administrative action or prosecution referral. The Federal Bureau of Prisons has investigators and referral investigators that have the specialized training in accordance with the PREA standard and the agency coordinates all investigations with them. There have been no reports of sexual abuse/sexual harassment within the past twelve (12) months.

The agency and facility are in compliance with the PREA standard.

Documentation Reviewed:
Facility Policy 4.13
MOU, Columbia Police Department
Telephone interview with BOP

Interviews:
Facility Director

Compliance Manager/PREA Coordinator

Conclusion:
Based upon the review and analysis of the available evidence, the Auditor has determined the facility is in compliance with this standard.

Standard 115.235: Specialized training: Medical and mental health care

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.235 (a)

- Does the agency ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in: How to detect and assess signs of sexual abuse and sexual harassment? ☐ Yes ☒ No

- Does the agency ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in: How to preserve physical evidence of sexual abuse? ☐ Yes ☒ No

- Does the agency ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in: How to respond effectively and professionally to victims of sexual abuse and sexual harassment? ☐ Yes ☒ No

- Does the agency ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in: How and to whom to report allegations or suspicions of sexual abuse and sexual harassment? ☐ Yes ☒ No

115.235 (b)

- If medical staff employed by the agency conduct forensic examinations, do such medical staff receive appropriate training to conduct such examinations? N/A if agency medical staff at the facility do not conduct forensic exams.) ☐ Yes ☐ No ☒ NA

115.235 (c)

- Does the agency maintain documentation that medical and mental health practitioners have received the training referenced in this standard either from the agency or elsewhere? ☐ Yes ☒ No

115.235 (d)

- Do medical and mental health care practitioners employed by the agency also receive training mandated for employees by §115.231? ☐ Yes ☒ No

- Do medical and mental health care practitioners contracted by and volunteering for the agency also receive training mandated for contractors and volunteers by §115.232? [N/A for

circumstances in which a particular status (employee or contractor/volunteer) does not apply.]
☐ Yes ☐ No ☒ NA

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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

The agency does not employ any medical or mental health staff. The agency coordinates with PRMH for emergency medical care as well as forensic examination services. The FBOP has a separate contractual agreement for mental health care in Columbia, South Carolina, that is available to all of the facility's residents.

CRRC Policy H809 states the agency does not employ any medical or mental health staff. The agency has a written agreement with National Sexual Assault Hotline and Sexual Trauma Services of the Midlands and Palmetto Richland Memorial Hospital (PRMH) Columbia, SC for emergency medical care as well as forensic examination services. Auditor has viewed and verified MOU'S are in affect. There have been no reports of sexual abuse within the past twelve (12) months.

Documentation Reviewed:
Facility Policy H809
MOU, PRMH

Interviews:
Facility Director
Compliance Manager/PREA Coordinator
Telephone interview with National Sexual Assault Hotline
Telephone interview with Sexual Trauma Services of the Midlands

Conclusion:

Based upon the review and analysis of the available evidence, the Auditor has determined the facility is in compliance with this standard.

SCREENING FOR RISK OF SEXUAL VICTIMIZATION AND ABUSIVENESS

Standard 115.241: Screening for risk of victimization and abusiveness

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.241 (a)

- Are all residents assessed during an intake screening for their risk of being sexually abused by other residents or sexually abusive toward other residents? ☒ Yes ☐ No

- Are all residents assessed upon transfer to another facility for their risk of being sexually abused by other residents or sexually abusive toward other residents? ☒ Yes ☐ No

115.241 (b)

- Do intake screenings ordinarily take place within 72 hours of arrival at the facility? ☒ Yes ☐ No

115.241 (c)

- Are all PREA screening assessments conducted using an objective screening instrument? ☒ Yes ☐ No

115.241 (d)

- Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: Whether the resident has a mental, physical, or developmental disability? ☒ Yes ☐ No

- Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: The age of the resident? ☒ Yes ☐ No

- Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: The physical build of the resident? ☒ Yes ☐ No

- Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: Whether the resident has previously been incarcerated? ☒ Yes ☐ No

- Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: Whether the resident's criminal history is exclusively nonviolent? ☒ Yes ☐ No

- Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: Whether the resident has prior convictions for sex offenses against an adult or child? ☐ Yes ☐ No

- Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: Whether the resident is or is perceived to be gay, lesbian, bisexual, transgender, intersex, or gender nonconforming (the facility affirmatively asks the resident about his/her sexual orientation and gender identity AND makes a subjective determination based on the screener's perception whether the resident is gender non-conforming or otherwise may be perceived to be LGBTI)? ☒ Yes ☐ No

- Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: Whether the resident has previously experienced sexual victimization? ☒ Yes ☐ No

- Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: The resident's own perception of vulnerability? ☒ Yes ☐ No

115.241 (e)

- In assessing residents for risk of being sexually abusive, does the initial PREA risk screening consider, when known to the agency: prior acts of sexual abuse? ☒ Yes ☐ No

- In assessing residents for risk of being sexually abusive, does the initial PREA risk screening consider, when known to the agency: prior convictions for violent offenses? ☒ Yes ☐ No

- In assessing residents for risk of being sexually abusive, does the initial PREA risk screening consider, when known to the agency: history of prior institutional violence or sexual abuse? ☒ Yes ☐ No

115.241 (f)

- Within a set time period not more than 30 days from the resident's arrival at the facility, does the facility reassess the resident's risk of victimization or abusiveness based upon any additional, relevant information received by the facility since the intake screening? ☒ Yes ☐ No

115.241 (g)

- Does the facility reassess a resident's risk level when warranted due to a: Referral? ☒ Yes ☐ No

- Does the facility reassess a resident's risk level when warranted due to a: Request? ☒ Yes ☐ No

- Does the facility reassess a resident's risk level when warranted due to a: Incident of sexual abuse? ☒ Yes ☐ No

- Does the facility reassess a resident's risk level when warranted due to a: Receipt of additional information that bears on the resident's risk of sexual victimization or abusiveness? ☒ Yes ☐ No

115.241 (h)

- Is it the case that residents are not ever disciplined for refusing to answer, or for not disclosing complete information in response to, questions asked pursuant to paragraphs (d)(1), (d)(7), (d)(8), or (d)(9) of this section? ☒ Yes ☐ No

115.241 (i)

- Has the agency implemented appropriate controls on the dissemination within the facility of responses to questions asked pursuant to this standard in order to ensure that sensitive information is not exploited to the resident's detriment by staff or other residents? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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

CRRC Policy H1202 states and based on interviews with the facility's intake staff and random residents, all residents are assessed during the intake screening and upon transfer to the facility for their risks of being sexually abused by other residents or sexually abusive toward other residents. Intake screening shall ordinarily take place within 72 hours of arrival and more often is completed within 24 to 48 hours of arrival due to the small size of the facility. Such assessments shall be conducted using an objective screening instrument. There were no residents received during this audit, but copies of prior assessments were viewed to see how staff used data of victimization and abusiveness during intake.

The intake screening shall consider, at minimum, the following criteria to assess residents for risk of sexual victimization:

1. Whether the resident has a mental, physical or developmental disability;
2. The age of the resident;
3. The physical build of the resident;
4. Whether the resident has previously been incarcerated;
5. Whether the resident's criminal history is exclusively nonviolent;
6. Whether the resident has prior convictions for sex offenses against an adult or child;
7. Whether the resident is or is perceived to be gay, lesbian, bisexual, transgender, intersex or gender nonconforming;
8. Whether the resident has previously experienced sexual victimization; and
9. The residents own perception of vulnerability.

The initial screening considers prior acts of sexual abuse, prior convictions for violent offenses, and history of prior institutional violence or sexual abuse, as known to the agency, in assessing residents for risk of being sexually abusive. A resident's risk level is reassessed when warranted due to a referral request, incident of sexual abuse, or receipt of additional information that bears on the resident's risk of sexual victimization or abusiveness. The residents are not to be disciplined for refusing to answer or for not disclosing complete information in response to questions asked.

The agency implements appropriate controls on the dissemination within the agency of responses to questions asked pursuant to this standard or order to ensure that sensitive information is not exploited to the resident's detriment by staff or other residents. Only limited staff have access to the risk screening form such as medical, mental health, Executive Director, Facility Director as well as the PREA Coordinator.

Documents Reviewed:
Facility Policy H1202
Sample of Vulnerability Assessment Risk of Victimization and/or Sexual Aggression
Random Resident Intake Files

Interviews:
Compliance Manager/PREA Coordinator
Staff Responsible for Risk Screening
Random Residents

Conclusion:
Based upon the review and analysis of the available evidence, the Auditor has determined the facility is in compliance with this standard.

Standard 115.242: Use of screening information

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.242 (a)

- Does the agency use information from the risk screening required by § 115.241, with the goal of keeping separate those residents at high risk of being sexually victimized from those at high risk of being sexually abusive, to inform: Housing Assignments? ☒ Yes ☐ No

- Does the agency use information from the risk screening required by § 115.241, with the goal of keeping separate those residents at high risk of being sexually victimized from those at high risk of being sexually abusive, to inform: Bed assignments? ☒ Yes ☐ No

- Does the agency use information from the risk screening required by § 115.241, with the goal of keeping separate those residents at high risk of being sexually victimized from those at high risk of being sexually abusive, to inform: Work Assignments? ☒ Yes ☐ No

- Does the agency use information from the risk screening required by § 115.241, with the goal of keeping separate those residents at high risk of being sexually victimized from those at high risk of being sexually abusive, to inform: Education Assignments? ☒ Yes ☐ No

- Does the agency use information from the risk screening required by § 115.241, with the goal of keeping separate those residents at high risk of being sexually victimized from those at high risk of being sexually abusive, to inform: Program Assignments? ☒ Yes ☐ No

115.242 (b)

- Does the agency make individualized determinations about how to ensure the safety of each resident? ☒ Yes ☐ No

115.242 (c)

- When deciding whether to assign a transgender or intersex resident to a facility for male or female residents, does the agency consider on a case-by-case basis whether a placement would ensure the residents health and safety, and whether a placement would present management or security problems (NOTE: if an agency by policy or practice assigns residents to a male or female facility on the basis of anatomy alone, that agency is not in compliance with this standard)? ☒ Yes ☐ No

- When making housing or other program assignments for transgender or intersex residents, does the agency consider on a case-by-case basis whether a placement would ensure the residents health and safety, and whether a placement would present management or security problems? ☒ Yes ☐ No

115.242 (d)

- Are each transgender or intersex resident's own views with respect to his or her own safety given serious consideration when making facility and housing placement decisions and programming assignments? ☒ Yes ☐ No

115.242 (e)

- Are transgender and intersex residents given the opportunity to shower separately from other residents? ☒ Yes ☐ No

115.242 (f)

- Unless placement is in a dedicated facility, unit, or wing established in connection with a consent decree, legal settlement, or legal judgment for the purpose of protecting lesbian, gay, bisexual, transgender, or intersex residents, does the agency always refrain from placing: lesbian, gay, and bisexual residents in dedicated facilities, units, or wings solely on the basis of such identification or status? ☒ Yes ☐ No

- Unless placement is in a dedicated facility, unit, or wing established in connection with a consent decree, legal settlement, or legal judgment for the purpose of protecting lesbian, gay, bisexual, transgender, or intersex residents, does the agency always refrain from placing: transgender residents in dedicated facilities, units, or wings solely on the basis of such identification or status? ☒ Yes ☐ No

- Unless placement is in a dedicated facility, unit, or wing established in connection with a consent decree, legal settlement, or legal judgment for the purpose of protecting lesbian, gay, bisexual, transgender, or intersex residents, does the agency always refrain from placing: intersex residents in dedicated facilities, units, or wings solely on the basis of such identification or status? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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

CRRC Policy H1202 states the agency shall use information from the risk screening to determine housing, bed, work, education and program assignments with the goal of keeping separate those residents of high risk of being sexually victimized from those at high risk of being sexually abusive. The agency shall make individualized determinations about how to ensure the safety of each resident. In deciding whether to assign a transgender or intersex resident to a room for male or female residents, and in making other housing and programming assignments, the agency shall consider on a case-by-case basis whether a placement would ensure the residents health and safety and whether the placement would present management or security problems. A transgender or intersex resident's own views with respect to his or her own safety shall be given serious consideration. Transgender and intersex residents shall be given the opportunity to shower separately from other residents. Interviews with the PREA Coordinator and Staff responsible for intake verified that information taken during screening of residents were being utilized. No transgender or intersex residents at the facility during audit to interview.

Documents Reviewed:
Facility Policy H1202
Sample of Vulnerability Assessment Risk of Victimization and/or Sexual Aggression
Random Resident Intake Files

Interviews:
Random Resident
Facility Director
Compliance Manager/PREA Coordinator
Staff Responsible for Risk Screening/Intake Coordinator

Conclusion:
Based upon the review and analysis of the available evidence, the Auditor has determined the facility is fully compliant with this standard regarding use of screening information. The facility uses information from the risk screening required by standard 115.241 to inform housing, bed, work, education and program assignments with the goal of keeping residents safe and free from sexual abuse.

REPORTING

Standard 115.251: Resident reporting

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.251 (a)

- Does the agency provide multiple internal ways for residents to privately report: Sexual abuse and sexual harassment? ☒ Yes ☐ No

- Does the agency provide multiple internal ways for residents to privately report: Retaliation by other residents or staff for reporting sexual abuse and sexual harassment? ☒ Yes ☐ No

- Does the agency provide multiple internal ways for residents to privately report: Staff neglect or violation of responsibilities that may have contributed to such incidents? ☒ Yes ☐ No

115.251 (b)

- Does the agency also provide at least one way for residents to report sexual abuse or sexual harassment to a public or private entity or office that is not part of the agency? ☒ Yes ☐ No

- Is that private entity or office able to receive and immediately forward resident reports of sexual abuse and sexual harassment to agency officials? ☒ Yes ☐ No

- Does that private entity or office allow the resident to remain anonymous upon request? ☒ Yes ☐ No

115.251 (c)

- Do staff members accept reports of sexual abuse and sexual harassment made verbally, in writing, anonymously, and from third parties? ☒ Yes ☐ No

- Do staff members promptly document any verbal reports of sexual abuse and sexual harassment? ☒ Yes ☐ No

115.251 (d)

- Does the agency provide a method for staff to privately report sexual abuse and sexual harassment of residents? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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

CRRC Policy H809 states the agency has multiple internal ways for residents to privately report per the PREA standard. The PREA Coordinator created a reporting form directly on the agency website which is available to all residents, staff, third parties and the general public. The agency has an agreement with an outside rape crisis center, National Sexual Assault Hotline and Sexual Trauma Services of the Midlands that is available to all residents and the general public via 24 hours help line. Agency staff is well trained on accepting resident reports in multiple formats either verbally, in writing, anonymously or from third parties.

Agency staff accepts reports made verbally, in writing anonymously or from third parties and shall promptly document any verbal reports. The agency provides a method for staff to privately report sexual abuse and sexual harassment of residents. This was further verified with random residents and random staff and PREA Coordinator interviews. There have been no reports of sexual abuse /sexual harassment within the past twelve (12) months.

Documents Reviewed:
Facility Policy H809
Third Party Reporting Forms
Resident Handbook
Observed Posters
Hot Line reporting Posters

Interviews:
Random Staff
Random Residents
Compliance Manager/PREA Coordinator

Conclusion:
Based upon the review and analysis of the available evidence, the Auditor has determined the facility is in compliance with this standard regarding resident reporting. The residents have multiple internal ways to privately report. Reports can be made verbally, in writing, anonymously, and from third parties. Verbal reports would be documented immediately. Staff can privately report sexual abuse and sexual harassment of residents.

Standard 115.252: Exhaustion of administrative remedies

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.252 (a)

- Is the agency exempt from this standard? NOTE: The agency is exempt ONLY if it does not have administrative procedures to address resident grievances regarding sexual abuse. This does not mean the agency is exempt simply because a resident does not have to or is not ordinarily expected to submit a grievance to report sexual abuse. This means that as a matter of

explicit policy, the agency does not have an administrative remedies process to address sexual abuse. ☐ Yes ☐ No ☒ NA

115.252 (b)

- Does the agency permit residents to submit a grievance regarding an allegation of sexual abuse without any type of time limits? (The agency may apply otherwise-applicable time limits to any portion of a grievance that does not allege an incident of sexual abuse.) (N/A if agency is exempt from this standard.) ☐ Yes ☐ No ☒ NA

- Does the agency always refrain from requiring a resident to use any informal grievance process, or to otherwise attempt to resolve with staff, an alleged incident of sexual abuse? (N/A if agency is exempt from this standard.) ☐ Yes ☐ No ☒ NA

115.252 (c)

- Does the agency ensure that: A resident who alleges sexual abuse may submit a grievance without submitting it to a staff member who is the subject of the complaint? (N/A if agency is exempt from this standard.) ☐ Yes ☐ No ☒ NA

- Does the agency ensure that: Such grievance is not referred to a staff member who is the subject of the complaint? (N/A if agency is exempt from this standard.) ☐ Yes ☐ No ☒ NA

115.252 (d)

- Does the agency issue a final agency decision on the merits of any portion of a grievance alleging sexual abuse within 90 days of the initial filing of the grievance? (Computation of the 90-day time period does not include time consumed by residents in preparing any administrative appeal.) (N/A if agency is exempt from this standard.) ☐ Yes ☐ No ☒ NA

- If the agency determines that the 90-day timeframe is insufficient to make an appropriate decision and claims an extension of time [the maximum allowable extension of time to respond is 70 days per 115.252(d)(3)] , does the agency notify the resident in writing of any such extension and provide a date by which a decision will be made? (N/A if agency is exempt from this standard.) ☐ Yes ☐ No ☒ NA

- At any level of the administrative process, including the final level, if the resident does not receive a response within the time allotted for reply, including any properly noticed extension, may a resident consider the absence of a response to be a denial at that level? (N/A if agency is exempt from this standard.) ☐ Yes ☐ No ☒ NA

115.252 (e)

- Are third parties, including fellow residents, staff members, family members, attorneys, and outside advocates, permitted to assist residents in filing requests for administrative remedies relating to allegations of sexual abuse? (N/A if agency is exempt from this standard.) ☐ Yes ☐ No ☒ NA

- Are those third parties also permitted to file such requests on behalf of residents? (If a third-party files such a request on behalf of a resident, the facility may require as a condition of processing the request that the alleged victim agree to have the request filed on his or her behalf, and may also require the alleged victim to personally pursue any subsequent steps in the administrative remedy process.) (N/A if agency is exempt from this standard.)
  ☐ Yes ☐ No ☒ NA

- If the resident declines to have the request processed on his or her behalf, does the agency document the residents decision? (N/A if agency is exempt from this standard.)
  ☐ Yes ☐ No ☒ NA

115.252 (f)

- Has the agency established procedures for the filing of an emergency grievance alleging that a resident is subject to a substantial risk of imminent sexual abuse? (N/A if agency is exempt from this standard.) ☐ Yes ☐ No ☒ NA

- After receiving an emergency grievance alleging a resident is subject to a substantial risk of imminent sexual abuse, does the agency immediately forward the grievance (or any portion thereof that alleges the substantial risk of imminent sexual abuse) to a level of review at which immediate corrective action may be taken? (N/A if agency is exempt from this standard.).
  ☐ Yes ☐ No ☒ NA

- After receiving an emergency grievance described above, does the agency provide an initial response within 48 hours? (N/A if agency is exempt from this standard.) ☐ Yes ☐ No ☒ NA

- After receiving an emergency grievance described above, does the agency issue a final agency decision within 5 calendar days? (N/A if agency is exempt from this standard.)
  ☐ Yes ☐ No ☒ NA

- Does the initial response and final agency decision document the agency's determination whether the resident is in substantial risk of imminent sexual abuse? (N/A if agency is exempt from this standard.) ☐ Yes ☐ No ☒ NA

- Does the initial response document the agency's action(s) taken in response to the emergency grievance? (N/A if agency is exempt from this standard.) ☐ Yes ☐ No ☒ NA

- Does the agency's final decision document the agency's action(s) taken in response to the emergency grievance? (N/A if agency is exempt from this standard.) ☐ Yes ☐ No ☒ NA

115.252 (g)

- If the agency disciplines a resident for filing a grievance related to alleged sexual abuse, does it do so ONLY where the agency demonstrates that the resident filed the grievance in bad faith? (N/A if agency is exempt from this standard.) ☐ Yes ☐ No ☒ NA

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)
- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- ☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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

CRRC Policy H809 states all of the agency's residents are federal inmate transfers from the FBOP in accordance with contractual agreements between the two agencies. The FBOP maintains ultimate authority over all residents at the Columbia, SC facility. Any form of administrative procedure for dealing with resident grievances regarding sexual abuse will be coordinated with the FBOP. CRRC does not impose a time limit when a resident may submit a grievance regarding an allegation of sexual abuse to their liaison officer with the FBOP. CRRC does not require a resident to use any informal grievance process, or otherwise attempt to resolve with staff an alleged incident of sexual abuse. Auditor spoke with residents in regard to their understanding of administrative remedies and those interviewed understood.

Documents Reviewed:
Facility Policy H809
Resident Handbook
Third Party Reporting Form

Interviews:
Random Residents
Random Staff

Conclusion:
Based upon the review and analysis of the available evidence, the Auditor has determined the facility is fully compliant with this standard regarding exhaustion of administrative remedies.

Standard 115.253: Resident access to outside confidential support services

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.253 (a)

- Does the facility provide residents with access to outside victim advocates for emotional support services related to sexual abuse by giving residents mailing addresses and telephone numbers, including toll-free hotline numbers where available, of local, State, or national victim advocacy or rape crisis organizations? ☒ Yes ☐ No

- Does the facility enable reasonable communication between residents and these organizations and agencies, in as confidential a manner as possible? ☒ Yes ☐ No

115.253 (b)

- Does the facility inform residents, prior to giving them access, of the extent to which such communications will be monitored and the extent to which reports of abuse will be forwarded to authorities in accordance with mandatory reporting laws? ☒ Yes ☐ No

115.253 (c)

- Does the agency maintain or attempt to enter into memoranda of understanding or other agreements with community service providers that are able to provide residents with confidential emotional support services related to sexual abuse? ☒ Yes ☐ No

- Does the agency maintain copies of agreements or documentation showing attempts to enter into such agreements? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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

CRRC Policy H809 states the agency maintains an agreement with an independent outside agency rape crisis center, National Sexual Assault Hotline and Sexual Trauma Services of the Midlands. The Auditor tested the resident telephone access for this outside confidential support service during the onsite portion of the audit and interviewed an employee. The rape crisis center

offers victim advocacy services at no cost to the resident or agency. The agency has posters and brochures with the rape crisis center contact information and is available to all residents, staff and public. The resident telephone calls are not monitored. Interviews with random residents revealed the knowledge of the accessibility of these support services. There have been no reports of sexual abuse within the past twelve (12) months.

Documents Reviewed:
Facility Policy H809
MOU, PRMH
Resident Handbook
Posted Information

Interviews:
Random Residents

Conclusion:
Based upon the review and analysis of the available evidence, the Auditor has determined the facility is fully compliant with this standard regarding resident access to outside confidential support services and legal representation.

Standard 115.254: Third-party reporting

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.254 (a)

- Has the agency established a method to receive third-party reports of sexual abuse and sexual harassment? ☒ Yes ☐ No

- Has the agency distributed publicly information on how to report sexual abuse and sexual harassment on behalf of a resident? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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

CRRC Policy H809 states the agency has a method to receive third party reports of sexual abuse and sexual harassment through its website reporting process and local rape crisis center. The agency shall distribute publicly information on how to report sexual abuse and sexual harassment on behalf of a resident. The agency has posters and brochures throughout the facility that are also available to anyone and explains third-party reporting options and processes. This practice was witnessed by the Auditor on the agency's website.

Documents Reviewed:
Facility Policy H809
Third Party Reporting Form
Agency Website

Interviews:
Random Staff
Random Residents

Conclusion:
Based upon the review and analysis of the available evidence, the Auditor determined the facility is in compliance regarding third-party reporting. The facility provides various methods for third-party reports of sexual abuse or sexual harassment.

OFFICIAL RESPONSE FOLLOWING A RESIDENT REPORT

Standard 115.261: Staff and agency reporting duties

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.261 (a)

- Does the agency require all staff to report immediately and according to agency policy any knowledge, suspicion, or information regarding an incident of sexual abuse or sexual harassment that occurred in a facility, whether or not it is part of the agency? ☒ Yes ☐ No

- Does the agency require all staff to report immediately and according to agency policy any knowledge, suspicion, or information regarding retaliation against residents or staff who reported an incident of sexual abuse or sexual harassment? ☒ Yes ☐ No

- Does the agency require all staff to report immediately and according to agency policy any knowledge, suspicion, or information regarding any staff neglect or violation of responsibilities

that may have contributed to an incident of sexual abuse or sexual harassment or retaliation? ☒ Yes ☐ No

115.261 (b)

- Apart from reporting to designated supervisors or officials, do staff always refrain from revealing any information related to a sexual abuse report to anyone other than to the extent necessary, as specified in agency policy, to make treatment, investigation, and other security and management decisions? ☒ Yes ☐ No

115.261 (c)

- Unless otherwise precluded by Federal, State, or local law, are medical and mental health practitioners required to report sexual abuse pursuant to paragraph (a) of this section? ☒ Yes ☐ No

- Are medical and mental health practitioners required to inform residents of the practitioner's duty to report, and the limitations of confidentiality, at the initiation of services? ☒ Yes ☐ No

115.261 (d)

- If the alleged victim is under the age of 18 or considered a vulnerable adult under a State or local vulnerable persons statute, does the agency report the allegation to the designated State or local services agency under applicable mandatory reporting laws? ☒ Yes ☐ No

115.261 (e)

- Does the facility report all allegations of sexual abuse and sexual harassment, including third-party and anonymous reports, to the facility's designated investigators? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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

CRRC Policy 3.4 states the agency requires all staff to report sexual abuse and sexual harassment immediately and according to agency policy report any knowledge, suspicion or information regarding an incident of sexual abuse or sexual harassment that occurred at the facility, whether or not it is part of the agency; retaliation against residents or staff who reported such an incident; and any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation. The agency reports all allegations of sexual abuse and sexual harassment including third-party and anonymous reports to the FBOP. This was further verified through interviews with Case Managers, Intake staff, Facility Director, PREA Coordinator, random staff and residents. There were no reports of sexual abuse/sexual harassment within the past twelve (12) months.

Documents Reviewed:
Facility Policy 3.4
PREA Questionnaire

Interviews:
Intake Staff
Facility Director
Compliance Manager/PREA Coordinator
Case Managers

Conclusion:
The interviews with intake staff, random staff, case managers, PREA Coordinator and Facility Director revealed their awareness of the requirements regarding the reporting duties. All staff interviewed acknowledged they are mandated reporters and a written report must immediately follow reported allegations and incidents. The random staff interviewed provided the reporting requirements and that staff is expected to document receipt of verbal reports immediately. The facility staff members are also required by the policy to report allegations that were made anonymously or by a third-party. During this audit period, there were no allegations of sexual abuse.

Standard 115.262: Agency protection duties

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.262 (a)

- When the agency learns that a resident is subject to a substantial risk of imminent sexual abuse, does it take immediate action to protect the resident? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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

CRRC Policy H809 and procedures along with Director of the Facility, PREA Coordinator, FBOP and random staff interviews during the on-site portion of the audit verified, once the agency staff learns that a resident is subject to a substantial risk of imminent sexual abuse, they will take immediate action to protect the resident. Follow-up coordination will occur between the agency and the FBOP to further ensure the resident's safety and security. Reports are private and confidential. There have been no reports of sexual abuse/sexual harassment within the past twelve (12) months.

Documents Reviewed:
Facility Policy H809
Criminal Investigation Checklist
Vulnerability Assessments

Interviews:
Random Staff
Facility Director
Compliance Manager/PREA Coordinator
Telephone Interview (BOP)

Conclusion:
Based upon the review and analysis of the available evidence, the Auditor determined the facility is in compliance with this standard and the provisions regarding agency protection duties.

Standard 115.263: Reporting to other confinement facilities

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.263 (a)

- Upon receiving an allegation that a resident was sexually abused while confined at another facility, does the head of the facility that received the allegation notify the head of the facility or appropriate office of the agency where the alleged abuse occurred? ☒ Yes ☐ No

115.263 (b)

- Is such notification provided as soon as possible, but no later than 72 hours after receiving the allegation? ☒ Yes ☐ No

115.263 (c)

- Does the agency document that it has provided such notification? ☒ Yes ☐ No

115.263 (d)

- Does the facility head or agency office that receives such notification ensure that the allegation is investigated in accordance with these standards? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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

CRRC Policy H809 states the Facility Director will notify and take action as soon as possible, but no later than seventy-two hours after receiving an allegation a resident was sexually abused while confined at another facility. The agency documents such notification and informs the head of the facility and head of the agency where the alleged abuse occurred. Based on interviews with the Facility Director there were no allegations reported by another facility that a resident alleged sexual abuse while at CRRC and there were no allegations made by CRRC residents that he or she was sexually abused while at another facility. However, if such reports were made by residents they would have reported it immediately. There have been no reports of sexual abuse while housed at another facility within the past 12 months. The agency will document such notifications to ensure the allegation is investigated in accordance with the PREA standard.

Documents Reviewed:
Facility Policy H809

Interviews:
Facility Director

Conclusion:
Based upon the review and analysis of the available evidence, the Auditor determined the facility is in compliance with this standard regarding reporting to other confinement facilities.

Standard 115.264: Staff first responder duties

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.264 (a)

- Upon learning of an allegation that a resident was sexually abused, is the first security staff member to respond to the report required to: Separate the alleged victim and abuser? ☒ Yes ☐ No

- Upon learning of an allegation that a resident was sexually abused, is the first security staff member to respond to the report required to: Preserve and protect any crime scene until appropriate steps can be taken to collect any evidence? ☒ Yes ☐ No

- Upon learning of an allegation that a resident was sexually abused, is the first security staff member to respond to the report required to: Request that the alleged victim not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating, if the abuse occurred within a time period that still allows for the collection of physical evidence? ☒ Yes ☐ No

- Upon learning of an allegation that a resident was sexually abused, is the first security staff member to respond to the report required to: Ensure that the alleged abuser does not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating, if the abuse occurred within a time period that still allows for the collection of physical evidence? ☒ Yes ☐ No

115.264 (b)

- If the first staff responder is not a security staff member, is the responder required to request that the alleged victim not take any actions that could destroy physical evidence, and then notify security staff? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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

CRRC Policy H809 states upon learning of an allegation that a resident was sexually abused, the first staff member to respond to the report shall separate the alleged victim and abuser; preserve and protect any crime scene until appropriate steps can be taken to collect any evidence; if the abuse occurred within a time period that still allows for the collection of physical evidence including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating; and if the abuse occurred within a time period that still allows for the collection of physical evidence, ensure that the alleged abused does not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking or eating.

If the first responder is not a security staff member, the responder shall be required to request the alleged victim not take any actions that could destroy physical evidence, and then notify security staff. Random staff interviews with security and non- security staff confirmed the procedure. There has been no report of sexual abuse within the past twelve (12) months.

Documents Reviewed:
Facility Policy H809

Interviews:
Random Staff
Non-Security Staff First Responder

Conclusion:
Based upon the review and analysis of the available evidence, the Auditor determined the facility is in compliance with this standard regarding staff first responder duties.

Standard 115.265: Coordinated response

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.265 (a)

- Has the facility developed a written institutional plan to coordinate actions among staff first responders, medical and mental health practitioners, investigators, and facility leadership taken in response to an incident of sexual abuse? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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

CRRC Policy H809 and procedure along with Director of the Facility and random staff interviews during the onsite portion of the audit, the Columbia, SC facility has a written institutional plan to coordinate actions taken in response to an incident of sexual abuse, among staff first responders, contract agencies, facility leadership and agency executive leadership. The Auditor observed agency and facility practices, reviewed data provided by the facility staff; interviewed residents and staff during the onsite visit and of the facility. The agency and facility are in compliance with this PREA standard.

Documents Reviewed:
Facility Policy H809
MOU, PRMH
Facility Written Plan

Interviews:
Facility Director
Random Staff

Conclusion:
Based upon the review and analysis of the available evidence, the Auditor determined the facility is in compliance with this standard regarding a coordinated response to an incident of sexual abuse. No allegations of sexual abuse have been reported during this audit period.

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

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.266 (a)

- Are both the agency and any other governmental entities responsible for collective bargaining on the agency's behalf prohibited from entering into or renewing any collective bargaining agreement or other agreement that limits the agency's ability to remove alleged staff sexual abusers from contact with any residents pending the outcome of an investigation or of a determination of whether and to what extent discipline is warranted? ☒ Yes ☐ No

115.266 (b)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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

CRRC Policy H809 and procedures along with interviews with the Facility Director, the facility is not bound by any form of collective bargaining in order to remove alleged staff sexual abusers from contact with any residents pending the outcome of an investigation or of a determination of whether and to what extent discipline is warranted. The state of South Carolina is considered a right to work state. The Auditor specifically reviewed personnel actions taken by the agency. No allegations of sexual abuse were made within the past twelve (12) months.

Standard 115.267: Agency protection against retaliation

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.267 (a)

- Has the agency established a policy to protect all residents and staff who report sexual abuse or sexual harassment or cooperate with sexual abuse or sexual harassment investigations from retaliation by other residents or staff? ☒ Yes ☐ No

- Has the agency designated which staff members or departments are charged with monitoring retaliation? ☒ Yes ☐ No

115.267 (b)

- Does the agency employ multiple protection measures, such as housing changes or transfers for resident victims or abusers, removal of alleged staff or resident abusers from contact with victims, and emotional support services for residents or staff who fear retaliation for reporting sexual abuse or sexual harassment or for cooperating with investigations? ☒ Yes ☐ No

115.267 (c)

- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor the conduct and treatment of residents or staff who reported the sexual abuse to see if there are changes that may suggest possible retaliation by residents or staff? ☒ Yes ☐ No

- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor the conduct and treatment of residents who were reported to have suffered sexual abuse to see if there are changes that may suggest possible retaliation by residents or staff? ☒ Yes ☐ No

- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Act promptly to remedy any such retaliation? ☒ Yes ☐ No

- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor any resident disciplinary reports? ☒ Yes ☐ No

- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor resident housing changes? ☒ Yes ☐ No

- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor resident program changes? ☒ Yes ☐ No

- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor negative performance reviews of staff? ☒ Yes ☐ No

- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor reassignments of staff? ☒ Yes ☐ No

- Does the agency continue such monitoring beyond 90 days if the initial monitoring indicates a continuing need? ☒ Yes ☐ No

115.267 (d)

- In the case of residents, does such monitoring also include periodic status checks? ☒ Yes ☐ No

115.267 (e)

- If any other individual who cooperates with an investigation expresses a fear of retaliation, does the agency take appropriate measures to protect that individual against retaliation? ☒ Yes ☐ No

115.267 (f)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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

CRRC Policy H809 and procedures along with interview with Facility Director the agency protects all residents and staff who report sexual abuse or sexual harassment or who cooperate with sexual abuse or sexual harassment investigations from retaliation by other residents or staff. The Columbia, SC Facility Director serves as the retaliation monitor.

The agency has multiple protection measures, such as transfers the resident victim or abuser, removal of alleged staff or resident abuser from contact with the victim, and emotional support services for residents or staff who fear retaliation for reporting sexual abuse or sexual harassment or for cooperating with investigations.

Policy requires the monitoring of residents and staff who have reported sexual abuse and sexual harassment or cooperated in a sexual abuse or sexual harassment investigation. The monitoring will take place for a period of ninety (90) days or longer, if needed. There were no incidents of retaliation within the past twelve (12) months. The Facility Director maintains a log of monitoring activities, if there is retaliation after reporting sexual abuse or sexual harassment.

Documentation Reviewed:
Facility Policy H809
Retaliation Monitoring Checklist

Interviews:
Facility Director/Retaliation Monitor

Conclusion:
Based upon the review and analysis of the available evidence, the Auditor determined the facility is in compliance with this standard.

INVESTIGATIONS

Standard 115.271: Criminal and administrative agency investigations

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.271 (a)

- When the agency conducts its own investigations into allegations of sexual abuse and sexual harassment, does it do so promptly, thoroughly, and objectively? [N/A if the agency/facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations. See 115.221(a).] ☐ Yes ☐ No ☒ NA

- Does the agency conduct such investigations for all allegations, including third party and anonymous reports? [N/A if the agency/facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations. See 115.221(a).]
  ☐ Yes ☐ No ☒ NA

115.271 (b)

- Where sexual abuse is alleged, does the agency use investigators who have received specialized training in sexual abuse investigations as required by 115.234? ☒ Yes ☐ No

115.271 (c)

- Do investigators gather and preserve direct and circumstantial evidence, including any available physical and DNA evidence and any available electronic monitoring data? ☒ Yes ☐ No

- Do investigators interview alleged victims, suspected perpetrators, and witnesses? ☒ Yes ☐ No

- Do investigators review prior reports and complaints of sexual abuse involving the suspected perpetrator? ☒ Yes ☐ No

115.271 (d)

- When the quality of evidence appears to support criminal prosecution, does the agency conduct compelled interviews only after consulting with prosecutors as to whether compelled interviews may be an obstacle for subsequent criminal prosecution? ☒ Yes ☐ No

115.271 (e)

- Do agency investigators assess the credibility of an alleged victim, suspect, or witness on an individual basis and not on the basis of that individual's status as resident or staff? ☒ Yes ☐ No

- Does the agency investigate allegations of sexual abuse without requiring a resident who alleges sexual abuse to submit to a polygraph examination or other truth-telling device as a condition for proceeding? ☒ Yes ☐ No

115.271 (f)

- Do administrative investigations include an effort to determine whether staff actions or failures to act contributed to the abuse? ☒ Yes ☐ No

- Are administrative investigations documented in written reports that include a description of the physical evidence and testimonial evidence, the reasoning behind credibility assessments, and investigative facts and findings? ☒ Yes ☐ No

115.271 (g)

- Are criminal investigations documented in a written report that contains a thorough description of the physical, testimonial, and documentary evidence and attaches copies of all documentary evidence where feasible? ☒ Yes ☐ No

115.271 (h)

- Are all substantiated allegations of conduct that appears to be criminal referred for prosecution? ☒ Yes ☐ No

115.271 (i)

- Does the agency retain all written reports referenced in 115.271(f) and (g) for as long as the alleged abuser is incarcerated or employed by the agency, plus five years? ☒ Yes ☐ No

115.271 (j)

- Does the agency ensure that the departure of an alleged abuser or victim from the employment or control of the agency does not provide a basis for terminating an investigation? ☒ Yes ☐ No

115.271 (k)

- Auditor is not required to audit this provision.

115.271 (l)

- When an outside entity investigates sexual abuse, does the facility cooperate with outside investigators and endeavor to remain informed about the progress of the investigation? [N/A if an outside agency does not conduct administrative or criminal sexual abuse investigations. See 115.221(a).] ☒ Yes ☐ No ☐ NA

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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

CRRC Policy 4.13 states when the agency conducts its own administrative investigations on staff of sexual abuse and sexual harassment, it does so promptly, thoroughly and objectively for all allegations, including third-party and anonymous reports. This was verified through an interview with the Director of Human Resources. Criminal investigations are handled by local law enforcement, Columbia Police Department, Richland County Sheriff Department and representatives from the FBOP or other designated federal investigators. The agency has a contract agreement with the FBOP and all residents are federal inmates.

The agency coordinates with other outside agencies in determining further action and prosecution. The agency does not compel residents to take a polygraph examination or other truth-telling devices as a condition for proceeding with an investigation. Investigations are documented in a written report which contains a thorough description of physical, testimonial and all other documentary evidence. The agency retains all written reports for as long as the alleged abuser is housed at the facility or employed by the agency, plus five (5) years. The departure of the alleged abuser or victim from the employment or control of the agency shall not provide a basis for terminating an investigation. There have been no reports of sexual abuse/sexual harassment within the past twelve (12) months.

Documents Reviewed:
Facility Policy 4.13
MOU, Columbia Police Department
MOU, PRMH
MOU, Richland County Sheriff Department

Interviews:
Telephone interview (BOP)
Facility Director
Random Staff
Compliance Manager/PREA Coordinator

Conclusion:

Based upon the review and analysis of the available evidence, the Auditor determined the facility is in compliance with this standard regarding criminal and administrative agency investigations.

Standard 115.272: Evidentiary standard for administrative investigations

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.272 (a)

- Is it true that the agency does not impose a standard higher than a preponderance of the evidence in determining whether allegations of sexual abuse or sexual harassment are substantiated? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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

CRRC Policy 4.13 states the agency imposes no standard higher than a preponderance of the evidence in determining whether allegations of sexual abuse or sexual harassment are substantiated. The Auditor observed agency and facility practices; reviewed data provided by the facility and interviewed residents and staff during the onsite visit and tour of the facility. The agency and facility are in compliance with the PREA standard.

Documents Reviewed:
Facility Policy 4.13

Interviews:
Telephone interview (BOP)

Conclusion:
Based upon the review and analysis of the available evidence, the Auditor determined the facility is in compliance with this standard regarding criminal and administrative agency investigations.

Standard 115.273: Reporting to residents

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.273 (a)

- Following an investigation into a resident's allegation that he or she suffered sexual abuse in an agency facility, does the agency inform the resident as to whether the allegation has been determined to be substantiated, unsubstantiated, or unfounded? ☒ Yes ☐ No

115.273 (b)

- If the agency did not conduct the investigation into a resident's allegation of sexual abuse in an agency facility, does the agency request the relevant information from the investigative agency in order to inform the resident? (N/A if the agency/facility is responsible for conducting administrative and criminal investigations.) ☒ Yes ☐ No ☐ NA

115.273 (c)

- Following a resident's allegation that a staff member has committed sexual abuse against the resident, unless the agency has determined that the allegation is unfounded, or unless the

resident has been released from custody, does the agency subsequently inform the resident whenever: The staff member is no longer posted within the resident's unit? ☒ Yes ☐ No

- Following a resident's allegation that a staff member has committed sexual abuse against the resident, unless the agency has determined that the allegation is unfounded, or unless the resident has been released from custody, does the agency subsequently inform the resident whenever: The staff member is no longer employed at the facility? ☒ Yes ☐ No

- Following a resident's allegation that a staff member has committed sexual abuse against the resident, unless the agency has determined that the allegation is unfounded, or unless the resident has been released from custody, does the agency subsequently inform the resident whenever: The agency learns that the staff member has been indicted on a charge related to sexual abuse in the facility? ☒ Yes ☐ No

- Following a resident's allegation that a staff member has committed sexual abuse against the resident, unless the agency has determined that the allegation is unfounded, or unless the resident has been released from custody, does the agency subsequently inform the resident whenever: The agency learns that the staff member has been convicted on a charge related to sexual abuse within the facility? ☒ Yes ☐ No

115.273 (d)

- Following a resident's allegation that he or she has been sexually abused by another resident, does the agency subsequently inform the alleged victim whenever: The agency learns that the alleged abuser has been indicted on a charge related to sexual abuse within the facility? ☒ Yes ☐ No

- Following a resident's allegation that he or she has been sexually abused by another resident, does the agency subsequently inform the alleged victim whenever: The agency learns that the alleged abuser has been convicted on a charge related to sexual abuse within the facility? ☒ Yes ☐ No

115.273 (e)

- Does the agency document all such notifications or attempted notifications? ☒ Yes ☐ No

115.273 (f)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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

CRRC Policy 4.13 states and further verified by interviews with the Facility Director, following a resident allegation a staff member has committed sexual abuse against a resident, the agency shall subsequently inform the resident (exception being if the allegation is determined to be unfounded) whenever and in coordination with the FBOP:

1. The staff member is no longer employed by the agency;
2. The agency learns the staff member has been indicted on a charge related to sexual abuse within the agency; or
3. The agency learns the staff member has been convicted on a charge related to sexual abuse within the agency.

Following a resident's allegation, he or she has been sexually abused by another resident, the agency shall subsequently inform the alleged victim whenever: The agency learns the alleged abuser has been indicted on a charge related to sexual abuse within the agency; or the agency learns that the alleged abuse has been convicted on a charge related to sexual abuse within the agency.

All such notification to the residents or attempted notifications are documented. There were no reports of sexual abuse within the last twelve (12) months.

Documents Reviewed:
Facility Policy 4.13

Interviews:
Telephone interview (BOP)
Facility Director
Compliance Manager/PREA Coordinator

Conclusion:
The interviews with identified staff confirm the policy requirements and their knowledge of the process of reporting to a resident regarding the outcomes of an allegation of sexual abuse. Based on the review and analysis of the available documentation and interviews, the Auditor has determined the facility is compliant with the standard regarding the reporting to residents**.**

DISCIPLINE

Standard 115.276: Disciplinary sanctions for staff

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.276 (a)

- Are staff subject to disciplinary sanctions up to and including termination for violating agency sexual abuse or sexual harassment policies? ☒ Yes ☐ No

115.276 (b)

- Is termination the presumptive disciplinary sanction for staff who have engaged in sexual abuse? ☒ Yes ☐ No

115.276 (c)

- Are disciplinary sanctions for violations of agency policies relating to sexual abuse or sexual harassment (other than engaging in sexual abuse) commensurate with the nature and circumstances of the acts committed, the staff member's disciplinary history, and the sanctions imposed for comparable offenses by other staff with similar histories? ☒ Yes ☐ No

115.276 (d)

- Are all terminations for violations of agency sexual abuse or sexual harassment policies, or resignations by staff who would have been terminated if not for their resignation, reported to: Law enforcement agencies unless the activity was clearly not criminal? ☒ Yes ☐ No

- Are all terminations for violations of agency sexual abuse or sexual harassment policies, or resignations by staff who would have been terminated if not for their resignation, reported to: Relevant licensing bodies? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's

conclusions. This discussion must also include corrective action recommendations where the facility does not meet the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

CRRC Policy 3.4 states disciplinary sanctions for violations of agency policies relating to sexual abuse or sexual harassment are commensurate with the nature and circumstance of the acts committed, the staff member's disciplinary history and the sanctions imposed for comparable offenses by other staff histories.

All terminations for violations of agency sexual abuse or sexual harassment policies or resignations by staff who would have been terminated if not for their resignation, shall be reported to law enforcement agencies, unless the activity was clearly not criminal and to any relevant licensing bodies. There have been no reports or sanctions on staff within the past twelve (12) months.

Documents Reviewed:
Facility Policy 3.4

Interviews:
Facility Director

Conclusion:
Based upon the review of policy and interview, the Auditor has determined the facility is compliant with this standard regarding disciplinary sanctions for staff.

Standard 115.277: Corrective action for contractors and volunteers

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.277 (a)

- Is any contractor or volunteer who engages in sexual abuse prohibited from contact with residents? ☒ Yes ☐ No
- Is any contractor or volunteer who engages in sexual abuse reported to: Law enforcement agencies unless the activity was clearly not criminal? ☒ Yes ☐ No
- Is any contractor or volunteer who engages in sexual abuse reported to: Relevant licensing bodies? ☒ Yes ☐ No

115.277 (b)

- In the case of any other violation of agency sexual abuse or sexual harassment policies by a contractor or volunteer, does the facility take appropriate remedial measures, and consider whether to prohibit further contact with residents? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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

CRRC Policy 4.3 and procedures along with an interview with the Facility Director and volunteer states any contractor or volunteer who engages in sexual abuse shall be prohibited from contact with residents and shall be reported to law enforcement agencies, unless the activity was clearly not criminal, and to relevant licensing bodies.

The agency takes appropriate remedial measures and shall consider whether to prohibit further contact with residents, in the case of any other violation of agency sexual abuse or sexual harassment policies by a contractor or volunteer. There have been no allegations of Sexual abuse and sexual harassment by contractors or volunteers within the past twelve (12) months.

Documents Reviewed:
Facility Policy 4.3

Interviews:
Volunteer
Facility Director

Conclusion:
Based upon the review of policy and interview, the Auditor has determined the facility is compliant with this standard regarding corrective action for contractors and volunteers.

Standard 115.278: Interventions and disciplinary sanctions for residents

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.278 (a)

- Following an administrative finding that a resident engaged in resident-on-resident sexual abuse, or following a criminal finding of guilt for resident-on-resident sexual abuse, are residents subject to disciplinary sanctions pursuant to a formal disciplinary process? ☒ Yes ☐ No

115.278 (b)

- Are sanctions commensurate with the nature and circumstances of the abuse committed, the resident's disciplinary history, and the sanctions imposed for comparable offenses by other residents with similar histories? ☒ Yes ☐ No

115.278 (c)

- When determining what types of sanction, if any, should be imposed, does the disciplinary process consider whether a resident's mental disabilities or mental illness contributed to his or her behavior? ☒ Yes ☐ No

115.278 (d)

- If the facility offers therapy, counseling, or other interventions designed to address and correct underlying reasons or motivations for the abuse, does the facility consider whether to require the offending resident to participate in such interventions as a condition of access to programming and other benefits? ☒ Yes ☐ No

115.278 (e)

- Does the agency discipline a resident for sexual contact with staff only upon a finding that the staff member did not consent to such contact? ☒ Yes ☐ No

115.278 (f)

- For the purpose of disciplinary action does a report of sexual abuse made in good faith based upon a reasonable belief that the alleged conduct occurred NOT constitute falsely reporting an incident or lying, even if an investigation does not establish evidence sufficient to substantiate the allegation? ☒ Yes ☐ No

115.278 (g)

- Does the agency always refrain from considering non-coercive sexual activity between residents to be sexual abuse? (N/A if the agency does not prohibit all sexual activity between residents.) ☒ Yes ☐ No ☐ NA

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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

CRRC Policy H1305 states residents are subject to disciplinary sanctions in accordance with the FBOP disciplinary listings and pursuant to a formal disciplinary process following an administrative finding that the resident engaged in resident-on-resident sexual abuse or following a criminal finding of guild for resident-on-resident sexual abuse.

Sanctions are commensurate with the nature and circumstances of the abuse committed, the resident's disciplinary history, coordination with the FBOP and the sanctions imposed for comparable offenses by other residents with similar histories. The disciplinary process considers whether a resident's mental disabilities or mental illness contributed to their behavior when determining what type of sanction, if any, should be imposed.

The agency disciplines a resident for sexual contact with staff only upon a finding that the staff member did not consent to such contact. A report of sexual abuse made in good faith based upon a reasonable belief that the alleged conduct occurred shall not constitute falsely reporting an incident or lying, even if an investigation does not establish evidence sufficient to substantiate the allegation. The agency prohibits all sexual activity between residents and may discipline residents for such activity. There have been no reports or sanctions on residents within the past twelve (12) months.

Documents Reviewed:
Facility Policy H1305

Interviews:
Facility Director

Conclusion:
Based upon the review and analysis of the available documentation, the Auditor has determined the facility is compliant with this standard regarding the interventions and disciplinary sanctions for the residents. Additionally, there have been no administrative or criminal findings of resident on resident sexual abuse in the past twelve (12) months.

MEDICAL AND MENTAL CARE

Standard 115.282: Access to emergency medical and mental health services

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.282 (a)

- Do resident victims of sexual abuse receive timely, unimpeded access to emergency medical treatment and crisis intervention services, the nature and scope of which are determined by medical and mental health practitioners according to their professional judgment?
  ☒ Yes ☐ No

115.282 (b)

- If no qualified medical or mental health practitioners are on duty at the time a report of recent sexual abuse is made, do security staff first responders take preliminary steps to protect the victim pursuant to § 115.262? ☒ Yes ☐ No

- Do security staff first responders immediately notify the appropriate medical and mental health practitioners? ☒ Yes ☐ No

115.282 (c)

- Are resident victims of sexual abuse offered timely information about and timely access to emergency contraception and sexually transmitted infections prophylaxis, in accordance with professionally accepted standards of care, where medically appropriate? ☒ Yes ☐ No

115.282 (d)

- Are treatment services provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident?
  ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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

CRRC Policy H809 resident victims of sexual abuse receive timely, unimpeded access to emergency medical treatment and crisis intervention services, the nature and scope of which are determined by medical and mental health practitioners according to their professional judgement. If no qualified medical or mental health practitioners are available at the time, a report of recent abuse is made, security staff first responders take preliminary steps to protect the victim and shall immediately notify the appropriate medical and mental health practitioners.

Resident victims of sexual abuse while housed are offered timely information about and timely access to emergency contraception and sexually transmitted infections prophylaxis, in accordance with professionally accepted standards of care, where medically appropriate. Treatment services are provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident.

The Auditor reviewed agency agreements and spoke with personnel affiliated with the rape crisis hotline (National Sexual Assault Hotline), Sexual Trauma Services of the Midlands and emergency forensic examination hospital (PRMH) to confirm compliance. There have been no reports of sexual abuse within the past twelve (12) months. Based on interviews with random security staff.

Documents Reviewed:
Facility Policy H809
Samples of Acknowledgement of PREA Education
MOU, SAFE/SANE PRMH

Interviews:
Facility Director
Random Staff
SAFE/SANE PRMH

Conclusion:
The Auditor reviewed agency agreements and spoke with personnel affiliated with the rape crisis center (National Assault Hotline), Sexual Trauma Services of the Midlands and emergency forensic examination hospital (PRMH) to confirm compliance. There have been no reports of sexual abuse within the past twelve (12) months. Based on interviews with random security staff, the agency and facility are in compliance with this PREA standard.

Standard 115.283: Ongoing medical and mental health care for sexual abuse victims and abusers

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.283 (a)

- Does the facility offer medical and mental health evaluation and, as appropriate, treatment to all residents who have been victimized by sexual abuse in any prison, jail, lockup, or juvenile facility? ☒ Yes ☐ No

115.283 (b)

- Does the evaluation and treatment of such victims include, as appropriate, follow-up services, treatment plans, and, when necessary, referrals for continued care following their transfer to, or placement in, other facilities, or their release from custody? ☒ Yes ☐ No

115.283 (c)

- Does the facility provide such victims with medical and mental health services consistent with the community level of care? ☒ Yes ☐ No

115.283 (d)

- Are resident victims of sexually abusive vaginal penetration while incarcerated offered pregnancy tests? (N/A if all-male facility.) ☒ Yes ☐ No ☐ NA

115.283 (e)

- If pregnancy results from the conduct described in paragraph § 115.283(d), do such victims receive timely and comprehensive information about and timely access to all lawful pregnancy-related medical services? (N/A if all-male facility.) ☒ Yes ☐ No ☐ NA

115.283 (f)

- Are resident victims of sexual abuse while incarcerated offered tests for sexually transmitted infections as medically appropriate? ☒ Yes ☐ No

115.283 (g)

- Are treatment services provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident? ☒ Yes ☐ No

115.283 (h)

- Does the facility attempt to conduct a mental health evaluation of all known resident-on-resident abusers within 60 days of learning of such abuse history and offer treatment when deemed appropriate by mental health practitioners? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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

The facility review team takes the following into consideration:

1) Consider whether the allegation or investigation indicates a need to change policy or practice to better prevent, detect or respond to sexual abuse;
2) Consider whether the allegation or investigation was motivated by race, ethnicity, gender identity, lesbian, gay, bisexual, transgender or intersex identification, status or perceived status, or gang affiliation; or was motivated or otherwise caused by other group dynamics at the facility;
3) Examine the area in the facility where the incident allegedly occurred to assess whether physical barriers in the area may enable abuse;
4) Assess the adequacy of staffing levels in that area during different shifts;
5) Assess whether monitoring technology should be deployed or augmented to supplement supervision by staff; and
6) Prepare a report of its findings, including but not necessarily limited to determinations made pursuant to above paragraph numbers 1 and 5, and any recommendations for improvement, and submit such report to the facility head and Prison RAPE Elimination Act compliance manager.

CRRC Policy H809 states the agency, in coordination with the FBOP, offers medical and mental health evaluations and as appropriate treatment to all residents who have been victimized by sexual abuse. The evaluation and treatment of such victims include, as appropriate, follow-up

services, treatment plans, and, when necessary, referrals for continued care following their transfer, or placement in other facilities or their release from custody. The treatment provides such victims with medical and mental health services consistent with the community level of care. Resident victims of sexual abuse while housed are offered tests for sexually transmitted infections as medically appropriate. Treatment services are provided to the victim with no financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident.

The agency offers 24-hour unimpeded access of medical and mental health care per written agreements with outside agencies. There have been no reports within the past twelve (12) months. Based on a review of policies and procedures, outside the agency agreements along with staff and resident interviews. The agency and facility are in compliance with the PREA standard.

Documents Reviewed:
Facility Policy H809
MOU, PRMH

Interviews:
Facility Director

Conclusion:
Based upon the review and analysis of the documentation, the Auditor has determined the facility is in compliance with this standard regarding ongoing medical and mental health care for sexual abuse victims and abusers.

DATA COLLECTION AND REVIEW

Standard 115.286: Sexual abuse incident reviews

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.286 (a)

- Does the facility conduct a sexual abuse incident review at the conclusion of every sexual abuse investigation, including where the allegation has not been substantiated, unless the allegation has been determined to be unfounded? ☒ Yes ☐ No

115.286 (b)

- Does such review ordinarily occur within 30 days of the conclusion of the investigation? ☒ Yes ☐ No

115.286 (c)

- Does the review team include upper-level management officials, with input from line supervisors, investigators, and medical or mental health practitioners? ☒ Yes ☐ No

115.286 (d)

- Does the review team: Consider whether the allegation or investigation indicates a need to change policy or practice to better prevent, detect, or respond to sexual abuse? ☒ Yes ☐ No
- Does the review team: Consider whether the incident or allegation was motivated by race; ethnicity; gender identity; lesbian, gay, bisexual, transgender, or intersex identification, status, or perceived status; gang affiliation; or other group dynamics at the facility? ☒ Yes ☐ No
- Does the review team: Examine the area in the facility where the incident allegedly occurred to assess whether physical barriers in the area may enable abuse? ☒ Yes ☐ No
- Does the review team: Assess the adequacy of staffing levels in that area during different shifts? ☒ Yes ☐ No
- Does the review team: Assess whether monitoring technology should be deployed or augmented to supplement supervision by staff? ☒ Yes ☐ No
- Does the review team: Prepare a report of its findings, including but not necessarily limited to determinations made pursuant to §§ 115.286(d)(1) - (d)(5), and any recommendations for improvement and submit such report to the facility head and PREA compliance manager? ☒ Yes ☐ No

115.286 (e)

- Does the facility implement the recommendations for improvement, or document its reasons for not doing so? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does

not meet the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

CRRC Policy 4.13 states the facility shall conduct a sexual abuse incident review at the conclusion every sexual abuse investigation, including where the allegation has not been substantiated, unless the allegation has been determined to be unfounded. The incident review team consist of PREA Coordinator, Director of Human Resources and the Facility Director. A review of the review team findings will be submitted to the Executive Director within 3 days of the review meeting. There were no reports within the past twelve (12) months, however the facility has the components for the incident review team in place.

Documents Reviewed:
Facility Policy 4.13

Interviews:
Facility Director
Incident Review Team Member

Conclusion:
Based upon the review and analysis of the available documentation, the Auditor has determined the facility is compliant with this standard regarding sexual abuse incident reviews.

Standard 115.287: Data collection

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.287 (a)

- Does the agency collect accurate, uniform data for every allegation of sexual abuse at facilities under its direct control using a standardized instrument and set of definitions? ☒ Yes ☐ No

115.287 (b)

- Does the agency aggregate the incident-based sexual abuse data at least annually? ☒ Yes ☐ No

115.287 (c)

- Does the incident-based data include, at a minimum, the data necessary to answer all questions from the most recent version of the Survey of Sexual Violence conducted by the Department of Justice? ☒ Yes ☐ No

115.287 (d)

- Does the agency maintain, review, and collect data as needed from all available incident-based documents, including reports, investigation files, and sexual abuse incident reviews?
  ☒ Yes ☐ No

115.287 (e)

- Does the agency also obtain incident-based and aggregated data from every private facility with which it contracts for the confinement of its residents? (N/A if agency does not contract for the confinement of its residents.) ☐ Yes ☐ No ☒ NA

115.287 (f)

- Does the agency, upon request, provide all such data from the previous calendar year to the Department of Justice no later than June 30? (N/A if DOJ has not requested agency data.)
  ☐ Yes ☐ No ☒ NA

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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

CRRC Policy 4.13 states the agency collects accurate, uniform data for every allegation of sexual abuse at facilities under direct control using a standardized instrument and set of definitions. The agency aggregates the incident-based sexual abuse data at least annually. The incident-based data collected shall include, at minimum, the data necessary to answer all questions from the most recent version of the Survey of Sexual Violence conducted by the Department of Justice (DOJ). The agency maintains, reviews and collects data from every facility. Upon request, the agency shall provide all such data from the previous calendar year to the DOJ no later than June 30. There have been no requests by DOJ in the past twelve (12) months. There have been no requests in the past twelve (12) months. The agency is aware of the data collection procedure. The agency and facility are in compliance with this PREA standard.

Documents Reviewed:
Facility Policy 4.13
PREA Data

Interviews:
Compliance Manager/PREA Coordinator
Facility Director

Conclusion:
Based upon the review and analysis of the available documentation, the Auditor has determined the facility is compliant with this standard.

Standard 115.288: Data review for corrective action

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.288 (a)

- Does the agency review data collected and aggregated pursuant to § 115.287 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training, including by: Identifying problem areas? ☒ Yes ☐ No

- Does the agency review data collected and aggregated pursuant to § 115.287 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training, including by: Taking corrective action on an ongoing basis? ☒ Yes ☐ No

- Does the agency review data collected and aggregated pursuant to § 115.287 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training, including by: Preparing an annual report of its findings and corrective actions for each facility, as well as the agency as a whole? ☒ Yes ☐ No

115.288 (b)

- Does the agency's annual report include a comparison of the current year's data and corrective actions with those from prior years and provide an assessment of the agency's progress in addressing sexual abuse ☒ Yes ☐ No

115.288 (c)

- Is the agency's annual report approved by the agency head and made readily available to the public through its website or, if it does not have one, through other means? ☒ Yes ☐ No

115.288 (d)

- Does the agency indicate the nature of the material redacted where it redacts specific material from the reports when publication would present a clear and specific threat to the safety and security of a facility? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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

CRRC Policy 4.13 states the agency reviews data collected and aggregated in order to assess and improve the effectiveness of its sexual abuse prevention, detection and response policies, practices and training by:

1. Identifying problem areas;
2. Taking corrective action on an ongoing basis; and
3. Preparing an annual report of its findings and corrective actions for each facility, as well as the agency as a whole.

The report shall include a comparison of the current year's data and corrective actions with those from prior years and shall provide assessment of the agency's progress addressing sexual abuse. The agency's report is approved by the Executive Director of the agency and made readily available to the public through its website. Auditor verified that report is on the agency's website. The agency redacts specific material from the reports when publication would present a clear and specific threat to the safety and security of a facility but must indicate the nature of the material redacted.

Documents Reviewed:
Facility Policy 4.13
Annual Report

Interviews:
Facility Director
Compliance Manager/PREA Coordinator

Conclusion:
Based upon the review and analysis of the documentation, the Auditor has determined the facility is compliant with this standard regarding data review for corrective action.

Standard 115.289: Data storage, publication, and destruction

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.289 (a)

- Does the agency ensure that data collected pursuant to § 115.287 are securely retained? ☒ Yes ☐ No

115.289 (b)

- Does the agency make all aggregated sexual abuse data, from facilities under its direct control and private facilities with which it contracts, readily available to the public at least annually through its website or, if it does not have one, through other means? ☒ Yes ☐ No

115.289 (c)

- Does the agency remove all personal identifiers before making aggregated sexual abuse data publicly available? ☒ Yes ☐ No

115.289 (d)

- Does the agency maintain sexual abuse data collected pursuant to § 115.287 for at least 10 years after the date of the initial collection, unless Federal, State, or local law requires otherwise? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does

not meet the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

CRRC Policy 4.13 states a review of documents, policy, procedure along with agency PREA compliance manager and coordinator, the agency ensures that data is collected and securely retained. The agency makes all aggregated sexual abuse data, from facilities under its direct control, readily available to the public at least annually through its website. The agency website is www.alstonwilkessociety.org. Before making aggregated sexual abuse data publicly available, the agency removes all personal identifiers. The agency maintains sexual abuse data collected for at least ten (10) years after the date of the initial collection.

Documents Reviewed:
Facility Policy 4.13
Annual Report

Interviews:
Facility Director
Compliance Manager/PREA Coordinator

Conclusion:
Based upon the review and analysis of the available documentation, the Auditor has determined the facility is compliant with this standard.

AUDITING AND CORRECTIVE ACTION

Standard 115.401: Frequency and scope of audits

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.401 (a)

- During the prior three-year audit period, did the agency ensure that each facility operated by the agency, or by a private organization on behalf of the agency, was audited at least once? (*Note: The response here is purely informational. A "no" response does not impact overall compliance with this standard.*) ☒ Yes ☐ No

115.401 (b)

- Is this the first year of the current audit cycle? (*Note: a "no" response does not impact overall compliance with this standard*.) ☒ Yes ☐ No

- If this is the second year of the current audit cycle, did the agency ensure that at least one-third of each facility type operated by the agency, or by a private organization on behalf of the agency, was audited during the first year of the current audit cycle? (N/A if this is **not** the *second* year of the current audit cycle.) ☒ Yes ☐ No ☐ NA

- If this is the third year of the current audit cycle, did the agency ensure that at least two-thirds of each facility type operated by the agency, or by a private organization on behalf of the agency, were audited during the first two years of the current audit cycle? (N/A if this is **not** the *third* year of the current audit cycle.) ☒ Yes ☐ No ☐ NA

115.401 (h)

- Did the auditor have access to, and the ability to observe, all areas of the audited facility? ☒ Yes ☐ No

115.401 (i)

- Was the auditor permitted to request and receive copies of any relevant documents (including electronically stored information)? ☒ Yes ☐ No

115.401 (m)

- Was the auditor permitted to conduct private interviews with inmates, residents, and detainees? ☒ Yes ☐ No

115.401 (n)

- Were residents permitted to send confidential information or correspondence to the auditor in the same manner as if they were communicating with legal counsel? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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

PREA audits for the facility have been conducted as required for the initial three-year period. The facility has embarked on fulfilling the auditing requirements for this second three-year period. The facility has provided the Auditor with the required documentation which has been maintained as required by the standards and the auditing process.

A comprehensive site review was provided to the Auditor during the site visit and additional documentation was reviewed during the site visit. The staff members were cooperative in providing additional documentation as requested. The Facility Director provided appropriate work space which included conditions for conducting interviews in private with the residents and staff.

The posted notices regarding the audit were observed throughout the facility, accessible to residents, staff, visitors, contractors and volunteers. The notices provided directions and contact information informing those who wanted to contact the Auditor of how to do so. No correspondence was received by the Auditor.

Standard 115.403: Audit contents and findings

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.403 (f)

- The agency has published on its agency website, if it has one, or has otherwise made publicly available, all Final Audit Reports within 90 days of issuance by auditor. The review period is for prior audits completed during the past three years PRECEDING THIS AGENCY AUDIT. In the case of single facility agencies, the auditor shall ensure that the facility's last audit report was published. The pendency of any agency appeals pursuant to 28 C.F.R. § 115.405 does not excuse noncompliance with this provision. (N/A if there have been no Final Audit Reports issued in the past three years, or in the case of single facility agencies that there has never been a Final Audit Report issued.) ☒ Yes ☐ No ☐ NA

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does

not meet the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The facility was previously audited 2015 and the Auditor confirmed the audit report was posted on the agency's website as is the practice with the facility. The report does not contain any personal identifying information and there were no conflicts of interest regarding the completion of the audit. The facility policies and other documentation were reviewed regarding compliance with the standards and have been identified in the report. The audit findings were based on a review of policies and procedures and supporting documentation, interviews with staff, residents, contractor, a volunteer and observations.

AUDITOR CERTIFICATION

I certify that:

☒ The contents of this report are accurate to the best of my knowledge.

☒ No conflict of interest exists with respect to my ability to conduct an audit of the agency under review, and

☒ I have not included in the final report any personally identifiable information (PII) about any resident or staff member, except where the names of administrative personnel are specifically requested in the report template.

Auditor Instructions:

Type your full name in the text box below for Auditor Signature. This will function as your official electronic signature. Auditors must deliver their final report to the PREA Resource Center as a searchable PDF format to ensure accessibility to people with disabilities. Save this report document into a PDF format prior to submission.[1] Auditors are not permitted to submit audit reports that have been scanned.[2] See the PREA Auditor Handbook for a full discussion of audit report formatting requirements.

Bernard McKie September 15, 2018

Auditor Signature **Date**

[1] See additional instructions here: https://support.office.com/en-us/article/Save-or-convert-to-PDF-d85416c5-7d77-4fd6-a216-6f4bf7c7c110 .

[2] See *PREA Auditor Handbook*, Version 1.0, August 2017; Pages 68-69.