

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

Interim Final

Date of Report September 16, 2019

Auditor Information

Name: Cheryl M. Anderson	Email: thechandegroup@gmail.com
Company Name: Correctional Management and Communications Group, LLC	
Mailing Address: Post Office Box 502	City, State, Zip: Blythewood, SC 29016
Telephone: 803-240-1209	Date of Facility Visit: August 19, 2019

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: 3519 Medical Drive		City, State, Zip: Columbia, SC 29203	
The Agency Is:	<input type="checkbox"/> Military	<input type="checkbox"/> Private for Profit	<input checked="" type="checkbox"/> Private not for Profit
<input type="checkbox"/> Municipal	<input type="checkbox"/> County	<input type="checkbox"/> State	<input type="checkbox"/> Federal
Agency Website with PREA Information: http://www.alstonwilkessociety.org/prea-information.html			

Agency Chief Executive Officer

Name: S. Anne Walker	
Email: sannewalker@aws1962.org	Telephone: 803-799-2490

Agency-Wide PREA Coordinator

Name: Tiffany Smith	
Email: tsmith@aws1962.org	Telephone: 843-519-1716
PREA Coordinator Reports to: Toi Reid-Worley, Director of Human Resources	Number of Compliance Managers who report to the PREA Coordinator: 0

Facility Information

Name of Facility: Florence Residential Re-Entry Center

Physical Address: 441 West Cheves Street

City, State, Zip: Florence, SC 29501

Mailing Address (if different from above):
N/A

City, State, Zip: N/A

The Facility Is:

Military

Private for Profit

Private not for Profit

Municipal

County

State

Federal

Facility Website with PREA Information: <http://www.alstonwilkessociety.org/prea-information.html>

Has the facility been accredited within the past 3 years? Yes No

If the facility has been accredited within the past 3 years, select the accrediting organization(s) – select all that apply (N/A if the facility has not been accredited within the past 3 years):

ACA

NCCHC

CALEA

Other (please name or describe: [Click or tap here to enter text.](#))

N/A

If the facility has completed any internal or external audits other than those that resulted in accreditation, please describe:
N/A

Facility Director

Name: Tiffany Smith

Email: tsmith@aws1962.org

Telephone: 843-519-1716

Facility PREA Compliance Manager

Name: Tiffany Smith

Email: tsmith@aws1962.org

Telephone: 843-519-1716

Facility Health Service Administrator N/A

Name: [Click or tap here to enter text.](#)

Email: [Click or tap here to enter text.](#)

Telephone: [Click or tap here to enter text.](#)

Facility Characteristics

Designated Facility Capacity:	37	
Current Population of Facility:	26	
Average daily population for the past 12 months:	33	
Has the facility been over capacity at any point in the past 12 months?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Which population(s) does the facility hold?	<input type="checkbox"/> Females <input type="checkbox"/> Males <input checked="" type="checkbox"/> Both Females and Males	
Age range of population:	Adults 18+	
Average length of stay or time under supervision	120 Days (4 months)	
Facility security levels/resident custody levels	Minimum	
Number of residents admitted to facility during the past 12 months	135	
Number of residents admitted to facility during the past 12 months whose length of stay in the facility was for 72 hours or more:	135	
Number of residents admitted to facility during the past 12 months whose length of stay in the facility was for 30 days or more:	124	
Does the audited facility hold residents for one or more other agencies (e.g. a State correctional agency, U.S. Marshals Service, Bureau of Prisons, U.S. Immigration and Customs Enforcement)?	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
<p>Select all other agencies for which the audited facility holds residents: Select all that apply (N/A if the audited facility does not hold residents for any other agency or agencies):</p>	<input checked="" type="checkbox"/> Federal Bureau of Prisons <input type="checkbox"/> U.S. Marshals Service <input type="checkbox"/> U.S. Immigration and Customs Enforcement <input type="checkbox"/> Bureau of Indian Affairs <input type="checkbox"/> U.S. Military branch <input type="checkbox"/> State or Territorial correctional agency <input type="checkbox"/> County correctional or detention agency <input type="checkbox"/> Judicial district correctional or detention facility <input type="checkbox"/> City or municipal correctional or detention facility (e.g. police lockup or city jail) <input type="checkbox"/> Private corrections or detention provider <input type="checkbox"/> Other - please name or describe: Click or tap here to enter text. <input type="checkbox"/> N/A	
Number of staff currently employed by the facility who may have contact with residents:	18	
Number of staff hired by the facility during the past 12 months who may have contact with residents:	3	

Number of contracts in the past 12 months for services with contractors who may have contact with residents:	1
Number of individual contractors who have contact with residents, currently authorized to enter the facility:	1
Number of volunteers who have contact with residents, currently authorized to enter the facility:	0
Physical Plant	
<p>Number of buildings:</p> <p>Auditors should count all buildings that are part of the facility, whether residents are formally allowed to enter them or not. In situations where temporary structures have been erected (e.g., tents) the auditor should use their discretion to determine whether to include the structure in the overall count of buildings. As a general rule, if a temporary structure is regularly or routinely used to hold or house residents, or if the temporary structure is used to house or support operational functions for more than a short period of time (e.g., an emergency situation), it should be included in the overall count of buildings.</p>	2
<p>Number of resident housing units:</p> <p>Enter 0 if the facility does not have discrete housing units. DOJ PREA Working Group FAQ on the definition of a housing unit: How is a "housing unit" defined for the purposes of the PREA Standards? The question has been raised in particular as it relates to facilities that have adjacent or interconnected units. The most common concept of a housing unit is architectural. The generally agreed-upon definition is a space that is enclosed by physical barriers accessed through one or more doors of various types, including commercial-grade swing doors, steel sliding doors, interlocking sally port doors, etc. In addition to the primary entrance and exit, additional doors are often included to meet life safety codes. The unit contains sleeping space, sanitary facilities (including toilets, lavatories, and showers), and a dayroom or leisure space in differing configurations. Many facilities are designed with modules or pods clustered around a control room. This multiple-pod design provides the facility with certain staff efficiencies and economies of scale. At the same time, the design affords the flexibility to separately house residents of differing security levels, or who are grouped by some other operational or service scheme. Generally, the control room is enclosed by security glass, and in some cases, this allows residents to see into neighboring pods. However, observation from one unit to another is usually limited by angled site lines. In some cases, the facility has prevented this entirely by installing one-way glass. Both the architectural design and functional use of these multiple pods indicate that they are managed as distinct housing units.</p>	4
Number of single resident cells, rooms, or other enclosures:	0
Number of multiple occupancy cells, rooms, or other enclosures:	0
Number of open bay/dorm housing units:	4
Does the facility have a video monitoring system, electronic surveillance system, or other monitoring technology (e.g. cameras, etc.)?	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Has the facility installed or updated a video monitoring system, electronic surveillance system, or other monitoring technology in the past 12 months?	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No

Medical and Mental Health Services and Forensic Medical Exams

Are medical services provided on-site?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Are mental health services provided on-site?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Where are sexual assault forensic medical exams provided? Select all that apply.	<input type="checkbox"/> On-site <input checked="" type="checkbox"/> Local hospital/clinic <input type="checkbox"/> Rape Crisis Center <input type="checkbox"/> Other (please name or describe: Click or tap here to enter text.)

Investigations

Criminal Investigations

Number of investigators employed by the agency and/or facility who are responsible for conducting CRIMINAL investigations into allegations of sexual abuse or sexual harassment:	0
When the facility received allegations of sexual abuse or sexual harassment (whether staff-on-resident or resident-on-resident), CRIMINAL INVESTIGATIONS are conducted by: Select all that apply.	<input type="checkbox"/> Facility investigators <input type="checkbox"/> Agency investigators <input checked="" type="checkbox"/> An external investigative entity
Select all external entities responsible for CRIMINAL INVESTIGATIONS: Select all that apply (N/A if no external entities are responsible for criminal investigations)	<input checked="" type="checkbox"/> Local police department <input checked="" type="checkbox"/> Local sheriff's department <input type="checkbox"/> State police <input checked="" type="checkbox"/> A U.S. Department of Justice component <input type="checkbox"/> Other (please name or describe: Click or tap here to enter text.) <input type="checkbox"/> N/A

Administrative Investigations

Number of investigators employed by the agency and/or facility who are responsible for conducting ADMINISTRATIVE investigations into allegations of sexual abuse or sexual harassment?	0
When the facility receives allegations of sexual abuse or sexual harassment (whether staff-on-resident or resident-on-resident), ADMINISTRATIVE INVESTIGATIONS are conducted by: Select all that apply	<input type="checkbox"/> Facility investigators <input type="checkbox"/> Agency investigators <input checked="" type="checkbox"/> An external investigative entity
Select all external entities responsible for ADMINISTRATIVE INVESTIGATIONS: Select all that apply (N/A if no external entities are responsible for administrative investigations)	<input type="checkbox"/> Local police department <input type="checkbox"/> Local sheriff's department <input type="checkbox"/> State police <input checked="" type="checkbox"/> A U.S. Department of Justice component <input type="checkbox"/> Other (please name or describe: Click or tap here to enter text.) <input type="checkbox"/> N/A

Audit Findings

Audit Narrative

The auditor's description of the audit methodology should include a detailed description of the following processes during the pre-onsite audit, onsite audit, and post-audit phases: documents and files reviewed, discussions and types of interviews conducted, number of days spent on-site, observations made during the site-review, and a detailed description of any follow-up work conducted during the post-audit phase. The narrative should describe the techniques the auditor used to sample documentation and select interviewees, and the auditor's process for the site review.

The Florence Residential Re-Entry Center (FRRC) is located in Florence, South Carolina. The onsite audit phase of the Prison Rape Elimination Act (PREA) audit was conducted on August 19, 2019 by Cheryl Anderson, a certified U. S. Department of Justice PREA Auditor. The facility's initial PREA audit was completed with a written report in August 2016. The current audit was attained and assigned to the Auditor by Correctional Management and Communications Group, LLC of Minneola, Florida.

The FRRC is a 37-bed minimum security level facility and houses adult female and adult male residents. The parent agency is Alston Wilkes Society (AWS). The agency is a multistate nonprofit organization that provides those most at risk with hope for a brighter future. AWS gives hope and rebuilds lives through rehabilitative and prevention services. The agency was founded in 1962 as a nonprofit organization led by a group of dedicated volunteers working under the direction of the Reverend Eli Alston Wilkes, Jr. Rev. Wilkes was a Methodist minister who labored as a tireless and devoted worker in helping those less fortunate. Today, the Alston Wilkes Society is providing direct services in North and South Carolina to not only offenders, but also the homeless, at-risk youth, veterans, and families in crisis.

The FRRC house federal offenders through contracts with the Federal Bureau of Prisons. AWS provides 24-hour supervision, housing, food, and intense case management. Many reentry programs are offered to help residents make a smooth transition back into the community. Such programs include parenting classes, life skills training, cultural diversity training, money management classes, and substance abuse counseling.

There are no known existing conflicts of interest with the Auditor and the facility and there were no barriers in completing any phase of the audit.

Audit Methodology

Pre-Onsite Audit Phase

The notifications of the on-site audit which provided Auditor contact information were posted six weeks prior to the audit. The postings of the notices were verified by photographs received electronically from the Facility Director, who also serves as the Agency PREA Coordinator. The photographs indicated notices were posted in various locations throughout the facility including the housing areas, dining areas, and administrative areas. The audit notice was posted using large print that was easy to see and read. The notices were strategically placed throughout the facility, accessible to residents, staff, and visitors. 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 their placement was made through observations during the site review. The original notice was provided to the facility by the Director of Human Resources and had previously been provided by CMCG to the Director of Human Resources. The notice was posted in English at eye levels easy for a person to see either standing or sitting. All residents in the facility during the time of the site visit spoke and read English.

The Pre-Audit Questionnaire (PAQ), completed July 29, 2019, policies and supporting documentation were received within an adequate timeframe prior to the onsite visit for review. The documents were uploaded to a USB flash drive. The initial review revealed the flash drive was well-organized and easy to navigate. Any additional information needed was discussed with the PREA Coordinator and was received within a timely manner or available for review during the onsite visit.

The Director of Human Resources had been previously provided a document by CMCG titled, “Information Requested to Determine Staff and Residents to be Interviewed During the On-Site PREA Audit.” The document was forwarded to the Agency’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 to confirm schedules and to clarify specialized PREA roles. A current resident 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 and 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.
Youthful inmates/detainees	Youthful pre-trial/probation residents are not housed in this facility.
Residents with disabilities	None were identified.
Residents who are Limited English Proficient	One was interviewed.
LGBTI Residents	None were identified.
Residents in segregated housing	There is no segregated housing.
Residents in Isolation	There is no isolation.
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	None
Volunteer who has contact with the residents	None
All grievances/allegations made in the 12 months preceding the audit	None
All allegations of sexual abuse and sexual harassment reported for investigation in the 12 months preceding the audit	None
Hotline calls made during the 12 months preceding the audit	None
Detailed list of number of sexual abuse and sexual harassment allegations in the 12 months preceding the audit	The facility reported there was one allegation 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 in development of the interview schedule to ensure clarity regarding specialized PREA roles among staff.

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. An array of information, pictures of the facility and contact information may be accessed from the informative page. 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 August 2016 is located on the website and it also contains the third-party reporting form.

Onsite Audit Phase

The PREA Auditor arrived onsite during the early morning hours in order to interview staff members on the overnight shift and observe early morning operations. An entrance meeting was conducted with the Human Resource Director, PREA Coordinator/Facility Director, and Quality Assurance Coordinator. Formal introductions were made and a review of the audit process, site visit activities and the itinerary were reviewed. Direct care/random staff members working the overnight shift were interviewed immediately upon the conclusion of the meeting to reduce the accrual of overtime hours.

Upon completion of the entrance meeting and overnight staff interviews, a comprehensive tour of the facility was conducted and led by the PREA Coordinator/Facility Director. The tour included all areas of the facility. 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 two buildings. The staff was observed providing direct supervision to the residents. The resident population on the first day of the onsite audit was 26.

During the tour, the printed notifications of the PREA on-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 and in English and Spanish. The facility was clean and well maintained. Staff announce themselves prior to entering the housing area of the opposite gender.

The posted information includes instructions on accessing the 24/7 hotline for reporting allegations and requesting advocacy services for Pee Dee Coalition (rape crisis center). A Memorandum of Understanding (MOU) exists with Pee Dee Coalition to receive allegations of sexual abuse and sexual harassment and for the provision of advocacy services upon request. The victim's advocacy service, Pee Dee Coalition, was contacted to determine the scope of services provided. A live person responded to the call and indicated no calls had been received from FRRC residents over the past 12 months. The conversation with the Pee Dee Coalition staff confirmed the advocacy services to be provided in accordance with the MOU.

Documentation and interview with the Facility Director confirmed forensic medical examinations are performed at the McLeod Medical Center Emergency Room. 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.

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

Residents were observed in the dayrooms of their living units, cleaning the grounds, in the recreational area, and in the visitation area. Telephones were observed in each living unit for reporting allegations of sexual abuse and sexual harassment; the telephones were checked by the Auditor and were in good 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.

Staff must announce their presence to alert the residents of the opposite gender that they are entering the housing unit. All residents interviewed stated the staff members do announce their presence prior to entering the housing unit. This practice was experienced and observed during the comprehensive tour.

Visibility is enhanced with the strategic use of cameras, mirrors and windows in doors. There are no cameras in bathrooms and reasonable privacy is provided to residents when they use the toilet, change clothes and shower. The shower procedures are printed and posted at the entrance of the bathroom on each unit.

Medical Request Forms, PREA forms, and the locked boxes for each are posted in the common area, accessible to all residents, staff and visitors. All residents have access to writing utensils needed for completing the forms. Signage was posted which indicated where residents were not allowed or only allowed with staff supervision. The doors to closets and storage rooms are kept locked.

Interviews

Eighteen staff members are currently employed at the facility that may have contact with residents. During the on-site visit, twelve random staff members were interviewed that covered all shifts and five individual specialized staff members were interviewed based on their job duties and PREA roles. The interviews revealed staff are knowledgeable of PREA standards and were able to articulate their responsibilities based on their job duties and PREA roles; however, most staff were not aware of the services provided by the victims' advocacy services. Staff took corrective action and conducted an education session to review the services provided by the victims' advocacy service. A staff signature roster verifying the actions taken was sent to the Auditor. The Agency Head was interviewed; however, they are not counted as specialized staff. Although five individuals were identified for specialized interviews, the specialized interviews conducted totaled eight due to staff members in this category serving in more than one PREA related specialized role. A total of 26 residents were in the facility during the site visit. Ten residents were interviewed as listed on the facility population report. The interviews revealed the residents were informed of their right to be free from sexual abuse and sexual harassment and how to report sexual abuse and sexual harassment, however, most residents were not aware of the services provided by the victims' advocacy services. The Facility Director/PREA Coordinator contacted the victim's advocacy service provider, Pee Dee Coalition, who agreed to conduct an education session to review the services provided by Pee Dee Coalition. Documentation of the session conducted was provided to the Auditor which included a roster signed by the residents. A previous inquiry was made regarding vulnerable categories within the residents' population related to the selection of targeted interviews. There were two targeted residents interviewed at this facility during this auditing cycle. The interviews revealed the agency take appropriate steps to ensure that vulnerable residents 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.

The training records of staff interviewed, and the files of residents interviewed were reviewed along with policies and other secondary documentation. The Auditor reviewed staff and contractors training records to ensure that all required training had been completed. The Auditor also reviewed staff personnel files related to completed investigations and disciplinary actions taken regarding PREA related allegations. There was one allegation of sexual abuse and/or sexual harassment within the facility in the past 12 months. A file review revealed it was handled administratively.

The interviews with residents and staff indicated their receipt of PREA training, which was also verified by a review of documentation, including training materials. Staff and residents' interviews were conducted by the Auditor and the interviews conducted onsite were done in the privacy of office space.

The Auditor conducted ten resident interviews in the following categories during the onsite phase of the audit:

Category of Residents	Number of Interviews
Random Residents	10
Residents who Identify as Gay or Bisexual	1
Residents with a Cognitive Disability	1
Residents with Physical Disability	0

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

Category of Staff	Number of Interviews
Medical Staff	0
Mental Health Staff	0
Non-medical involved in cross-gender search	1
Administrative (Human Resources) Staff	1
Intermediate or Higher-level Facility Staff	1
Volunteers who have Contact with Residents	0
Contractors who have Contact with Residents	0
Investigative Staff	0
Staff who Perform Screening for Risk of Victimization and Abusiveness	1
Staff on the Incident Review Team	1
Designated Staff Member Charged with Monitoring Retaliation	1
Non-Security Staff First Responders	1
Intake Staff	1
Number of Specialized Staff Interviews	8
Number of Random Staff Interviews	12
Total Random and Specialized Interviews	20
Total Interviews plus PREA Coordinator and Facility Director	21

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 Vulnerability Assessments; PREA Form; Medical Request Form; PREA education and training acknowledgement forms; training records; checklists; sexual abuse coordinated response plan; annual staffing plan assessment; staff schedules; retaliation monitoring form; organization chart; and other documentation. The facility reports there was one allegation of sexual abuse or sexual harassment in the past 12 months.

After the completion of the site visit process, an exit briefing was held in the common area of the Annex building (female dorm). The attendees were the Human Resource Director, Facility Director/PREA Coordinator, and Quality Assurance Coordinator. The exit briefing served to review the onsite process and review program strengths. The facility and Alston Wilkes Society 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 Facility Director/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. The report was submitted to the Human Resource Director to be reviewed and subsequently forwarded to the facility.

After corrective actions were addressed, the facility was found to be in compliance with all applicable standards as indicated below and detailed throughout this report.

Facility Characteristics

The auditor's description of the audited facility should include details about the facility type, demographics and size of the residents, resident or detainee population, numbers and type of staff positions, configuration and layout of the facility, numbers of housing units, description of housing units including any special housing units, a description of programs and services, including food service and recreation. The auditor should describe how these details are relevant to PREA implementation and compliance.

The FRRRC is a 37-bed minimum security level facility and houses adult female and adult male residents. The parent agency is Alston Wilkes Society (AWS). The agency is a multistate nonprofit organization that provides those most at risk with hope for a brighter future. AWS gives hope and rebuilds lives through rehabilitative and prevention services. The agency was founded in 1962 as a nonprofit organization led by a group of dedicated volunteers working under the direction of the Reverend Eli Alston Wilkes, Jr. Rev. Wilkes was a Methodist minister who labored as a tireless and devoted worker in helping those less fortunate. Today, the Alston Wilkes Society is providing direct services in North and South Carolina to not only offenders, but also the homeless, at-risk youth, veterans, and families in crisis.

The FRRRC house federal offenders through contracts with the Federal Bureau of Prisons. AWS provides 24-hour supervision, housing, food, and intense case management. Many reentry

programs are offered to help residents make a smooth transition back into the community. Such programs include parenting classes, life skills training, cultural diversity training, money management classes, and substance abuse counseling.

The FRRC offers residents access to books, various reading materials, computers, exercise equipment, case management, counseling, and vocational education. The job placement staff refers residents to various employment options and assists them with obtaining such items as birth certificates, social security cards, as well as a driver's license. The average length of stay is approximately 90 days. One hundred and thirty-five residents have been admitted to the FRRC in the past 12 months. The FRRC is in a commercial and residential neighborhood with access to public transportation and other community-based resources. The facility consists of four buildings. (1) The Annex is the newest addition and was constructed in 2014. It consists of a control room, Employment and Placement Specialist office, common area with TV and computer, small gym area, staff restroom, female laundry room, mechanical room, and female dorm with five beds, bathroom/single-stall shower area and utility room. (2) A storage shed which is notated as off-limits to residents. (3) An outer building (attached to the main building) utilized as indoor recreation and weight room. (4) The Main building, which houses the male residents was a warehouse converted to residential use in 2003. There is a staff office inside the front entrance, which is the control room, which allows for monitoring the entrance, the main hallway, staff restroom, and visiting room. This building has a recreation room, a dining area/multi-purpose room, administrative offices, three dormitories and a laundry room. Dorm 1 has six beds, two single-stall showers, one toilet, and dining room, Dorm 2 has 22 beds, handicap bathroom, three single-stall shower rooms, male laundry room, two Case Manager offices, maintenance office, Facility Director's office/clothing closet, and main camera monitor. Dorm 3 has two beds. Both, the male resident and female resident buildings consist of open-bay style dormitories. The dormitories have double bunks and locker space for the residents. There is no camera access to the bathrooms. Residents can change clothes, shower and use the toilet without being viewed by staff of the opposite gender. There is a reasonable amount of privacy. The FRRC is equipped with a video surveillance system which includes 26 cameras.

Direct care staff/random staff are responsible for the daily and direct supervision of residents and manage them during their daily activities. The camera monitoring system, in addition to mirrors, support the direct supervision provided by staff.

There is a host of management, supervisory, and support staff members who provide oversight of or participation in processes and activities that contribute to the facility operations. Allegations that are criminal in nature are investigated by the Florence County Sheriff's Office or the Florence Police Department as confirmed through interviews.

The resident interviews, documentation and observations confirmed the provision of the programs and services described. The residents indicated they could communicate with their family through telephone calls and visits. Observations during the comprehensive site review revealed adequate space for conducting the programs and services described. There is enough space to accommodate visitation and meetings in private, as needed. The facility provides supervision of the residents in a safe, secure and humane environment. The facility operates

with a total of eighteen full time employees including an Administrative Staff, three Program Staff, and 14 Direct Care Staff.

Summary of Audit Findings

The summary should include the number and list of standards exceeded, number of standards met, and number and list of standards not met.

Auditor Note: *No standard should be found to be “Not Applicable” or “NA”. A compliance determination must be made for each standard.*

Standards Exceeded

Number of Standards Exceeded: 0
List of Standards Exceeded: N/A

Standards Met

Number of Standards Met: 41

Standards Not Met

Number of Standards Not Met: 0
List of Standards Not Met: N/A

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.

FRRRC meets the requirements of this standard based upon the following evidence:

Documentation Reviewed:
PREA Pre-Audit Questionnaire

Agency/Facility Policy and Procedures 3.4, Workplace Commitment and Expectations/PREA
Organizational Chart
PREA Coordinator's Job Description
2018 Annual Report

Interviews:

Human Resource Director
Facility Director/PREA Coordinator
Random Staff
Residents

Provision (a):

An agency shall have a written policy mandating zero tolerance toward all forms of sexual abuse and sexual harassment and outlining the agency's approach to preventing, detecting, and responding to such conduct.

The facility Policy mandates a zero-tolerance policy toward all forms of sexual abuse and sexual harassment. The policy outlines the facility's approach to preventing, detecting, and responding to such conduct. The policy includes definitions of prohibited behaviors regarding sexual abuse and sexual harassment and includes sanctions for those found to have participated in prohibited behaviors. The Policy provides for the appointment of a PREA Coordinator by the Agency Executive Director.

The Policy addresses detection of sexual abuse and sexual harassment through resident education, staff training, and intake screening for risk of sexual victimization and abusiveness. The Policy includes but is not limited to responding to sexual abuse and sexual harassment through reporting, investigations, assessments, crisis intervention, and disciplinary sanctions for residents and staff.

Provision (b):

An agency shall employ or designate an upper-level, agency-wide PREA 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 organizational chart shows the Facility Director/PREA Coordinator reports directly to the Human Resource Director as confirmed by staff interviews. The interview with the PREA Coordinator and observations revealed she has the time and authority to perform her PREA duties.

The evidence shows the facility has designated an upper-level position of PREA Coordinator as verified through the organization chart; Policy; Facility Director Job Description; review of the PREA Pre-Audit Questionnaire; and the interviews with the Facility Director/PREA Coordinator and random staff. The PREA Coordinator has demonstrated she has sufficient time and authority to accomplish her PREA related responsibilities.

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.) 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.

FRRC meets the requirements of this standard based upon the following evidence:

Documentation Reviewed:

PREA Pre-Audit Questionnaire

Interviews:

Agency Executive Director
Human Resource Director
Facility Director/PREA Coordinator

Provision (a):

A public agency that contracts for the confinement of its residents with private agencies or other entities, including other government agencies, shall include in any new contract or contract renewal the entity's obligation to adopt and comply with the PREA standards.

The FRRC houses only federal residents as a result of a contractual agreement between the federal Bureau of Prisons (BOP) and Alston Wilkes Society. The residents are under the authority of the United States Bureau of Prisons and any form of resident transfer or other confinement is in coordination and direction of the federal Bureau of Prisons and to a certain extent the United States Probation Office. The agency does not contract with other entities for the confinement of residents.

Provision (b):

Any new contract or contract renewal shall provide for agency contract monitoring to ensure that the contractor is complying with the PREA standards.

FRRC does not contract for the confinement of its residents.

Conclusion:

Based upon the review and analysis of the documentation, the Auditor has determined the facility does not contract for the confinement of its 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 facility have a documented staffing plan that provides for adequate levels of staffing and, where applicable, video monitoring, to protect residents against sexual abuse?
 Yes No

- In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: The physical layout of each facility? Yes No
- In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: The composition of the resident population? Yes No
- In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: The prevalence of substantiated and unsubstantiated incidents of sexual abuse? Yes No
- In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: Any other relevant factors? 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.

FRRC meets the requirements of this standard based upon the following evidence:

Documentation Reviewed:

PREA Pre-Audit Questionnaire
Agency/Facility Policy and Procedures, H1303 PREA Policy
Staffing Plan
Staffing Plan Assessment
Monthly Schedule
Resident Daily Roster

Interviews:

Human Resource Director
Facility Director/PREA Coordinator

Provision (a):

The facility shall have a documented staffing plan that provides for adequate levels of staffing, and, where applicable, video monitoring, to protect residents against sexual abuse. In calculating adequate staffing levels and determining the need for video monitoring, facilities shall take into consideration:

- (1) The physical layout of each facility;
- (2) The composition of the resident population;
- (3) The prevalence of substantiated and unsubstantiated incidents of sexual abuse; and
- (4) Any other relevant factors.

Facility Policy provides that the camera system is monitored constantly, and the provisions of the standard are taken into consideration regarding adequate staffing levels as confirmed through the interview with the Facility Director, review of staffing plan and observations. The work schedules are based on the staffing plan and facility policy.

Provision (b):

In circumstances where the staffing plan is not complied with, the facility document and justify all deviations from the plan.

The agency shall comply with the staffing plan except during limited and discrete exigent circumstances and shall fully document deviations from the plan during such circumstances.

The Agency Policy states in the event that the staffing plan is unable to be maintained during exigent circumstances, the deviation must be documented. The facility documents any deviations from the staffing plan.

The staffing plan is based upon the facility's capacity of 37 residents. The facility's Policy requires the facility to document deviations from the staffing plan on the Shift Report; however, the facility uses an emergency call-in plan for coverage as needed; however, by moving to 12 hour shifts, the facility has been short staffed and there has been a delay in hiring. The facility was appropriately staffed during this audit cycle.

Provision (c):

Whenever necessary, but no less frequently than once each year, the facility shall assess, determine, and document whether adjustments are needed to:

- (1) The staffing plan established pursuant to paragraph (a) of this section;
- (2) Prevailing staffing patterns;
- (3) The facility's deployment of video monitoring systems and other monitoring technologies; and
- (4) The resources the facility has available to commit to ensure adequate staffing levels.

Documentation of the annual assessment of the staffing plan dated August 8, 2019 was reviewed and found to be in compliance with all elements contained in (c)-1 of this standard.

The Agency Policy and Staffing Plan mandates that the Alston Wilkes Society will provide staffing and monitoring at facilities in accordance with contractual and PREA obligations. These plans will be evaluated at minimum annually.

The staffing plan outlines the minimum number of staff required for the program during the two shifts, seven days per week. The facility utilizes direct staff supervision and video monitoring to protect residents from sexual abuse and sexual harassment.

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 the facility does not have female 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 the facility does not have female 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? (N/A if the facility does not have female residents). Yes No NA

115.215 (d)

- Does the facility have policies 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 have procedures that enables 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.

FRRC meets the requirements of this standard based upon the following evidence:

Documentation Reviewed:

PREA Pre-Audit Questionnaire
Agency/Facility Policy and Procedures, PREA Policy
Training Curriculum
Training Acknowledgement Statements
Training Sign-in Sheet

Interviews:

Facility Director/PREA Coordinator
Random Staff
Random Residents

Provision (a):

The facility shall not conduct cross-gender strip searches or cross-gender visual body cavity searches (meaning a search of the anal or genital opening) except in exigent circumstances or when performed by medical practitioners.

Agency policy prohibit cross-gender strip searches and cross-gender visual body cavity searches. There is no evidence of cross-gender strip searches or cross-gender visual body cavity searches occurring at the facility. Based on the review of the Pre-audit questionnaire and according to the Facility Director, no such searches have been conducted.

Provision (b):

The agency shall not conduct cross-gender pat-down searches except in exigent circumstances.

Agency policy prohibit cross-gender strip searches and cross-gender visual body cavity searches. There is no evidence of cross-gender strip searches or cross-gender visual body cavity searches occurring at the facility. Based on the review of the Pre-audit questionnaire and according to the Facility Director, no such searches have been conducted.

Provision (c):

The facility shall document and justify all cross-gender strip searches, cross-gender visual body cavity searches, and cross-gender pat-down searches.

Agency policy prohibit cross-gender strip searches and cross-gender visual body cavity searches. There is no evidence of cross-gender strip searches or cross-gender visual body cavity searches occurring at the facility. Based on the review of the Pre-audit questionnaire and according to the Facility Director, no such searches have been conducted.

Provision (d):

The facility shall 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. Such policies and procedures shall require staff of the opposite gender to announce their presence when entering a resident housing unit.

Agency policy states the facility will enable residents to shower, perform bodily functions, and change clothes without non-medical staff of the opposite gender viewing them except in exigent circumstances or during routine room checks. Staff members of the opposite gender are required to announce themselves upon entering the unit. This practice was confirmed through observation of signage indicating such, observations and interviews with residents and staff. No residents interviewed reported ever having been naked in full view of opposite gender staff while showering, changing clothing, and performing bodily functions. The evidence shows residents shower, perform bodily functions, and change clothing without nonmedical staff of the opposite gender viewing their breasts, buttocks, or genitalia.

Based on the review of the documentation, staff and resident interviews, and observations, the facility follows this provision of the standard. Additionally, viewing of the cameras and staff and resident interviews confirmed that residents are not directly viewed by staff when showering, using the toilet or changing clothes.

Provision (e):

The facility shall not search or physically examine a transgender or intersex resident for the sole purpose of determining the resident's genital status. If the resident's genital status is unknown, it may be determined 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.

Agency policy prohibits the search of transgender or intersex residents solely for the purpose of determining the residents' genital status and staff interviews verified no such searches have occurred in the past 12 months. According to the Policy, if the resident's genital status is unknown, it may be determined during conversations with the resident, by reviewing medical records, or by learning that information as part of a broader medical examination conducted in private by a medical practitioner. One hundred percent of direct care staff received the training on conducting cross-gender pat-down searches and searches of transgender and intersex

residents. Staff interviews confirmed they are aware facility policy prohibits them from conducting a physical examination of transgender or intersex resident solely for the purpose of determining the resident's genital status. Based on the documentation reviewed and staff interviews, the facility meets this provision of the standard.

Provision (f):

The agency shall train security staff in how to conduct cross-gender pat-down searches, and searches of transgender and intersex residents, in a professional and respectful manner, and in the least intrusive manner possible, consistent with security needs.

Agency policy states that staff shall be trained in how to conduct cross-gender pat-down searches, and searches of transgender and intersex residents, in a professional and respectful manner, and in the least intrusive manner possible, consistent with security needs. The documentation and staff interviews support the training is conducted at least annually. Training participation is documented with sign-in sheets and training acknowledgement forms. The evidence shows staff are trained in how to conduct cross-gender pat-down searches, and searches of transgender and intersex residents, in a professional and respectful manner, and in the least intrusive manner possible, consistent with security needs.

Conclusion:

Based on the reviewed documentation and interviews, the facility follows this provision of the 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.

FRRRC meets the requirements of this standard based upon the following evidence:

Documentation Reviewed:

PREA Pre-Audit Questionnaire
Agency/Facility Policy and Procedures, H1301 PREA Policy
Palmetto Interpreters Contract

Interviews:

Human Resource Director
Facility Director/PREA Coordinator
Random Staff

Provision (a):

The agency shall take appropriate steps to ensure that residents with disabilities (including, for example, residents who are deaf or hard of hearing, those who are blind or have low vision, or those who have intellectual, psychiatric, or speech 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. Such steps shall include, when necessary to ensure effective communication with residents who are deaf or hard of hearing, providing access to interpreters who can interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary. In addition, the agency shall 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, limited reading skills, or who are blind or have low vision.

The facility Policy addresses the provision of support services for disabled residents by providing these residents the equal opportunity to participate in or benefit from all aspects of the facility's efforts to prevent, detect, and respond to sexual abuse and sexual harassment. The Policy prohibits use of resident interpreters, resident readers, or other types of resident assistants except in limited circumstances where an extended delay in obtaining an effective interpreter could compromise the resident's safety, performance of first responder duties, or the investigation of the allegations. Staff interviews confirmed that residents have access to Palmetto Interpreters which offers interpreter services. Per agency policy, "in the event of residents, who are limited English proficient, an interpreter will be provided to them at no cost to the resident". The Facility Director reported zero incidents in the past 12 months where residents required interpreters.

Provision (b):

The agency shall 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, including steps to provide interpreters who can interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary.

A contract with Palmetto Interpreters is in place. The evidence shows residents with disabilities and who may be 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. All staff interviewed confirmed residents are not used as interpreters and understand prior arrangements have been made regarding language interpreters. The PREA audit notice was printed in bold print on colored paper to be seen and read by all. The evidence shows the facility ensures 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, including taking steps to provide interpreters who can interpret effectively, accurately, and impartially, using any necessary specialized vocabulary.

Provision (c):

The agency shall 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 performance of first-response duties under § 115.264, or the investigation of the resident's allegations.

According to Agency Policy, the facility prohibits the use of resident interpreters, resident readers or any kind of resident assistants except when a delay in obtaining interpreter services could jeopardize a resident's safety, performance of the first responder duties, or the investigation of the allegation. Staff interviews confirmed residents have not been used to relate PREA information to or from other residents in the past 12 months. There were no residents in need of an interpreter during the site visit.

Conclusion:

Based upon the review and analysis of the evidence, the Auditor has determined the facility is compliant with this standard regarding residents with disabilities and residents who are limited

English Proficient. One targeted resident was interviewed and confirmed that 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 who may have contact with residents? Yes No
- Does the agency consider any incidents of sexual harassment in determining whether 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)

- 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.

FRRC meets the requirements of this standard based upon the following evidence:

Documentation Reviewed:

PREA Pre-Audit Questionnaire
Agency/Facility Policy and Procedures, PREA Policy
Personnel Files

Interviews:

Human Resource Director
Facility Director/PREA Coordinator

Provision (a) & (f):

(a) The agency shall not hire or promote anyone who may have contact with residents, and shall not enlist the services of any contractor who may have contact with residents, who—

(1) 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);

(2) 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

(3) Has been civilly or administratively adjudicated to have engaged in the activity described in paragraph (a)(2) of this section.

(f) The agency shall 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 and in any interviews or written self-evaluations conducted as part of reviews of current employees. The agency shall also impose upon employees a continuing affirmative duty to disclose any such misconduct.

Facility Policy addresses hiring and promotion processes and decisions and background checks. The Policy is aligned with the requirements of the provisions of the standard and provides background checks occur prior to employment and every five years thereafter. Initial background checks and five-year checks were reviewed while on site. Additional personnel information reviewed during the pre-audit and the onsite audit phases included: Pre-Hire Interview

Questions; New Hire Application Packet; Applications. The interview with the Facility Director and a review of Policy provide details about the hiring process, completion of background checks, and the grounds for termination in accordance with the PREA standard. According to the interview, staff has a continuing duty to report related misconduct and omission of sexual misconduct or providing false information will be grounds for termination. The forms completed and included in the personnel files are in response to the above provisions of this standard.

According to facility Policy, all applicants are asked about any prior misconduct involving any sexual activity. In addition, FIRC shall not hire or promote anyone who has been civilly or administratively adjudicated to have been convicted of engaging in or attempted to engage in sexual activity by any means. Also, FIRC does not hire anyone who has engaged in sexual abuse in a prison, jail, community confinement facility, or anyone, who has used or attempted to use force in the community to engage in sexual abuse.

Provision (b):

The agency shall 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.

The facility Policy states any incidents of sexual harassment by a staff member will be taken into consideration if the staff member is eligible for promotion. The interview with the Facility Director was aligned with the standard. The interview questions for employment also address previous misconduct. The evidence shows the facility 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. Based on the review of the personnel files, records provided during the pre-audit phase, and the interview with the Facility Director, the facility follows this provision of the standard.

Provisions (c) & (d):

(c) Before hiring new employees or (d) contractors who may have contact with residents, the agency shall:

- (1) Perform a criminal background records check;
- (2) and 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.

The policy requires background checks to occur prior to residents receiving services from contractors and volunteers and confirmed by the Human Resource Director's interview. Additionally, best efforts should be made 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. Based on the review of documentation and interview with the Human Resource Director, the facility follows this provision of the standard.

Provision (e):

The agency shall 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.

The Policy is aligned with the requirements of the provisions of the standard and provides background checks occur prior to employment and every five years thereafter. Initial background checks and five-year checks were reviewed while onsite and during the pre-audit phase. This was also confirmed during the Human Resource Director's interview. Based on the review of documentation and the interview, the evidence shows the facility practices are aligned with the provisions of this standard.

Provision (g):

Material omissions regarding such misconduct, or the provision of materially false information, shall be grounds for termination.

Facility Policy states material omissions regarding such misconduct, or the provision of materially false information, shall be grounds for termination. Based on the review of the documentation and the interview with the Facility Director, the evidence shows the facility follows this provision of the standard.

Provision (h):

Unless prohibited by law, the agency shall 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.

The interview with the Human Resource Director confirmed the facility would provide this information if requested to do so. Facility Policy states the information would be provided when requested unless it is prohibited by law to provide the information.

Conclusion:

Based upon the review and analysis of the available evidence, the Auditor has determined the facility is compliant with the provisions of the standard regarding hiring and promotion decisions.

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.

FRRC meets the requirements of this standard based upon the following evidence:

Documentation Reviewed:

PREA Pre-Audit Questionnaire
Agency/Facility Policy and Procedures, PREA Policy
Schematic and Camera Placement

Interviews:

Human Resource Director
Facility Director/PREA Coordinator

The interview with the Facility Director and according to the Pre-Audit Questionnaire, no substantial modification to the facility occurred since the last PREA audit in 2016. Facility Policy states that when there is substantial expansion to the facility, the ability to protect residents and staff from sexual abuse will be reviewed and ensured.

Facility Policy provides that when installing or updating a video monitoring system, electronic surveillance system, or other monitoring technology, the agency considers how such technology may enhance the agency's ability to protect residents from sexual abuse. The auditor noted that the facility added and updated the video monitoring system to total 26 cameras located throughout the facility.

Conclusion:

Based upon the review and analysis of the available evidence, the Auditor has determined the facility is compliant with the provisions of the standard regarding hiring and promotion decisions.

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? (N/A if agency *always* makes a victim advocate from a rape crisis center available to victims.) Yes No NA
- 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 agency 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? (N/A if agency *always* makes a victim advocate from a rape crisis center available to victims.) 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.

FRRC meets the requirements of this standard based upon the following evidence:

Documentation Reviewed:

PREA Pre-Audit Questionnaire

Agency/Facility Policy and Procedures H809, PREA Policy

Memorandum of Understanding (MOU), Pee Dee Coalition

Memorandum of Understanding (MOU), McLeod Medical Center

PREA Poster

Interviews:

Human Resource Director

Facility Director/PREA Coordinator

Direct Care Staff

Provisions (a) & (b):

(a) To the extent the agency is responsible for investigating allegations of sexual abuse, the agency shall follow a uniform evidence protocol that maximizes the potential for obtaining usable physical evidence for administrative proceedings and criminal prosecutions.

(b) The protocol shall be developmentally appropriate for youth and, as appropriate, shall be 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.

Facility Policy provides the Protocol is outlined regarding appropriateness for youth and adults. The Protocol, developed by related professionals, addresses but is not limited to interviewing; evidence collection; victim services; notifications; and prosecution of sexual assault cases. The Federal Bureau of Prisons (BOP) conduct all administrative and criminal investigations for the allegations of sexual abuse. The BOP agrees to follow the Agency's Protocol. Staff interviews confirmed an understanding of the facility's protocol for obtaining usable physical evidence if a resident alleges sexual abuse and knowledge of the entities responsible for conducting investigations.

Provision (c):

The agency shall 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. Such examinations shall be performed by Sexual Assault Forensic Examiners (SAFEs) or Sexual Assault Nurse Examiners (SANEs) where possible. If SAFEs or SANEs cannot be made available, the examination can be performed by other qualified medical practitioners. The agency shall document its efforts to provide SAFEs or SANEs.

The Policy states forensic medical examinations will be conducted at the McLeod Medical Center who employs Sexual Assault Nurse Examiners (SANE) and Sexual Assault Forensic Examiners. The Sexual Assault Policy of the Hospital states that the medical forensic examination will be conducted by a SANE or SAFE. The facility Policy states that the services will be provided at no cost to the victim. The PREA Coordinator's interview was aligned with the facility Policy.

Provisions (d) & (e):

(d) The agency shall attempt to make available to the victim a victim advocate from a rape crisis center. If a rape crisis center is not available to provide victim advocate services, the agency shall make available to provide these services a qualified staff member from a community-based organization or a qualified agency staff member. Agencies shall document efforts to secure services from rape crisis centers. For the purpose of this standard, a rape crisis center refers to an entity that provides intervention and related assistance, such as the services specified in 42 U.S.C. 14043g(b)(2)(C), to victims of sexual assault of all ages. The agency may utilize a rape crisis center that is part of a governmental unit as long as the center is not part of the criminal justice system (such as a law enforcement agency) and offers a comparable level of confidentiality as a nongovernmental entity that provides similar victim services.

(e) As requested by the victim, the victim advocate, qualified agency staff member, or qualified community-based organization staff member shall accompany and support the victim through the forensic medical examination process and investigatory interviews and shall provide emotional support, crisis intervention, information, and referrals.

The facility has a MOU with Pee Dee Coalition for victim advocacy services. According to the MOU, the supportive services to victims include access to 24-hour reporting and contact for advocacy service; emotional support; accompaniment through forensic examination and investigative interview upon request; and provision of information and resources. The Facility Director confirmed that advocacy services will be provided in accordance with the MOU. The interview with the Facility Director confirmed the resident and/or facility staff members are able to utilize the hotline to request a victim advocate.

Provision (f)

(f) To the extent the agency itself is not responsible for investigating allegations of sexual abuse, the agency shall request that the investigating agency follow the requirements of paragraphs (a) through (f) of this section.

Allegations of sexual abuse that are criminal in nature are conducted by the BOP and/or the local law enforcement.

Provision (g):

Auditor is not required to audit this provision.

Provision (h):

For the purposes of this standard, a qualified agency staff member or a qualified community-based staff member shall be an individual who has been screened for appropriateness to serve in this role and has received education concerning sexual assault and forensic examination issues in general.

The facility has a MOU with Pee Dee Coalition for victim advocacy services. According to the MOU, the supportive services to victims include access to 24-hour reporting and contact for advocacy service; emotional support; accompaniment through forensic examination and investigative interview upon request; and provision of information and resources. The Facility Director confirmed that advocacy services will be provided in accordance with the MOU.

Conclusion:

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

FRRC meets the requirements of this standard based upon the following evidence:

Documentation Reviewed:

PREA Pre-Audit Questionnaire
Agency/Facility Policy and Procedures, 3.4 PREA Policy

Interviews:

Agency Executive Director
Human Resource Director
Facility Director/PREA Coordinator
Random Staff

Provision (a):

The agency shall ensure that an administrative or criminal investigation is completed for all allegations of sexual abuse and sexual harassment.

The Policy directs staff to report all allegations of sexual abuse and sexual harassment and to document the reports. Staff members are aware of the Policy requirements as verified through their interviews. The facility reports one administrative investigation was completed for an allegation of sexual abuse and sexual harassment.

Provision (b) and (c):

The agency shall have in place a policy 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. 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 shall document all such referrals. **Provision (c):** If a separate entity is responsible for conducting criminal investigations, such publication shall describe the responsibilities of both the agency and the investigating entity.

The facility’s website provides the information and related policies for reporting allegations of sexual abuse. A third-party reporting form is also on the website. Reporting information is also posted in various areas of the facility including but not limited to living units. The posted information is accessible to residents, staff, contractors and visitors. All staff interviews reflected and confirmed their knowledge on the reporting, referral process and policy's requirements. The Policy and interviews confirmed allegations of sexual abuse and sexual harassment are investigated. All investigations are conducted by the federal Bureau of Prisons (BOP).

Provision (d):

Auditor is not required to audit this provision.

Provision (e):

Auditor is not required to audit this provision.

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.

FRRC meets the requirements of this standard based upon the following evidence:

Documentation Reviewed:

PREA Pre-Audit Questionnaire
Agency/Facility Policy and Procedures, PREA Policy
Employee PREA Training Log
Training Attendance Record (Sign-in Sheets)
Training Acknowledgement Statements

Interviews:

Human Resource Director
Facility Director/PREA Coordinator
Random Staff

Provisions (a) and (c):

The agency shall train all employees who may 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) Residents' 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;

(c) All current employees who may have contact with residents shall receive PREA training. The agency shall 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. In years in which an employee does not receive refresher training, the agency shall provide refresher information on current sexual abuse and sexual harassment policies.

The facility Policy addresses PREA related training for staff. All interviewed staff members were familiar with the PREA information regarding primary components of preventing, detecting and responding to sexual abuse or sexual harassment. PREA training is provided to staff, as indicated by a review of Policy and training documents. Documentation and staff interviews support refresher training is conducted and documented.

The direct care staff interviewed and the PREA Coordinator reported the training is provided as required. All direct care staff members interviewed, and document review verified the general topics below were included in the training:

1. Zero-tolerance PREA related policies.
2. Staff responsibilities and how to fulfill them regarding allegations or incidents of sexual abuse or sexual harassment.
3. Residents' right to be free from sexual abuse and sexual harassment.
4. The right for staff and residents to be free from retaliation for reporting allegations or cooperating in an investigation.
5. Dynamics of sexual abuse and sexual harassment in juvenile facilities.
6. Residents and employees rights to be free from retaliation for reporting sexual abuse and sexual harassment.
7. How to avoid inappropriate relationships with residents.
8. Common reactions of sexual abuse and sexual harassment by victims.
9. Communicating effectively and professionally with residents, including lesbian, gay, bisexual, transgender, intersex, or gender non-conforming residents.
10. Mandatory reporting laws.

The Policy, training materials, staff interviews, review of the trainings log and acknowledgement statements verify the staff training occurs. Training is conducted annually, and refresher training is provided as needed. Staff interviews confirmed they have received training on the 10 required topics.

The evidence shows staff members are provided all of the required training topics. Based on the review of the Pre-audit questionnaire, training curriculum, associated training materials and records, and staff interviews, the facility complies with the provisions of the standard.

Provision (b):

Such training shall be tailored to the gender of the residents at the employee's facility. The employee shall receive additional training if the employee is reassigned from a facility that houses only male residents to a facility that houses only female residents, or vice versa.

The facility houses female and male residents and the training considers the needs of the population as determined by a review of training curricula and interviews with random staff. The Policy state the training shall be tailored to the needs and attributes to the population served.

Provision (d):

The agency shall document, through employee signature or electronic verification that employees understand the training they have received.

The Policy provides all training be documented. Staff members sign training rosters and training acknowledgement statements. A checklist is utilized for orientation training for all new employees and contains the elements of PREA training. The facility provided the Auditor with several examples for verification of the training occurring and the training was verified through staff interviews. All staff interviews reflected and confirmed their knowledge on the reporting, referral process and policy's requirements. The facility follows this provision of the standard.

Conclusion:

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

FRRC meets the requirements of this standard based upon the following evidence:

Documentation Reviewed:

PREA Pre-Audit Questionnaire
Agency/Facility Policy and Procedures, 4.27 PREA Policy

Interviews:

Human Resource Director
Facility Director/PREA Coordinator

Provision (a):

The agency shall ensure 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.

The Policies require volunteers and contractors who have contact with residents, be trained on PREA and their responsibilities regarding sexual assault prevention, detection, and response to allegations of sexual abuse and sexual harassment. A review of training records and interviews document the training occurs.

Provision (b):

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, but all volunteers and contractors who have contact with residents shall be notified of the agency's zero-tolerance policy regarding sexual abuse and sexual harassment and informed how to report such incidents.

The interviews revealed the PREA training informs the participants of their role in reporting allegations of sexual abuse and sexual harassment. The participants are informed of their responsibilities regarding sexual abuse prevention, detection, and response to a PREA allegation. The training is based on the services provided by the contractors and volunteers.

Provision (c):

The agency shall maintain documentation confirming that volunteers and contractors understand the training they have received.

The PREA Notification document contains the information reviewed with the contractor and volunteer. The document also serves as the training acknowledgement statement containing the signature of the participant and the date, confirming their understanding of the PREA information.

Conclusion:

Based upon the review and analysis of the available evidence, the Auditor has determined the facility is compliant with the provisions of this standard regarding volunteer and contractor training.

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.

FRRC meets the requirements of this standard based upon the following evidence:

Documentation Reviewed:

PREA Pre-Audit Questionnaire
 Agency/Facility Policy and Procedures, PREA Policy
 PREA Education & Screening Log
 Resident Guide
 Acknowledgement Statements
 Posters Observed

Interviews:

Human Resource Director
Facility Director/PREA Coordinator
Random Residents
Intake Staff

Provisions (a):

During the intake process, residents shall receive information explaining the agency's zero tolerance policy regarding sexual abuse and sexual harassment and how to report incidents or suspicions of sexual abuse or sexual harassment. During intake, residents receive information explaining: Their rights to be free from sexual abuse and sexual harassment. During intake, residents receive information explaining: Their rights to be free from retaliation for reporting such incidents. During intake, residents receive information regarding agency policies and procedures for responding to such incidents.

Agency Policy provides that the agency shall provide comprehensive education to residents either in person or through video regarding their rights to be free from sexual abuse and sexual harassment and to be free from retaliation for reporting such incidents, and regarding agency policies and procedures for responding to such incidents.

Agency Policy provides all residents admitted receive information about the facility, including PREA education. Residents receive directions on how to report allegations of sexual abuse and sexual harassment; and the right to be free from retaliation for reporting. According to the Intake Coordinator who provides PREA education to residents and the residents interviewed, an orientation is provided to residents during the intake process. Policy provides that residents receive a comprehensive PREA education session upon arrival at the facility. The results of the staff and resident interviews indicated the information provided to the residents is comprehensive.

The intake staff's interview revealed he ensures residents are educated regarding their rights to be free from sexual abuse and sexual harassment, and to be free from retaliation for reporting such incidents. The PREA education sessions include a review of the Safety Brochure. The residents sign acknowledgement statements confirming their receipt of the PREA information. A review of documentation showing dates and indicating residents' participation in PREA education sessions confirmed the PREA education sessions occur. The PREA related information is provided to staff in policies and procedures, training and staff meetings.

Provision (b):

The agency provides refresher information whenever a resident is transferred to a different facility.

Current residents who have not received such education shall be educated within one year of the effective date of the PREA standards and shall receive education upon transfer to a different facility to the extent that the policies and procedures of the resident's new facility differ from those of the previous facility.

Provision (c):

The agency shall provide resident education in formats accessible to all residents, including those who are limited English proficient, deaf, visually impaired, or otherwise disabled, as well as to residents who have limited reading skills.

The facility has the capability to provide the PREA education in formats accessible to all residents including those who may be hearing impaired; Deaf; have intellectual, psychiatric and speech disabilities; low vision; blind; limited reading, limited English proficient, and based on the individual need of the resident. PREA signage was not displayed in all areas frequented by the residents; therefore, the Auditor recommended additional PREA signage be posted and ensure signage has bold print. Corrective actions were taken to rectify this issue. Additional signage was posted in the needed areas. Photos have been sent to the Auditor to verify the actions taken. Posted PREA information is in English and Spanish accessible to residents, staff, contractors, volunteers, and visitors. Staff interviews confirmed residents are not used as translators or readers for other residents.

Provision (d):

The agency shall maintain documentation of resident participation in these education sessions.

A sample of signed acknowledgement statements were reviewed which supported the residents' involvement in PREA education sessions. The residents were aware of PREA information, including their rights regarding PREA, how to report allegations and that they would not be punished for reporting allegations of sexual abuse or sexual harassment. The Intake Coordinator was interviewed regarding PREA education for residents. He ensures residents' receipt of the information, including the resident signing the acknowledgement form.

Provision (e):

In addition to providing such education, the agency shall ensure that key information is continuously and readily available or visible to residents through posters, resident handbooks, or other written formats.

The PREA education materials provide residents information on how to report allegations of sexual harassment and sexual abuse. A brochure is provided to each resident to eliminate incidents of sexual abuse and sexual harassment. The brochure provides educational information regarding sexual abuse and victims. The residents revealed they can report allegations of sexual abuse or sexual harassment by telling a staff member; telling a family member who may report the allegation for them; access to the hotline to report allegations of sexual abuse or sexual harassment; or complete a PREA/grievance form. Each resident is provided a Resident Brochure.

There was one targeted resident to be interviewed at this facility during this auditing cycle. The Agency has a narrative that is required to be read to all residents at intake and it appears that this is being conducted as required by Agency policy.

Conclusion:

Based upon the review and analysis of the available evidence, the Auditor has determined the facility is compliant with the provision of 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 receive 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.

FRRC meets the requirements of this standard based upon the following evidence:

Documentation Reviewed:

PREA Pre-Audit Questionnaire
 Agency/Facility Policy and Procedures, PREA Policy

Interviews:

Agency Executive Director
 Human Resource Director
 Facility Director/PREA Coordinator

The agency does not conduct criminal investigations or administrative investigations involving residents. The agency does conduct administrative investigations concerning agency staff sexual misconduct. The federal Bureau of Prisons has investigators and referral investigators that have the specialized training in accordance with the Prison Rape Elimination Act and the Agency coordinates all investigations with them. The Human Resource Director confirmed that she conducts administrative investigations involving staff.

The agency does not conduct criminal investigations or administrative investigations involving residents; therefore, this standard is not applicable.

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? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners who work regularly in its facilities.)
 - Yes
 - No
 - NA

- 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? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners who work regularly in its facilities.) Yes No NA
- 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? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners who work regularly in its facilities.) Yes No NA
- 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? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners who work regularly in its facilities.) Yes No NA

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 does not employ medical staff or the medical staff employed by the agency 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? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners who work regularly in its facilities.) Yes No NA

115.235 (d)

- Do medical and mental health care practitioners employed by the agency also receive training mandated for employees by §115.231? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners employed by the agency.) Yes No NA
- 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 if the agency does not have any full- or part-time medical or mental health care practitioners contracted by or volunteering for the agency.) 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.

FRRC meets the requirements of this standard based upon the following evidence:

Documentation Reviewed:

PREA Pre-Audit Questionnaire

Agency/Facility Policy and Procedures, PREA Policy

Interviews:

Agency Executive Director

Human Resource Director

Facility Director/PREA Coordinator

The Agency does not employ any medical or mental health staff. The agency coordinates with the McLeod Regional Medical Center of Florence located in Florence, South Carolina, which conducts forensic examinations if needed. The local rape crisis center, Pee Dee Coalition Against Domestic and Sexual Assault makes available to the victim a victim advocate from the rape crisis center that accompanies the resident and supports the victim throughout the forensic medical examination process and investigatory interviews and shall provide emotional support, crisis intervention, information, and referrals. The federal Bureau of Prisons has a separate contractual agreement for mental health care in South Carolina, that is available to all of the facility's residents.

The Agency does not have any full- or part-time medical or mental health care practitioners who work regularly in its facilities; therefore, this standard is not applicable.

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.

FRRC meets the requirements of this standard based upon the following evidence:

Documentation Reviewed:

PREA Pre-Audit Questionnaire
Agency/Facility Policy and Procedures, H1202 PREA Policy
Sample of Vulnerability Assessment Instrument
PREA Education & Screening Log

Interviews:

Facility Director/PREA Coordinator
Staff Responsible for Risk Screening
Random Residents

Provision (a):

All residents are assessed during an intake screening for their risk of being sexually abused by other residents or sexually abusive toward other residents. All residents are assessed upon transfer to another facility for their risk of being sexually abused by other residents or sexually abusive toward other residents.

The Intake Coordinator will interview the resident at intake to obtain information about the residents' personal history and behavior in order to reduce the risk of sexual abuse by or upon a resident. The resident's risk level is reassessed periodically. A review of documentation, interviews with residents and staff confirmed the Vulnerability Assessment is administered. The information for the instrument may be obtained by asking questions from the form, medical and mental health screenings and other methods. All residents interviewed could identify specific areas inquired about in the administration of the Vulnerability Assessment. Reassessments are conducted periodically. PREA Education and Screening log was reviewed and it is maintained indicating the administration of the initial assessment and the completion of the follow-up assessments.

The facility provided the Auditor with examples of the screening tool. The Intake Coordinator, responsible for risk screening, confirmed residents are screened whether a new admission or transfer from another facility for risk of sexual abuse victimization or sexual abusiveness toward the other residents.

Provision (b):

Intake screenings ordinarily take place within 72 hours of arrival at the facility.

The risk screening occurs within 72 hours of intake, usually on the first day. Risk levels are reassessed periodically per the Intake Coordinator and a review of documents. All residents interviewed entered the facility within the past 12 months. They confirmed they were asked questions like the following examples at intake:

- (1) Have you have ever been sexually abused?
- (2) Do you identify with being gay, bisexual or transgender?
- (3) Do you have any disabilities?
- (4) Do you think you might be in danger of sexual abuse at the facility?

Based on the review of the Pre-audit questionnaire, review of resident records, interview with the staff responsible for risk screening, and resident interviews, the evidence shows that resident's risk levels are assessed during intake, but no later than 24-48 hours of their arrival at the facility. Additionally, risk levels are reassessed periodically. The facility follows this provision of the standard.

Provision (c):

Such assessments shall be conducted using an objective screening instrument.

The Vulnerability Assessment is used to obtain the information required by the standard, including but not limited to prior sexual victimization or abusiveness; self-identification; current charges and offense history; intellectual or developmental disabilities; and a resident's concern regarding his own safety. The interview and review of Policy revealed how the objective instrument is administered to glean information to assist staff in keeping residents safe. The responses on the instrument garner a score and the risk level is determined by definition and the corresponding number to that definition. The Policy states residents will be screened within 24-48 hours of admission however interviews with residents indicated it is also administered earlier.

Provisions (d), (e), (f), (g), (h):

At a minimum, the agency shall attempt to ascertain information about the residents:

- (1) Mental, physical, or developmental disabilities;
- (2) Age;
- (3) Physical build;
- (4) Prior incarcerations;
- (5) Whether criminal history is exclusively nonviolent;
- (6) Prior convictions for sex offenses against an adult or child;

- (7) Any gender nonconforming appearance or manner or identification as lesbian, gay, bisexual, transgender, or intersex, and whether the resident may therefore be vulnerable to sexual abuse;
- (8) Prior sexual victimization or abusiveness;
- (9) The resident's own perception of vulnerability; and
- (10) Any other specific information about individual residents that may indicate heightened needs for supervision, additional safety precautions, or separation from certain other residents.

The Auditor reviewed the Vulnerability Assessment screening instrument and determined all factors required by this provision of the standard are included. The interview with the Intake Coordinator confirmed he is aware of the elements of the risk screening instrument. The resident interviews also confirmed the administration of the screening instrument.

This information shall be ascertained through conversations with the resident during the intake process and medical and mental health screenings; during classification assessments; and by reviewing court records, case files, facility behavioral records, and other relevant documentation from the resident's files.

The facility Policy states the information shall be ascertained through conversations with the resident during the intake process and medical and mental health screenings; during classification assessments; and by reviewing court records, case files, facility behavioral records, and other relevant documentation from the resident's file. The staff and resident interviews are aligned with the Policy and this provision of the standard. The review of the instrument and interview with the Intake Coordinator responsible for risk screening confirmed the information is ascertained through conversations with the residents using the Vulnerability Assessment screening instrument. Resident interviews also revealed the instrument is used. Additional screening instruments are used and based on the needs of the resident.

Provision (i):

The agency shall implement 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.

The Policy provides for appropriate controls be taken to ensure that sensitive information is protected and not exploited. The interview with the PREA Coordinator revealed the information is only available to the Intake Coordinator and the designated case manager. The Auditor observed the files to be maintained in a secure manner. The evidence shows the facility follows this provision of the standard.

Most resident interviews and the documentation revealed that risk screenings are being conducted on the same day as the admission. Staff interviews confirmed a screening is completed on each resident upon admission to the program. Although there have been no transgender or intersex residents admitted to the facility within the past year, staff were aware of giving consideration for the residents on views of their safety in placement and programming assignment.

Conclusion:

Based upon the review and analysis of the available evidence, the Auditor has determined the facility is fully compliant with this standard regarding screening for risk of victimization and abusiveness.

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 resident's 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

resident's 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? (N/A if the agency has a dedicated facility, unit, or wing solely for the placement of LGBT or I residents pursuant to a consent decree, legal settlement, or legal judgement.) Yes No NA
- 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? (N/A if the agency has a dedicated facility, unit, or wing solely for the placement of LGBT or I residents pursuant to a consent decree, legal settlement, or legal judgement.) Yes No NA
- 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? (N/A if the agency has a dedicated facility, unit, or wing solely for the placement of LGBT or I residents pursuant to a consent decree, legal settlement, or legal judgement.) 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.

FRRC meets the requirements of this standard based upon the following evidence:

Documentation Reviewed:

PREA Pre-Audit Questionnaire
Agency/Facility Policy and Procedures, H1202 PREA Policy
Sample of Vulnerability Assessment
PREA Education & Screening Log

Interviews:

Human Resource Director
Facility Director/PREA Coordinator
Random Residents
Staff Responsible for Risk Screening/Intake Coordinator
Random Staff

Provisions (a) (b):

The agency shall use all information obtained pursuant to § 115.241 and subsequently to make housing, bed, program, education, and work assignments for residents with the goal of keeping all residents safe and free from sexual abuse.

The facility Policy provides guidance to staff regarding the use of the information obtained from the Vulnerability Assessment. The staff interviews, and information obtained through the administration of the screening instrument assist in determining bed, education and other program assignments with the goal of keeping all residents safe and meeting the needs of each resident. This information was verified through a review of specific samples of the aforementioned completed screening instrument. The facility also uses additional screening instruments.

Provision (c):

When deciding whether to assign a transgender or intersex resident to a facility for male or female residents, the agency considers on a case-by-case basis whether a placement would ensure the resident's health and safety, and whether a placement would present management or security problems.

Policy provides lesbian, gay, bisexual, transgender, or intersex residents shall not be placed in particular housing, bed, or other assignments solely on the basis of such identification or status, nor shall agencies consider lesbian, gay, bisexual, transgender, or intersex identification or status as an indicator of likelihood of being sexually abusive.

The Policy prohibits placing lesbian, bisexual, transgender, or intersex residents in specific housing or making other assignments solely based on how the residents identify or their status. The Policy prohibits staff from considering the identification as an indicator that these residents may be more likely to be sexually abusive. During the comprehensive site review, there were no rooms observed to be reserved for transgender or intersex residents. The restroom/showers were observed and were configured for a reasonable amount of privacy.

Provision (d):

A transgender or intersex residents' own views with respect to his or her own safety shall be given serious consideration.

The resident's concern for his own safety is considered through the administration of the Vulnerability Assessment and this applies to every resident. The residents confirmed in the interviews, they are asked about their safety concerns. A review of the PREA Education & Screening Log demonstrated the additional documentation of the screening assessments and re-assessments completed for each resident. The staff interviews revealed staff members are aware of the Policy which requires the provision of the standard to be followed.

Provision (e):

Transgender and intersex residents shall be given the opportunity to shower separately from other residents.

The Policy states transgender or intersex residents shall be given the opportunity to shower separately from other residents which is also supported by staff interviews.

Placement and programming assignments for each transgender or intersex resident shall be reassessed at least twice each year to review any threats to safety experienced by the resident.

The Policy states placement and programming assignments for each transgender or intersex resident shall be reassessed at least twice each year. This function would be done to review any threats to safety experienced by the resident and the Intake Coordinator is aware of the requirement. The Intake Coordinator confirmed each transgender or intersex resident would be reassessed at least twice each year to review any threats to safety experienced by the resident. Based on the review of the Pre-audit Questionnaire and interview with the Intake Coordinator, the evidence shows the facility follows this provision of the standard.

Provision (f):

In deciding whether to assign a transgender or intersex resident to a facility 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 resident's health and safety, and whether the placement would present management or security problems.

The Policy also provides that housing and program assignments for transgender or intersex residents would be made on a case-by-case basis and these residents would not be placed in particular or special housing which was evident from staff interviews. There were no

transgender or intersex residents in the facility during the site visit and this audit period. The Intake Coordinator's interview confirmed the facility would consider on a case-by-case basis whether a placement would ensure the resident's health and safety, and whether the placement would present management or security problems.

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 §115.241 to inform housing, bed, work, education, and program assignments with the goal of keeping all residents safe and free from sexual abuse. The facility prohibits placing LGBTI residents in particular housing, bed, or other assignments solely on the basis of such identification or status and does not consider such identification or status as an indicator of likelihood of being sexually abusive. The facility is prepared to provide a safe and secure environment and follow all provisions of this standard.

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.

FRRC meets the requirements of this standard based upon the following evidence:

Documentation Reviewed:

PREA Pre-Audit Questionnaire
Agency/Facility Policy and Procedures, H809 PREA Policy
PREA/Grievance Forms
Third Party Reporting Forms
Safety Pamphlet
Sample of Incident Report
Observed PREA Posters
MOU, Pee Dee Coalition

Interviews:

Human Resource Director
Facility Director/PREA Coordinator
Random Staff
Residents

Provision (a):

The agency shall provide multiple internal ways for residents to privately report sexual abuse and sexual harassment, retaliation by other residents or staff for reporting sexual abuse and

sexual harassment, and staff neglect or violation of responsibilities that may have contributed to such incidents.

Facility Policy addresses this standard and provides for multiple internal ways a resident may report allegations of sexual abuse and sexual harassment, including how he can privately report sexual abuse and sexual harassment; retaliation for reporting; and staff neglect or violations of responsibilities that may have contributed to such. Residents may report allegations of sexual abuse or sexual harassment by telephone through the 24-hour hotline of an agency not a part of the facility as confirmed by resident interviews, posters, staff, MOU, and posted phone instructions. Direct care staff interviews revealed residents may use personal telephone, or telephone located on each unit, to privately report sexual abuse and sexual harassment. The facility telephone was tested during the comprehensive site review and was found to be in working order. The victim advocate information postings were limited. Reporting procedures are provided to residents through the Resident/PREA Orientation, brochure, and Resident Rule Booklet. Most staff and resident interviews along with the orientation and supporting documentation verified compliance with this standard. After the on-site visit, the victim advocate information was clearly posted in various areas throughout the facility. The Facility Director sent photos verifying this corrective action to this auditor prior to the submission of this report.

The residents also identified internal ways a resident may report such as completing a PREA form; talking to a trusted staff member; or tell an outside person or family member. There are designated locked boxes and forms on the living units for depositing the written grievance forms. If a resident uses a grievance form to report allegations of sexual abuse or sexual harassment, she/he just needs to place her/his name on the form, check the appropriate space and place it in the grievance box.

The resident receives a Safety Pamphlet which provides PREA related information, including how to report allegations of sexual abuse. Posters are located in the living units and other areas visible to residents, staff, contractors and visitors. Residents revealed they have contact with someone who does not work at the facility such as a family member or other person they could report abuse to if needed. Staff members receive information on how to report allegations of sexual abuse or sexual harassment through policies and procedures, training, and staff meetings

Provision (b):

The agency shall also provide at least one way for residents to report abuse or harassment to a public or private entity or office that is not part of the agency and that is able to receive and immediately forward resident reports of sexual abuse and sexual harassment to agency officials, allowing the resident to remain anonymous upon request.

Residents may use their personal phone, or the telephones located in the facility. The resident may dial a number to reach a victim advocate at Pee Dee Coalition to report an allegation of abuse and/or request advocacy services. Signs are posted explaining how to access Pee Dee Coalition and contains non-emergency numbers for agencies, including the Sheriff's Office or Police Department. The resident is also instructed on the signage to dial 911 for emergencies. Direct care staff revealed staff could use the phones in facility to report allegations of abuse. Allegations of sexual abuse have not been reported during this audit period.

Provision (c):

Staff shall accept reports made verbally, in writing, anonymously, and from third parties and shall promptly document any verbal reports.

The staff interviews confirmed the methods available to residents for reporting allegations of sexual abuse and sexual harassment. Staff members are required to accept third-party reports and to document verbal reports. All residents interviewed revealed they are familiar with the provisions of the standard. The resident interviews demonstrated their familiarity with the various ways they may report either in person, in writing, by phone, completing a grievance, or through a third-party. The residents were aware third-party reports could be made and that reports can be made anonymously. Staff members interviewed were aware of their duty to receive and document third-party reports.

Provision (d):

The agency shall provide a method for staff to privately report sexual abuse and sexual harassment of residents.

The staff interviews revealed staff can privately report allegations of sexual abuse. The interviews collectively identified the following ways a report can be made privately: use of personal phones; use of telephone in an office; third-party reporting form online; report by email to administrative staff; and/or talk to supervisor in private.

Conclusion:

Based upon the review and analysis of the available evidence, the Auditor has determined the facility is compliant with this standard regarding resident reporting. The residents have multiple internal ways for to privately report. Reports can be made verbally, in writing, anonymously, and from third parties. Verbal reports would be documented immediately. Residents have access to pens and pencils to write a PREA report. 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

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 resident's 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.

FRRC meets the requirements of this standard based upon the following evidence:

Documentation Reviewed:

PREA Pre-Audit Questionnaire
Agency/Facility Policy and Procedures, H809 PREA Policy
Resident Brochure
Administrative Review of PREA form
Third Party Reporting Form

Interviews:

Human Resource Director
Facility Director/PREA Coordinator
Residents

The residents are federal resident transfers from the BOP in accordance with contractual agreements between the two agencies. The BOP maintains ultimate authority over all of the residents at the facility. Any form of administrative procedure for dealing with resident grievances relating to alleged sexual abuse will be coordinated with the BOP.

The Alston Wilkes Society does not have an administrative remedies process to address sexual abuse; therefore, this standard is not applicable.

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.

FRRC meets the requirements of this standard based upon the following evidence:

Documentation Reviewed:

PREA Pre-Audit Questionnaire
 Agency/Facility Policy and Procedures, H809 PREA Policy
 MOU, Pee Dee Coalition (rape crisis center)
 PREA Brochure (Safety Pamphlet)
 PREA Notification/Acknowledgement Form
 Posted Information

Interviews:

Human Resource Director
 Facility Director/PREA Coordinator
 Residents
 Advocacy Agency Representative

Provision (a):

The facility shall provide residents with access to outside victim advocates for emotional support services related to sexual abuse, by providing, posting, or otherwise making accessible mailing addresses and telephone numbers, including toll-free hotline numbers where available, of local, State, or national victim advocacy or rape crisis organizations. The facility shall enable reasonable communication between residents and these organizations and agencies, in as confidential a manner as possible.

Contact information for advocacy services is a part of the PREA education sessions and is also provided to each resident in the PREA brochure. Information is also provided through signs and posters in various parts of the facility including each living unit. The resident interviews revealed their knowledge of the advocacy services available to them and the limitations of confidentiality. The hotline telephone number and the contact information for services from the agencies was posted. The facility telephone was tested and deemed in working order.

Resident interviews revealed limited knowledge of how to access outside services. Since the initial review and on-site visit, the facility's PREA postings located in their housing units were updated to clearly post the victim advocate services and the telephone number. The PREA Coordinator sent photos to verify the actions taken to this auditor prior to the submission of this report.

Provision (b):

The facility shall 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.

The Policy addresses confidentiality of the advocacy support services. The resident receives information regarding the limitations of confidentiality during the intake process. An acknowledgement statement specific to the review of the reporting and advocacy services contains information regarding the advocacy services to be provided by Pee Dee Coalition. Samples of acknowledgement statements were reviewed.

Provision (c):

The agency shall 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. The agency shall maintain copies of agreements or documentation showing attempts to enter into such agreements.

The facility Policy states the facility has a MOU with the advocacy agency, available by telephone to the resident for access to outside confidential support services. The resident may use a personal phone or facility phone to gain access and speak with a victim advocate. The agency is identified on the signage along with directions for reporting allegations or requesting advocacy services. The PREA Coordinator confirmed the availability and accessibility of outside confidential support services to residents. The Program Manager of the advocacy agency stated that an advocate would go to the facility or the hospital upon request.

Conclusion:

Based upon the review and analysis of the available evidence, the Auditor has determined the facility is 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.

FRRC meets the requirements of this standard based upon the following evidence:

Documentation Reviewed:

PREA Pre-Audit Questionnaire
Agency/Facility Policy and Procedures, H809 PREA Policy
Acknowledgement Statements
Third Party Reporting Form

Interviews:

Human Resource Director
Facility Director/PREA Coordinator

Random Staff
Residents

Provision

The agency shall establish a method to receive third-party reports of sexual abuse and sexual harassment and shall distribute publicly information on how to report sexual abuse and sexual harassment on behalf of a resident.

The Policy addresses third-party reporting and interviews revealed random staff members are aware third-party reporting of sexual abuse and sexual harassment can be done and stated they will be accepted and reported. Staff members also stated they are to immediately document all verbal reports received. The interviews revealed they may report allegations privately through the use of the abuse reporting hotline or a third-party reporting form.

All residents interviewed stated they knew someone who did not work at the facility they could report to regarding allegations of sexual abuse and that person could make a report for them. The interviews with the residents revealed their knowledge of third-party reporting. The residents identified the methods within the facility in which they may make third party reports such as file a PREA report, report to staff or a family member, or utilize the abuse reporting hotline telephone.

Information regarding reporting is provided through observed postings located in various areas of the facility accessible to visitors, residents, staff, contractors and volunteers. The facility's website contains information regarding third-party reporting of allegations of sexual abuse. The Third-Party Reporting Form is observed to be located on the website. Copies of the Third-Party Reporting form are maintained in the reception area. There were no third- party reports received during this audit period.

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.

FRRC meets the requirements of this standard based upon the following evidence:

Documentation Reviewed:

PREA Pre-Audit Questionnaire

Agency/Facility Policy and Procedures, 3.4 PREA Policy

Interviews:

Human Resource Director

Facility Director/PREA Coordinator

Random Staff

Provision (a):

The agency shall require all staff to report immediately and according to agency policy any knowledge, suspicion, or information they receive regarding an incident of sexual abuse or sexual harassment that occurred in a facility, whether or not it is part of the agency; 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 Policies collectively address provisions of the standard including providing all staff immediately report any knowledge, suspicion, information, or receipt of information regarding an incident or allegation of sexual abuse, sexual harassment or incidents of retaliation and according to mandatory reporting laws of the State of South Carolina. The agency reports all allegations of sexual abuse and sexual harassment, including third-party and anonymous reports, to the federal Bureau of Prisons.

Reporting according to the State's mandatory reporting laws and the facility Policies was evident through document review regarding disclosures by residents of allegations that did not occur in the facility or an institutional setting. The documented case notes show the reporting by staff in accordance with facility Policies and the requirements of the standard. The staff interviews were aligned with the requirements of the Policies and standard. A review of documentation demonstrates information reported to staff is reported to the appropriate authorities. Staff members are instructed to immediately report all allegations of sexual abuse or sexual harassment to a Supervisor or the Facility Director.

Provision (b): Apart from reporting to designated supervisors or officials, staff shall 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

Facility Policy supports that after allegations have been appropriately reported, staff will not be permitted to give out any other information relating to what was reported except when necessary to obtain treatment for the resident, aid in the investigation, or help retain the security of the facility. Staff is expected to continue to abide by the confidentiality requirements of the facility. Interviews with staff indicated their knowledge of the prohibition of revealing any information related to a sexual abuse report to anyone other than to the extent necessary to make treatment, investigation, and other security and management decisions. Based on the review of documentation and interviews with staff, it is evident the facility follows this provision of the standard.

Provision (c):

(1) Medical and mental health practitioners shall be required to report sexual abuse to designated supervisors and officials pursuant to paragraph (a) of this section, as well as to the designated State or local services agency where required by mandatory reporting laws.

(2) Such practitioners shall be required to inform residents at the initiation of services of their duty to report and the limitations of confidentiality.

There are no medical or mental health staff employed at this facility.

Provision (d):

If the alleged victim is under the age of 18 or considered a vulnerable adult under a State or local vulnerable persons statute, the agency reports the allegation to the designated State or local services agency under applicable mandatory reporting laws.

Allegations of sexual abuse will be made by the Facility Director/designee which includes but is not limited to the BOP, local law enforcement, and Judges of their committing courts of alleged victim and alleged perpetrator. This information was verified through Policy review and the interview with the Facility Director.

Provision (e):

The facility shall report all allegations of sexual abuse and sexual harassment, including third-party and anonymous reports, to the facility's designated investigators.

Allegations of sexual abuse will be made by the Facility Director/designee which includes but is not limited to the BOP, local law enforcement, and Judges of their committing courts of alleged victim and alleged perpetrator. This information was verified through Policy review and the interview with the Facility Director.

Conclusion:

The interviews with random staff, 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 or 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.

FRRC meets the requirements of this standard based upon the following evidence:

Documentation Reviewed:

PREA Pre-Audit Questionnaire
Agency/Facility Policy and Procedures, H809 PREA Policy
Vulnerability Assessments

Interviews:

Human Resource Director
Facility Director/PREA Coordinator
Random Staff

Provision (a):

When an agency learns that a resident is subject to a substantial risk of imminent sexual abuse, it shall take immediate action to protect the resident.

Facility Policy requires staff to protect the residents through implementing protective measures. Administration of the Vulnerability Assessment provides information that assists and guide staff

in keeping residents safe through housing and program assignments. The interviews of the random staff and the Facility Director revealed protective measures include but are not limited to alerting supervisors and management staff and separating the residents including moving to a different housing unit. The Facility Director and the random staff indicated the expectation is that any action to protect a resident would be taken immediately.

The interviews with the residents revealed during the intake process, how they feel about their safety is part of the inquiries by staff in completing paperwork. A review of a sample of Vulnerability Assessments supports the information provided by residents. The Facility Director report during the past 12 months, no residents were identified as being subject to substantial risk of imminent sexual abuse.

Conclusion:

Based upon the review and analysis of the available evidence, the Auditor has determined the facility is compliant 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.

FRRC meets the requirements of this standard based upon the following evidence:

Documentation Reviewed:

PREA Pre-Audit Questionnaire

Agency/Facility Policy and Procedures, H809 PREA Policy

Interviews:

Human Resource Director

Facility Director/PREA Coordinator

Provisions (a), (b), (c), and (d):

(a) Upon receiving an allegation that a resident was sexually abused while confined at another facility, the head of the facility that received the allegation shall notify the head of the facility or appropriate office of the agency where the alleged abuse occurred and shall also notify the appropriate investigative agency. **(b)** Such notification shall be provided as soon as possible, but no later than 72 hours after receiving the allegation. **(c)** The agency shall document that it has provided such notification. **(d)** The facility head or agency office that receives such notification shall ensure that the allegation is investigated in accordance with these standards.

Alston Wilkes Society Policy provides that upon receiving an allegation that a resident was sexually abused while confined at another facility, the Facility Director/designee shall notify the head of the facility or appropriate office of the agency where the alleged abuse occurred and the appropriate investigative agency. Notification should be made as soon as possible but no longer than 72 hours after receiving the information. The Facility Director/designee must document the notification as required by Policy. It is the responsibility of the receiving agency to ensure an investigation is completed. According to the Facility Director, there has been no allegation of sexual abuse made by a resident regarding confinement at another facility. The Facility Director is familiar with the Policy and her responsibilities regarding such situation.

Conclusion:

Based upon the information received and interviews, the Auditor has determined the facility is compliant 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.

FRRC meets the requirements of this standard based upon the following evidence:

Documentation Reviewed:
PREA Pre-Audit Questionnaire

Interviews:

Random Staff

Provision (a):

Upon learning of an allegation that a resident was sexually abused, the first staff member to respond to the report shall be required to:

- (1) Separate the alleged victim and abuser;
- (2) Preserve and protect any crime scene until appropriate steps can be taken to collect any evidence;
- (3) If the abuse occurred within a time period that still allows for the collection of physical evidence, request that the alleged victim not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating; and
- (4) If the abuse occurred within a time period that still allows for the collection of physical evidence, ensure that the alleged abuser does not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating.

Facility Policy provides that upon learning of an allegation that a resident was sexually abused, the first security-level staff member to respond to the report shall be required to:

- a. Separate the alleged victim and abuser;
- b. Preserve and protect any crime scene until appropriate steps can be taken to collect any evidence;
- c. If the abuse occurred within a time period that still allows for the collection of physical evidence, request that the alleged victim not take any actions that could destroy physical evidence.

The interviews with staff confirmed awareness of first responder duties and the training they had been provided. There was one allegation that a resident was sexually abused in the last 12 months.

Provision (b):

If the first staff responder is not a security staff member, the responder shall be required to request that the alleged victim not take any actions that could destroy physical evidence, and then notify security staff.

The Employment Placement Specialist interviewed as non-security staff who may act as a first responder was familiar with her duties in that role. She indicated she would alert the supervisor, separate the victim and perpetrator, and request the victim and perpetrator do not take any actions that could destroy physical evidence. She further stated she would go with the victim to the hospital.

Conclusion:

Based upon the review and analysis of the available evidence, the Auditor has determined the facility is compliant 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.

FRRC meets the requirements of this standard based upon the following evidence:

Documentation Reviewed:

PREA Pre-Audit Questionnaire
Agency/Facility Policy and Procedures, H809 PREA Policy
Facility’s Institutional Plan

Interviews:

Human Resource Director
Facility Director/PREA Coordinator
Random Staff

Provision (a):

The facility shall develop a written institutional plan to coordinate actions taken in response to an incident of sexual abuse among staff first responders, medical and mental health practitioners, investigators, and facility leadership.

The facility has developed a written institutional plan which is aligned with the detailed information in the policy regarding the response to an allegation or incident of sexual abuse. The Plan outlines the actions of the identified staff members such as the first responders; contract agencies, facility leadership, and agency executive leadership. The plan maps out the steps to take and staff responsibilities.

The random staff interviewed was familiar with the roles regarding the response to an allegation of sexual abuse. The Facility Director discussed the coordinated actions in response to an incident of sexual abuse which was parallel to Policy and the plan. Staff members are directed to follow the steps outlined and to utilize the institutional plan in addressing the situation.

Forensic medical examinations will be provided free of charge to the victim at McLeod Medical Center by a Sexual Assault Nurse Examiner (SANE). The Hospital has 24/7 access to a SANE provider. A qualified medical professional shall perform a forensic medical examination if there is no SANE available as stated in the Hospital's Sexual Assault Policy. The victim will be provided unimpeded access to crisis intervention and medical services.

Conclusion:

Based upon the review and analysis of the available evidence, the Auditor has determined the facility complies with the provisions of the standard regarding a coordinated response to an incident of sexual abuse. One allegation of sexual abuse has 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.

FRRRC meets the requirements of this standard based upon the following evidence:

Documentation Reviewed:

PREA Pre-Audit Questionnaire
 Agency/Facility Policy and Procedures, PREA Policy

Interviews:

Agency Executive Director
 Human Resource Director

Based on agency policy and procedures along with interviews with agency staff and residents, the agency 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.

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.

FRRC meets the requirements of this standard based upon the following evidence:

Documentation Reviewed:

PREA Pre-Audit Questionnaire

Agency/Facility Policy and Procedures, H809 PREA Policy

Interviews:

Human Resource Director

Facility Director/PREA Coordinator

Provision (a):

The agency shall establish 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 and shall designate which staff members or departments are charged with monitoring retaliation.

The FRRC Policy states the facility shall protect all residents and staff from retaliation who report sexual abuse, sexual harassment or cooperate with sexual abuse or sexual harassment investigations. The PREA Coordinator is charged with monitoring retaliation. The interview with the PREA Coordinator confirmed she serves as the retaliation monitor and she understands the role of the retaliation monitor.

Provision (b):

The agency shall 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.

The Policy identifies measures to protect staff and residents including the following:

- a. Initiating housing changes or transfers for resident victims or abusers;
- b. Removing alleged staff or resident abusers from contact with victims; and
- c. Providing emotional support services.

The interview confirmed the facility would protect residents and staff from retaliation for sexual abuse and sexual harassment allegations. Protective measures would include housing changes, transfers, removing alleged abusers, and emotional support services. The PREA Coordinator identified protective measures that are aligned with the Policy and standard, including separating the alleged abuser from the alleged victim.

Provision (c):

For at least 90 days following a report of sexual abuse, the agency shall monitor the conduct or treatment of residents or staff who reported the sexual abuse and 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 and shall act promptly to remedy any such retaliation. Items the agency should monitor include any resident disciplinary reports, housing, or program changes, or negative performance reviews or reassignments of staff. The agency shall continue such monitoring beyond 90 days if the initial monitoring indicates a continuing need.

The Policy requires the monitoring of items identified in this provision of the standard. The PREA Coordinator explained during the interview how she would discharge those duties, including monitoring the items identified in the standard and whether a resident filed a PREA report alleging sexual abuse or sexual harassment. Retaliation monitoring would occur for 90 days to see if there are any changes that may suggest possible retaliation by residents or staff, and shall act promptly to remedy any such retaliation, according to Policy. The monitoring will continue beyond ninety (90) days, if the initial monitoring indicates a continuing need. There have been no incidents of retaliation during the 12 months preceding the audit.

Provision (d):

In the case of residents, such monitoring shall also include periodic status checks.

The PREA Coordinator indicated status checks would be initiated with staff and residents. The Policy states periodic status will occur. The Retaliation Status Checklist would be used to document the status checks as well as the Retaliation Monitoring Checklist to document the ongoing monitoring and use of the Retaliation Status Checklist.

Provision (e):

If any other individual who cooperates with an investigation expresses a fear of retaliation, the facility shall take appropriate measures to protect that individual against retaliation.

The Policy states if any other individual who cooperates with an investigation expresses the occurrence retaliation from another resident or staff member, FRRRC shall take appropriate measures to protect that individual against retaliation.

Provision (f):

Auditor is not required to audit this provision.

Conclusion:

Based upon the review and analysis of the available evidence, the Auditor has determined the facility is compliant with this standard regarding agency protection against retaliation.

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.

FRRC meets the requirements of this standard based upon the following evidence:

Documentation Reviewed:

PREA Pre-Audit Questionnaire
Agency/Facility Policy and Procedures, 4.13 PREA Policy

Interviews:

Human Resource Director
Facility Director/PREA Coordinator
Random Staff

Provision (a):

When the agency conducts its own investigations into allegations of sexual abuse and sexual harassment, it shall do so promptly, thoroughly, and objectively for all allegations, including third-party and anonymous reports.

Based on agency policy and procedures, along with agency staff and resident interviews, 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. The agency and facility reported no allegations that appeared to be criminal.

Provision (b):

Where sexual abuse is alleged, the agency shall use investigators who have received special training in sexual abuse investigations pursuant to § 115.234.

Criminal investigations are handled by local law enforcement, Police Department, and representatives from the federal Bureau of Prisons or other designated federal investigators. The agency has a contract agreement with the federal Bureau of Prisons and all of the residents are under the jurisdiction of the federal Bureau of Prisons. The agency and facility reported no allegations that appeared to be criminal.

Provision (c):

Investigators shall gather and preserve direct and circumstantial evidence, including any available physical and DNA evidence and any available electronic monitoring data; shall interview alleged victims, suspected perpetrators, and witnesses; and shall review prior complaints and reports of sexual abuse involving the suspected perpetrator.

Per Agency Policy, the administrative staff has received additional training in conducting investigations as confirmed by a review of training certificates, training log, and training curriculum. The training course specifically addresses conducting administrative investigations in confinement settings as confirmed by the staff interviews and the documents reviewed.

Provision (d):

When the quality of evidence appears to support criminal prosecution, the agency shall conduct compelled interviews only after consulting with prosecutors as to whether compelled interviews may be an obstacle for subsequent criminal prosecution.

Criminal investigations are handled by local law enforcement, Police Department, and representatives from the federal Bureau of Prisons or other designated federal investigators. The agency has a contract agreement with the federal Bureau of Prisons and all of the residents are under the jurisdiction of the federal Bureau of Prisons. The agency and facility reported no allegations that appeared to be criminal.

Provision (e):

The credibility of an alleged victim, suspect, or witness shall be assessed on an individual basis and shall not be determined by the person's status as resident or staff. No agency shall require a resident who alleges sexual abuse to submit to a polygraph examination or other truth-telling device as a condition for proceeding with the investigation of such an allegation.

Policy states the credibility of an alleged victim, suspect, or witness shall be assessed on an individual basis and not be determined by the person's status as a resident or staff. Additionally, no resident who alleges sexual abuse will be subjected to a polygraph examination or other truth

telling device as a condition for proceeding with the investigation of the allegation. The interview with the Human Resource Director supports the Policy.

Provision (f):

Administrative investigations:

(1) Shall include an effort to determine whether staff actions or failures to act contributed to the abuse; and (2) Shall be documented in written reports that include a description of the physical and testimonial evidence, the reasoning behind credibility assessments, and investigative facts and findings.

The Policies, interviews and training documentation are inclusive of this provision of the standard. Administrative staff members have been identified as administrative investigator: Human Resource Director. The Policy provides for the investigators to be trained. The investigators have received the regular PREA training as evident through documentation. The administrative staff has received additional training in conducting administrative investigations as confirmed by a review of training certificates, training log, and curriculum. The training course specifically addresses conducting administrative investigations in confinement settings, including the provisions of the standard, as confirmed by the staff interviews.

Provision (g):

Criminal investigations shall be documented in a written report that contains a thorough description of physical, testimonial, and documentary evidence and attaches copies of all documentary evidence where feasible.

Policy is inclusive of this provision of the standard. No criminal investigations have been conducted at the facility during this audit period.

Provision (h):

Substantiated allegations of conduct that appears to be criminal shall be referred for prosecution.

Criminal investigations are handled by local law enforcement, Police Department, and representatives from the federal Bureau of Prisons or other designated federal investigators. The agency has a contract agreement with the federal Bureau of Prisons and all of the residents are under the jurisdiction of the federal Bureau of Prisons. The agency and facility reported no allegations that appeared to be criminal.

Provision (i):

The agency shall retain all written reports referenced in paragraphs (g) and (h) of this section for as long as the alleged abuser is incarcerated or employed by the agency, plus five years, unless the abuse was committed by a juvenile resident and applicable law requires a shorter period of retention.

Policy states all reports shall be retained while the abuser is incarcerated or employed by the agency, plus five years, unless applicable law requires a shorter period of retention.

Provision (j):

The departure of the alleged abuser or victim from the employment or control of the facility or agency shall not provide a basis for terminating an investigation.

Policy and interviews provide support that the departure of the alleged abuser or victim from employment or control of FRRC shall not provide a basis for terminating an investigation, which was also supported by interviews.

Provision (k):

Auditor is not required to audit this provision.

Provision (l):

When outside agencies investigate sexual abuse, the facility shall cooperate with outside investigators and shall endeavor to remain informed about the progress of the investigation.

FRRC Policy states staff shall cooperate with any outside investigators and shall remain informed about the progress of the investigation. According to the Facility Director, the case number is provided when an outside investigation is conducted so that follow-up can occur as needed.

Conclusion:

Based upon the review and analysis of the available evidence, the Auditor has determined the facility is compliant 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.

FRRC meets the requirements of this standard based upon the following evidence:

Documentation Reviewed:

PREA Pre-Audit Questionnaire
Agency/Facility Policy and Procedures, 4.13 PREA Policy

Interviews:

Facility Director/PREA Coordinator

Provision (a):

The agency shall impose no standard higher than a preponderance of the evidence in determining whether allegations of sexual abuse or sexual harassment are substantiated.

An interview with the Facility Director indicated that the Agency Investigator conduct fact finding investigations and do not make conclusions following their investigations (which are administrative in nature) therefore the Facility Director in consultation with legal and her supervisory staff and Human Resources would make a determination regarding disciplinary actions to be imposed and the standard they would use is the preponderance of evidence.

Conclusion:

Based upon the review and analysis of the available evidence and the interviews, the Auditor has determined the facility is compliant with this standard regarding evidentiary standard for administrative 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 the agency's 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.

FRRC meets the requirements of this standard based upon the following evidence:

Documentation Reviewed:

PREA Pre-Audit Questionnaire

Agency/Facility Policy and Procedures, 4.13 PREA Policy

Interviews:

Human Resource Director

Facility Director/PREA Coordinator

Provision (a):

Following an investigation into a resident's allegation of sexual abuse suffered in an agency facility, the agency shall inform the resident as to whether the allegation has been determined to be substantiated, unsubstantiated, or unfounded.

Facility Policy addresses the resident being informed by staff when the investigation is completed, informed of the outcome of the investigation, and the documentation of the notification. The Facility Director will remain abreast of an investigation conducted by any of the investigative entities by serving as the primary contact person(s), as determined by the interviews. The FRRC Policy provides that any resident who makes an allegation of sexual abuse shall be informed verbally by the Human Resource Director and in writing following an investigation, as to whether or not the allegation was substantiated, unsubstantiated, or unfounded.

Provision (b):

If the agency did not conduct the investigation, it shall request the relevant information from the investigative agency in order to inform the resident.

Agency's Policy provides that following a resident allegation that 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 federal Bureau of Prisons.

Provision (c):

Following a resident's allegation that a staff member has committed sexual abuse against the resident, the agency shall subsequently inform the resident (unless the agency has determined that the allegation is unfounded) whenever:

- (1) The staff member is no longer posted within the resident's unit;
- (2) The staff member is no longer employed at the facility;
- (3) The agency learns that the staff member has been indicted on a charge related to sexual abuse within the facility; or
- (4) The agency learns that the staff member has been convicted on a charge related to sexual abuse within the facility.

The Policy requires that following a resident's allegation that a staff member committed sexual abuse against the resident, the resident will be informed of the following, unless it has been determined that the allegation is unfounded, whenever:

- a. The staff member is no longer assigned within the resident's housing unit;
- b. The staff member is no longer employed at the facility;
- c. The staff member has been indicted on a charge related to sexual abuse within FRRRC;
- or
- d. The staff member has been convicted on a charge related to sexual abuse within the facility.

Provision (d):

Following a resident's allegation that he or she has been sexually abused by another resident, the agency shall subsequently inform the alleged victim whenever:

- (1) The agency learns that the alleged abuser has been indicted on a charge related to sexual abuse within the facility; or
- (2) The agency learns that the alleged abuser has been convicted on a charge related to sexual abuse within the facility.

Agency's Policy provides that following a resident allegation that 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 federal Bureau of Prisons.

Provision (e):

All such notifications or attempted notifications shall be documented.

Agency's Policy provides that following a resident allegation that 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 federal Bureau of Prisons

Provision (f):

Auditor is not required to audit this provision.

Conclusion:

The interviews with the 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 this standard regarding 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 actually 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.

FRRC meets the requirements of this standard based upon the following evidence:

Documentation Reviewed:

PREA Pre-Audit Questionnaire

Agency/Facility Policy and Procedures, 3.4 PREA Policy

Interviews:

Human Resource Director

Facility Director/PREA Coordinator

Provision (a):

Staff shall be subject to disciplinary sanctions up to and including termination for violating agency sexual abuse or sexual harassment policies.

Agency Policy provides that staff disciplinary sanctions up to and including termination for violating facility's sexual abuse or harassment policies. Also, the policy mandates that the violation be reported to local law enforcement. All disciplinary sanctions are maintained in the employees HR file in accordance with Alston Wilkes Society policy and procedures. Termination is the presumptive sanction for staff who have engaged in sexual abuse. Additionally, staff may not escape sanctions by resigning. Staff who resign because they would have been terminated, are reported to the local law enforcement, unless the activities were not clearly criminal. There has been no employee disciplined in the past 12 months for violation of the facility's sexual abuse or harassment policies. The Facility Director interview validated her technical knowledge of the reporting process was consistent with Alston Wilkes Society policies and procedures.

Provision (b):

Termination shall be the presumptive disciplinary sanction for staff who have engaged in sexual abuse.

The Policy states that termination shall be the presumptive disciplinary sanction for staff who has engaged in sexual abuse with a resident as confirmed by the Facility Director.

Provision (c):

Disciplinary sanctions for violations of agency policies relating to sexual abuse or sexual harassment (other than actually engaging in sexual abuse) shall be 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.

FRRC Policy provides that disciplinary sanctions for violations of FRRC policies relating to sexual abuse or sexual harassment (other than actually engaging in sexual abuse) shall be 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. Additionally, the Policy states all employee discipline and termination are governed solely by At Will employee law.

Provision (d):

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.

FRRC Policy states all terminations for violations of the facility's sexual abuse or sexual harassment policies, or staff resignations related to violations of this policy, shall be reported to law enforcement, unless the activity is clearly not criminal. In addition, it shall be reported to relevant licensing bodies.

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.

FRRC meets the requirements of this standard based upon the following evidence:

Documentation Reviewed:

PREA Pre-Audit Questionnaire
Agency/Facility Policy and Procedures, 4.3 PREA Policy

Interviews:

Human Resource Director
Facility Director/PREA Coordinator

Provision (a):

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 Policy provides for contractors and volunteers who engage in sexual abuse to be reported to law enforcement and to relevant licensing bodies. Training records revealed the facility provides volunteers and contractors a clear understanding that sexual misconduct with a resident is strictly prohibited. During this audit period, there have been no allegations of sexual abuse or sexual harassment regarding a contractor or volunteer.

Provision (b):

The facility shall take 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.

The Policy states the Human Resource Director will take appropriate remedial measures and consider whether to prohibit further contact with residents in the case of any other violation of the sexual abuse and sexual harassment policies by a contractor or volunteer.

Conclusion:

Based upon the review and analysis of the available documentation, the Auditor has determined the facility is in 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)

- If the agency prohibits all sexual activity between residents, 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.

FRRC meets the requirements of this standard based upon the following evidence:

Documentation Reviewed:

PREA Pre-Audit Questionnaire

Agency/Facility Policy and Procedures, H1305 PREA Policy

Interviews:

Human Resource Director

Facility Director/PREA Coordinator

Provision (a):

A resident may be subject to disciplinary sanctions only 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 guilt for resident-on-resident sexual abuse.

Residents are subject to disciplinary sanctions in accordance with the federal Bureau of Prisons 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 guilt for resident-on-resident sexual abuse.

Provision (b):

Any disciplinary sanctions shall be commensurate with the nature and circumstances of the abuse committed, the resident's disciplinary history, and the sanctions imposed for comparable offenses by other residents with similar histories. In the event a disciplinary sanction results in

the isolation of a resident, agencies shall not deny the resident daily large-muscle exercise or access to any legally required educational programming or special education services. Residents shall have access to other programs and work opportunities to the extent possible.

FRRC Policy provides that disciplinary sanctions are 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.

Provision (c):

The disciplinary process shall consider whether a resident's mental disabilities or mental illness contributed to his or her behavior when determining what type of sanction, if any, should be imposed.

The FRRC Policy provides that the disciplinary process considers whether a resident's mental disabilities or mental illness contributed to his or her behavior when determining what type of sanction, if any, should be imposed. This was confirmed by the interview with the Facility Director.

Provision (d):

If the facility offers therapy, counseling, or other interventions designed to address and correct underlying reasons or motivations for the abuse, the facility shall consider whether to offer the offending resident participation in such interventions. The agency may require participation in such interventions as a condition of access to any rewards-based behavior management system or other behavior-based incentives, but not as a condition to access to general programming or education.

Sanctions are commensurate with the nature and circumstances of the abuse committed, the resident's disciplinary history, coordination with the federal Bureau of Prisons, 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.

Provision (e):

The agency may discipline a resident for sexual contact with staff only upon a finding that the staff member did not consent to such contact.

FRRC Policy provides the facility may discipline a resident for sexual contact with staff only upon finding that the staff member did not consent to such contact.

Provision (f):

For the purpose of disciplinary action, 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 FRRC Policy states 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 and facility prohibit all sexual activity between residents and may discipline residents for such activity.

Provision (g):

An agency may, in its discretion, prohibit all sexual activity between residents and may discipline residents for such activity. An agency may not, however, deem such activity to constitute sexual abuse if it determines that the activity is not coerced.

The Policy prohibits any sexual conduct between residents. All such conduct is subject to disciplinary action. Court processes occur after determination the sexual activity was coerced.

Conclusion:

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

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.

FRRC meets the requirements of this standard based upon the following evidence:

Documentation Reviewed:

PREA Pre-Audit Questionnaire
Agency/Facility Policy and Procedures, H809 PREA Policy
Samples of Acknowledgement of PREA Education

Interviews:

Human Resource Director
Facility Director/PREA Coordinator

Provision (a):

Resident victims of sexual abuse shall 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.

The Policy mandates the victim receives timely and unimpeded access to emergency medical treatment, crisis intervention services and advocacy services. The agency does not employ any medical or mental health staff. The victim would be transported to the McLeod Medical Center for a forensic examination, at no cost to the victim which is acknowledged by facility and the McLeod Medical Center Policies. The Policy and interviews with the Facility Director revealed

the mental health services are determined according to the professional judgment of the practitioner. Residents are informed of medical services during intake and sign acknowledgement statements indicating key information reviewed in the education session which includes treatment services.

Residents are provided access to an outside victim advocacy agency for services through a MOU with Pee Dee Coalition which includes but is not limited to emotional support and accompaniment through the forensic examination and investigative interviews. The advocate will go to the facility or the hospital to provide services. There have been no allegations of sexual abuse during this audit period.

Provision (b):

If no qualified medical or mental health practitioners are on duty at the time a report of recent abuse is made, staff first responders shall take preliminary steps to protect the victim pursuant to § 115.262 and shall immediately notify the appropriate medical and mental health practitioners.

The agency does not employ any medical or mental health staff. The interview with Human Resource Director revealed residents have access to unimpeded access to emergency services. The Policy and the written coordinated response plan provide guidance to staff in protecting residents and for contacting the appropriate staff regarding allegations or incidents of sexual abuse, including contacting medical and mental health staff. Review of the coordinated plan; and staff interviews indicated unimpeded medical and crisis intervention services will be available to a victim of sexual abuse.

Provision (c):

Resident victims of sexual abuse shall be 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.

The Policy and interviews confirmed processes and services are in place for a victim to receive timely access to sexually transmitted infection prophylaxis, where medically appropriate. Additionally, follow-up services as needed will be provided. The facility houses females and males.

Provision (d):

Treatment services shall be 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 Policy states treatment services shall be 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. This was also confirmed through staff interviews.

Conclusion:

Facility Policy revealed emergency services will be provided. It is documented through Policy and understood by the staff that treatment services will be provided at no cost to the victim. Based upon the review and analysis of the available evidence, the Auditor has determined the facility is compliant with this standard regarding access to emergency medical and mental health services.

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. *Note: in “all-male” facilities, there may be residents who identify as transgender men who may have female genitalia. Auditors should be sure to know whether such individuals may be in the population and whether this provision may apply in specific circumstances.*) 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. *Note: in “all-male” facilities, there may be residents who identify as transgender men who may have female genitalia. Auditors should be sure to know whether such individuals may be in the population and whether this provision may apply in specific circumstances.*) 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.

FRRC meets the requirements of this standard based upon the following evidence:

Documentation Reviewed:

PREA Pre-Audit Questionnaire
Agency/Facility Policy and Procedures, H1102 PREA Policy
Vulnerability Assessment

Interviews:

Human Resource Director
Facility Director/PREA Coordinator

Provision (a):

The facility shall 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.

The Policy requires that a medical and mental health evaluation and treatment be offered to resident victims of sexual abuse. The Policy and interviews support medical and mental health evaluations and treatment will be offered to all residents who have been victimized by sexual abuse.

Provision (b):

The evaluation and treatment of such victims shall 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.

Interviews with the Human Resource Director and Facility Director and observations confirmed on-going medical and mental health care will be provided as appropriate and will include but not limited to additional testing and medical services; medication management, if prescribed; individual counseling; trauma group; and referrals as needed. The Policy states that follow-up services will be provided.

Provision (c):

The facility shall provide such victims with medical and mental health services consistent with the community level of care.

Agency/Facility Policy, staff interviews, and observations revealed medical and mental health services are consistent with the community level of care.

Provision (d):

Resident victims of sexually abusive vaginal penetration while incarcerated shall be offered pregnancy tests.

Policy provides that FRRC shall offer pregnancy test to resident victims of sexually abuse vaginal penetration.

Provision (e):

If pregnancy results from conduct specified in paragraph (d) of this section, such victims shall receive timely and comprehensive information about and timely access to all lawful pregnancy-related medical services.

Policy provides that FRRC shall ensure timely and comprehensive information about and timely access to all lawful pregnancy-related medical services if pregnancy results from conduct specified in paragraph (d).

Provision (f):

Resident victims of sexual abuse while incarcerated shall be offered tests for sexually transmitted infections as medically appropriate.

The Policy and interviews ensure that victims of sexual abuse will be provided tests for sexually transmitted infections as medically appropriate. Testing would be done at McLeod Medical Center and follow-up services may be done as needed.

Provision (g):

Treatment services shall be 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.

All treatment services will be provided at no cost to the victim, according to Policy and staff interviews.

Provision (h):

The facility shall 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.

Facility Policy provides for attempts to be made for a mental health practitioner to conduct a mental health evaluation within 60 days on all known resident-on-resident abusers and offer appropriate treatment. Services will include but not be limited to individual, group and family counseling. Additionally, an evaluation or reassessment will be administered utilizing the Vulnerability Assessment. The Facility Director's interview supported the Policy.

Conclusion:

Based upon the review and analysis of the documentation, the Auditor has determined the facility is compliant 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.

FRRC meets the requirements of this standard based upon the following evidence:

Documentation Reviewed:

Sexual Abuse Incident Reviews
Post Incident Review form
PREA Pre-Audit Questionnaire
Agency/Facility Policy and Procedures, 4.13 PREA Policy

Interviews:

Human Resource Director
Facility Director/PREA Coordinator
Incident Review Team Member

Provision (a):

The facility shall 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.

The Policy requires the facility to 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 deemed to be unfounded. The Facility Director is familiar with the Policy requirements.

Provision (b):

Such review shall ordinarily occur within 30 days of the conclusion of the investigation.

The Policy requires that the reviews occur within 30 days of the conclusion of the investigation. There has been one allegation of sexual abuse, and the Facility Director confirmed that an incident review occurred within 30 days of the conclusion of the investigation in accordance with facility Policy and the standard.

Provision (c):

The review team shall include upper-level management officials, with input from line supervisors, investigators, and medical or mental health practitioners.

The Policy identifies the incident review team members as administrators with input from line supervisors, investigators, mental health staff, and Counselors. The interview with the Facility Director confirmed the Policy requirements.

Provision (d):

The review team shall:

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

The Policy outlines the requirements of the standard for the areas to be assessed by the incident review team. The interview with the Facility Director, review of Policy and documentation method confirmed the incident review team is charged with considering the factors identified in this standard provision regarding the results of the investigation, including:

- considering the make-up and vulnerability of the population such as gang affiliation; whether the resident identifies as gay, bisexual, transgender, or intersex;
- other group dynamics;
- assessment of the area relative to the allegations; and
- adequacy of staffing.

The Policy requires the meeting to be documented, including recommendations and the document provided to the Facility Director. The interview with the PREA Coordinator/Incident Review Team Member confirmed the facility would prepare a report of its findings and any recommendations for improvement when conducting a sexual abuse incident review. She confirmed the team would consider all factors required by the standard.

Provision (e):

The facility shall implement the recommendations for improvement or shall document its reasons for not doing so.

The Policy states the facility shall implement the recommendations for improvement or shall document its reasons for not doing so. The Facility Director is familiar with this Policy requirement. The AWS form 4.13.1 form has been developed for documenting the incident review team meeting and it allows for documentation of the considerations of the standard. Additionally, the form provides for recommendations for improvement by the team members. There was one allegation of sexual abuse in the past 12 months.

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.

FRRC meets the requirements of this standard based upon the following evidence:

Documentation Reviewed:

FRRC data log for Alston Wilkes Society
PREA Data (Annual Report)
Instrument with Definitions
PREA Pre-Audit Questionnaire
Agency/Facility Policy and Procedures, 4.13 PREA Policy

Interviews:

Human Resource Director
Facility Director/PREA Coordinator

Provisions (a) & (c):

The agency shall collect accurate, uniform data for every allegation of sexual abuse at facilities under its direct control using a standardized instrument and set of definitions. The incident-based data collected shall 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.

The Policy requires the use of a standardized instrument with definitions to collect accurate, uniform data for every allegation of sexual abuse. A review of the PREA Data document demonstrates that it includes data necessary to answer all questions from the most recent version of the Survey of Sexual Violence conducted by the U. S. Department of Justice.

Provision (b):

The agency shall aggregate the incident-based sexual abuse data at least annually.

The Policy and review of the annual report and data gathering instrument and other documents confirm the facility collects incident-based, uniform data regarding allegations of sexual abuse and sexual harassment. A standardized instrument and specific guidelines and definitions are used to assist in identifying the data.

Provision (d):

The agency shall maintain, review, and collect data as needed from all available incident-based documents, including reports, investigation files, and sexual abuse incident reviews.

The facility maintains and collects various types of identified data and related documents regarding PREA. The facility collects and maintains data in accordance with Policy directives and Alston Wilkes Society and aggregates the data which culminates into an annual report.

Provision (e):

The agency also shall obtain incident-based and aggregated data from every private facility with which it contracts for the confinement of its residents.

FIRC does not contract with outside facilities for confinement of its residents.

Provision (f):

Upon request, the agency shall provide all such data from the previous calendar year to the Department of Justice no later than June 30.

The Policy states that upon request, FIRC shall provide all such data from the previous calendar year to the Department of Justice no later than June 30. A request was not made for the previous calendar year.

Conclusion:

Based upon the review and analysis of the documentation, the Auditor has determined the facility is compliant with this standard regarding data collection.

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.

FRRC meets the requirements of this standard based upon the following evidence:

Documentation Reviewed:

Agency/Facility Policy and Procedures, 4.13 PREA Policy

Interviews:

Human Resource Director
Facility Director/PREA Coordinator

The Policy requires the review of data collected and aggregated in order to improve the PREA efforts. The interviews revealed the collected and aggregated data is reviewed to assess and improve the effectiveness of the PREA related initiatives by identifying problem areas; developing and implementing corrective actions where needed; and preparing an annual report based on the collected data. The interviews supported the provisions of the Policy and the standard. The Policy also indicates an annual report will be prepared that will provide information regarding the facility's corrective actions in addressing sexual abuse.

The annual report is approved as required by Policy, per the interviews and a review of the report was conducted by the Auditor. The annual report reflects a comparison of the results of annual

data, by calendar year. The annual report has been reviewed and the report is accessible to the public through the facility's website. There are no personal identifiers on the annual report.

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.

FRRC meets the requirements of this standard based upon the following evidence:

Documentation Reviewed:

PREA Pre-Audit Questionnaire
Agency/Facility Policy and Procedures, 4.13 PREA Policy
Annual Report

Interviews:

Human Resource Director
Facility Director/PREA Coordinator

The Policy provides that all data collected will be securely stored and maintained for at least 10 years after the initial collection date, unless State or local statutes require otherwise. According to the facility Policy, the aggregated sexual abuse data will be readily available to the public through the agency's website; the practice is that the report is posted on the agency's website. A review of the annual report verified there are no personal identifiers and it was observed posted on the website, as required. Related documentation in the facility was observed to be securely stored.

Conclusion:

Based upon the review and analysis of the documentation, interviews and observations, the Auditor has determined the facility is compliant with this standard regarding data storage, publication, and destruction.

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 residents? 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.

FRRRC meets the requirements of this standard based upon the following evidence:

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

A comprehensive site tour 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/PREA Coordinator provided appropriate workspace 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; and visitors. 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. The review period is for prior audits completed during the past three years PRECEDING THIS AGENCY AUDIT. The pendency of any agency appeal 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.

FRRC meets the requirements of this standard based upon the following evidence:

This facility was previously audited August 2016 and the Auditor confirmed the audit report was posted on the agency's website as is the practice with the facility. This 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, 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.

Cheryl M. Anderson

September 16, 2019

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.