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

☐ **Interim** ☒ **Final**

Date of Interim Audit Report: Click or tap here to enter text. ☒ **N/A**
If no Interim Audit Report, select N/A
Date of Final Audit Report: December 28, 2023

Auditor Information

Name: Demetrius Henderson	**Email:** **dhend64@gmail.com**
Company Name: Correctional Management and Communications Group	
Mailing Address: 301 Deer Crossing Road	**City, State, Zip:** Elgin, South Carolina 29045
Telephone: 803-565-9742	**Date of Facility Visit:** November 27 & 28, 2023

Agency Information

Name of Agency: Alston Wilkes Society			
Governing Authority or Parent Agency *(If Applicable)*: Click or tap here to enter text.			
Physical Address: 3519 Medical Drive		**City, State, Zip:** Columbia SC 2920	
Mailing Address: 3519 Medical Drive		**City, State, Zip: Columbia SC 29203**	
The Agency Is:	☐ Military	☒ Private for Profit	☐ Private not for Profit
☐ Municipal	☐ County	☐ State	☐ Federal
Agency Website with PREA Information: hhtps://www.alstonwilkessociety.org/about-us/prea-information			

Agency Chief Executive Officer

Name: S. Anne Walker	
Email: annewalker@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**	**Number of Compliance Managers who report to the PREA Coordinator:** 0

Facility Information

Name of Facility: Charleston Residential Reentry Center (RRC)			
Physical Address: 3290 Meeting Street		**City, State, Zip:** Charleston, SC 29405	
Mailing Address (if different from above): Click or tap here to enter text.		**City, State, Zip:** Click or tap here to enter text.	
The Facility Is:	☐ Military	☐ Private for Profit	☒ Private not for Profit
☐ Municipal	☐ County	☐ State	☐ Federal

Facility Website with PREA Information: Click or tap here to enter text.

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:	Ben Rager		
Email:	Brager@aws1962.org	**Telephone:**	843-744-4917

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:	33
Current Population of Facility:	21
Average daily population for the past 12 months:	25

Has the facility been over capacity at any point in the past 12 months?	☐ Yes ☒ No
Which population(s) does the facility hold?	☐ Females ☐ Males ☒ Both Females and Males
Age range of population:	18+
Average length of stay or time under supervision	100
Facility security levels/resident custody levels	FBOP/USPO; Pre-Release, Community Corrections Component, Home Confinement
Number of residents admitted to facility during the past 12 months	130
Number of residents admitted to facility during the past 12 months whose length of stay in the facility was for *72 hours or more*:	130
Number of residents admitted to facility during the past 12 months whose length of stay in the facility was for *30 days or more:*	130
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)?	☒ Yes ☐ No
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):	☒ Federal Bureau of Prisons ☐ U.S. Marshals Service ☐ U.S. Immigration and Customs Enforcement ☐ Bureau of Indian Affairs ☐ U.S. Military branch ☐ State or Territorial correctional agency ☐ County correctional or detention agency ☐ Judicial district correctional or detention facility ☐ City or municipal correctional or detention facility (e.g. police lockup or city jail) ☐ Private corrections or detention provider ☐ Other - please name or describe: Click or tap here to enter text. ☐ N/A
Number of staff currently employed by the facility who may have contact with residents:	15
Number of staff hired by the facility during the past 12 months who may have contact with residents:	1
Number of contracts in the past 12 months for services with contractors who may have contact with residents:	0
Number of individual contractors who have contact with residents, currently authorized to enter the facility:	0
Number of volunteers who have contact with residents, currently authorized to enter the facility:	0

Physical Plant	
Number of buildings: **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.**	1
Number of resident housing units: **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.**	2
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:	2
Does the facility have a video monitoring system, electronic surveillance system, or other monitoring technology (e.g. cameras, etc.)?	☒ Yes ☐ No
Has the facility installed or updated a video monitoring system, electronic surveillance system, or other monitoring technology in the past 12 months?	☒ Yes ☐ No

Medical and Mental Health Services and Forensic Medical Exams	
Are medical services provided on-site?	☐ Yes ☒ No
Are mental health services provided on-site?	☐ Yes ☒ No
Where are sexual assault forensic medical exams provided? Select all that apply.	☐ On-site ☒ Local hospital/clinic ☐ Rape Crisis Center ☐ 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.	☐ Facility investigators ☐ Agency investigators ☒ 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)	☒ Local police department ☐ Local sheriff's department ☐ State police ☒ A U.S. Department of Justice component ☐ Other (please name or describe: Click or tap here to enter text.) ☐ 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	☐ Facility investigators ☐ Agency investigators ☒ 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)	☐ Local police department ☐ Local sheriff's department ☐ State police ☒ A U.S. Department of Justice component ☐ Other (please name or describe: Click or tap here to enter text.) ☐ N/A

Audit Findings

Audit Narrative (including Audit Methodology)

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.

On September 23, 2023, the Management and Communications Group, LLC (CMCG) located in Florida contracted with Demetrius Henderson, United States Department of Justice Certified PREA Auditor to conduct a PREA audit at Alston Wilkes Charleston Residential Reentry Center (CRRC) located in North Charleston, South Carolina. The Audit site visit was scheduled to take place on November 27 and 28, 2023. There are no existing conflict of interest with the auditor and facility, and there were no barriers to completing any part of the audit.

Charleston Residential Reentry Center (CRRC) is a 33-bed secure community confinement (minimum Security) facility that houses male and female residents 18 years and older. The parent Agency is Alston Wilkes Society (AWS) located in Columbia, South Carolina. The Bureau of Prisons refer residents to the facility for residential reentry. CRRC provides 24-hour supervision, housing, food, intensive case management and supported employment services. These services help residents integrate back into the community with the supports to become productive citizens in their communities.

The facility is also accredited by the American Correctional Association (ACA). The facility's last PREA report was completed in December 2020.

Audit Methodology

Pre-Audit Preparation:

The audit process started on October 3, 2023, with the Certified PREA-Auditor (CPA) meeting the PREA Coordinator by telephone to send information to post the PREA Notice at the facility. The PREA Coordinator sent photos of the posting in several areas of the facility on October 12, 2023, the CPA started reviewing the facility's website and did a literature search on the facility. The CPA reviewed the Facility's policies and procedures related to PREA Standards. The CPA reviewed the PRE-Audit Questionnaire (PAQ) which identified the current population at 21 residents and a 12-month average resident population of 25. There were no letters from any residents addressed to the CPA.

The CPA viewed CRRC website that describes the Facility's mission "Rebuilding lives for a safer community". The website informed the CPA that Austin Wilkes has four residential reentry facilities located in Columbia, SC, Florence, SC, Charleston, SC, and Fayetteville, NC. The four residential reentry facilities annually house approximately 626 residents.

Alston Wilkes Charleston Residential Reentry Center (CRRC) has a recently signed memorandum of understanding with Tri-County Speaks to provide residents with confidential emotional support services related to sexual abuse and to help victims of sexual abuse during their transition from CRRC into the community. Any sexual abuse investigations are completed by an external entity the BOP.

An internet search of the facility confirmed no litigation of federal consent decrees. General and specific information about the facility and the programs and services provided are detailed on the facility's website. The facility's website also contains PREA information on zero-tolerance and coordinated response policies and reporting form and numbers to contact. The last PREA audit report for the 2020 is located on the website.

Entrance Briefing and Site Visit:

The onsite visit for the Prison Rape Elimination Act (PREA) compliance audit for Alston Wilkes Charleston Residential Reentry Center (CRRC) was held on November 27-28, 2022, by Demetrius Henderson, United States Certified PREA Auditor (CPA). The population for the first day for CRRC was 22 residents and 22 residents the second day. The rated capacity is 33. The average range of residents is between 18-65 years of age. The average population for the past 12 months was 100 days.

On November 27, 2023, an entrance meeting initiated the onsite audit with the CPA, PREA Coordinator (PC), Facility Director, and Director of Human Resources (HR). During the meeting, the PREA- Auditor outlined his auditing process and transparency communication, sampling and scheduling of interviews, discussion of logistics for the facility tour, and the need to review additional documents. The CPA communicated the need to review the entire facility, interview a minimum of five (5) targeted residents and five (5) random residents. Specialized Staff interviews were completed electronically, and the CPA conveyed the need to interview at a minimum ten (10) random staff members. The facility provided the CPA with documents of completed specialize staff interview questionnaires. Documentation on PREA policies and procedures and the facility's sexually abusive behavior prevention and intervention program as it relates to the PREA standards were all uploaded on the PREA online system. Specialized staff interviews documents and onsite interviews of 10 residents and ten (10) random staff. The following is a breakdown of all interviews completed by staff and residents.

Resident Interviews

Residents	Comments
Youthful Detainees	No residents under 18 years of age is admitted to the facility. No one under 18 years of age were at the facility during the site visit.
Residents with Disability	None were identified during the on-site visit. However, there was a resident that used a wheelchair that was interviewed**.**
LBGTI	None were identified during the on-site visit. The last LBGTI admitted to the facility was a transgender about three years ago.
Residents with Limited English Proficiency	None were identified during the on-site visit. In the past residents who primary language was Spanish were admitted but these residents also understood English.
Residents that reported sexual abuse at the Facility	None were identified during the on-site visit. This was also confirmed during interviews with residents.
Residents who reported sexual victimization during risk screening	None were identified during the on-site visit. This was also confirmed during interviews with residents.

Residents in Segregated Housing	None were identified during the on-site visit. The facility is setup where there is no segregated housing.
10 Random Residents were interviewed	Most residents were employed in the community and the CPA had to be flexible to achieve the minimum number of residents to eb interviewed.

Staff Interviews

Facility Director	Targeted interviews were sent to the PREA Coordinator. Completed prior to the site visit
Human Resources	Targeted interviews were sent to the PREA Coordinator. Completed prior to the site visit. CPA also interviewed on site.
PREA Coordinator/PREA Manager	Targeted interviews were sent to the PREA Coordinator. Completed prior to the site visit.
Case Manager	Targeted interviews were sent to the PREA Coordinator. Completed prior to the site visit. CPA also interviewed case manager on site.
Employment Specialist	Targeted interviews were sent to the PREA Coordinator. Completed prior to the site visit. CPA also interviewed on site. CPA also interviewed on site.
Supervision Staff	Targeted interviews were sent to the PREA Coordinator. Completed prior to the site visit. CPA also interviewed on site.
Designated Member Charged with Monitoring Retaliation	Targeted interviews were sent to the PREA Coordinator. Completed prior to the site visit CPA also interviewed on site.
Staff who perform screening for victimization and abusiveness	Targeted interviews were sent to the PREA Coordinator. Completed prior to the site visit. CPA also interviewed on site.
Staff acting as first responders	Targeted interviews were sent to the PREA Coordinator. Completed prior to the site visit. CPA also interviewed on site.
Intake Staff	Targeted interviews were sent to the PREA Coordinator. Completed prior to the site visit. CPA also interviewed on site.
High Level Staff	Targeted interviews were sent to the PREA Coordinator. Completed prior to the site visit.
Volunteer Staff	No Volunteer Staff. This was also confirmed during interviews with management and random staff.
Contract Staff	No Contract Staff. This was also confirmed during interviews with management and random staff.
All Grievances/allegations made in previous 12 months prior to 2023 PREA Audit	None
Allegations of sexual abuse or sexual harassment reported for investigation in the previous 12 months prior to the 2023 PREA Audit	None
Hotline Calls made during the past 12 months	None

10 total random Staff among each work shift	Interview a total of 10 Supervision Specialist and Case Managers staff representing all three work shifts.

Random Staff Interviews 10

The CPA observed PREA signs throughout the facility, and cameras in the facility that eliminated blind spots. The facility added cameras and there are no blind spots except for beds and shower areas. The posted information includes instructions on accessing the 24/7 hotline for reporting allegations and requesting advocacy services from Tri-Cunty Speaks. To receive allegations of sexual allegations of sexual abuse and sexual harassment and for the provision of advocacy services upon request. The representative from the hotline was interviewed by phone and confirmed the advocacy and availability to residents. The CPA called the hotline and confirmed the functioning of the hotline. The staff was observed providing direct supervision to the residents. The resident population on the first day of the onsite audit was 30.

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. 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 Tri-County Speaks formerly known as People Against Rape (rape crisis center). A Memorandum of Understanding (MOU) exists with Tri-County Against Rape to receive allegations of sexual abuse and sexual harassment and for the provision of advocacy services upon request. The conversation with the People Against Rape staff confirmed the advocacy services to be provided in accordance with the MOU.

Documentation and interview with a nurse at the Medical University South Carolina of Charleston (MUSC) the emergency room confirmed forensic medical examinations are performed in the Emergency Room. The hospital's Sexual Assault Policy provides that a Sexual Assault Nurse Examiner (SANE) will conduct the examinations. The nurse confirmed that a SANE nurse is always available 24/7.

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 staff and residents. There were no new admissions during the site visit.

Residents were observed in the dayroom, housing area, and in the hallway area preparing to leave for work. Most residents were employed in good paying jobs. Telephones were observed in the common hallway 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.

The first day of the onsite visit, the PREA-Auditor provided the Facility with two (2) corrective actions to reduce the risk of sexual assaults and sexual harassment. The were no residents under the age of 18 years of age or female residents at that time of the onsite audit visit. The following are the first-day corrective actions and the only corrective action from the CPA.

1) *Create a PREA Brochure in Spanish.*
2) Add language with the intent that employees are to notify the organization on any related sexual allegations in the employee agreement.

The second day consisted of interviewing third shift staff and collecting documents including the brochure that was translated into Spanish. The exit briefing served to review the onsite process and review facility's 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.

It should be noted that Alston Wilkes Charleston Residential Reentry Center (CRRC) management team responded immediately with corrective actions and demonstrated the corrective actions were corrected by the end of the site visit.

Post Onsite Audit Phase

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 PREA Coordinator/PREA Manager.

As Noted, Alston Wilkes Charleston Residential Reentry Center (CRRC) management team responded immediately with corrective actions and demonstrated the corrective actions were corrected by the end of the site visit. The facility was found to be compliant 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.

Alston Wilkes Charleston Residential Reentry Center (CRRC) is a 33-bed minimum security level facility and houses adult female and adult male residents. The parent agency is Alston Wilkes Society (AWS).

The CRRC 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. The programs include parenting classes, life skills training, cultural diversity training, money management classes, and substance abuse counseling.

The CRRC 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 100 days. One hundred and thirty (130) residents have been admitted to the CRRC in the past 12 months. The CRRC is in a commercial and residential neighborhood with access to public transportation and other community-based resources. The facility consists of one building. It consists of a front lobby/reception area, control room, administrative offices, multipurpose room with TV, lounge area and computer, staff restroom, common laundry area, female dorm with five beds, bathroom/single-stall shower area and utility room, male dorm with 28 beds, bathroom/single-stall shower area, and outside recreational area. Both, the male resident, and female resident housing area 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 CRRC is equipped with a video surveillance camera throughout the facility.

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 oversite of or participation in processes and activities that contribute to the facility operations. Allegations that are criminal in nature are investigated by the North Charleston 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. CRRC provides residents with employment placement services, and the following programs to help residents transition back into the community:

1) Anger Management
2) Cultural Diversity Training
3) Life Skills Training
4) Money Management
5) Parenting Classes
6) Substance abuse Counseling

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.

The CPA and Facility agreed on the 2 corrective actions:

1) *Create a PREA Brochure in Spanish.*
2) Add language with the intent that employees are to notify the organization on any related sexual allegations in the employee agreement.

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: 0

Standards Met

Number of Standards Met: 41

Standards Not Met

Number of Standards Not Met: 0
List of Standards Not Met: 0

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.

A review of CRRC policy 3.4 Sexual Abuse, Harassment and Misconduct, confirmed the facility mandates zero tolerance toward all forms of sexual abuse and sexual harassment and outlines the agency's approach to preventing, detecting, and responding to such conduct based on interview with the PREA Coordinator (PC). The agency has one upper-level, agency-wide PC with sufficient time and authority to develop, implement and oversee agency efforts to comply with the PREA standards in all its facilities. Based on the organizational chart, the Agency's PC, and the Facility's PCM reports to Director of Human Resources who is an upper level of management and have the authority to perform their duties.

Based on a review of policy, procedure, and practice to include staff, residents, Human Resource Director, PC/PCM, the agency and facility is following standard 115.211

Interviews:

PC/PCM
Human Resource Director
Specialized Staff
Random Staff
Residents

Document Reviewed:

PREA Pre-Audit Questionnaire
Facility Policy 3.4, Prison Rape Elimination (PREA)

Policy Organizational Chart

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.

CRRC houses residents from Federal Institutions. CRRC has a contract with the BOP for federal resident reentry services. The residents are under the authority of the BOP and any resident transferred is under the direction of the BOP. The CRRC does not contract with other entities for the confinement of residents.

Based upon review of documents and interview with PC/PCM, the facility is complying with standard 115.212

Interviews:
PC/PCM
Documents Reviewed:
PREA Pre-Audit Questionnaire Facility Policy 3.4

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.

The CPA reviewed CRRC Policy H1303 for compliance with staffing plan confirms the facility considers the following in the development of staffing plan: staffing plan that provides for adequate levels of staffing and, where applicable, video monitoring, to protect residents against sexual abuse, physical layout, video monitoring; and any findings of inadequacy from internal or external oversight bodies. The policy states in the event the staffing plan is unable to maintain, the deviation must be documented. The facility has document deviation with justification. During the on-site visit appropriate staffing was observed.

The staffing plan consists of assigning a minimum of two staff to each shift. Case Managers augment this scheduling by working alternate schedules to ensure coverage. Current facility policy is to check living areas at least hourly at night. Hourly checks are documented. The Facility has a capacity of 33 residents. During the time of the onsite visit 22 residents were being housed at the Facility.

Documentation reviews confirm there has been no judicial findings of inadequacy, findings of inadequacy from federal investigation agencies or findings of inadequacy from internal or external oversight bodies.

No identified blind spots were seen during the onsite review. Interview with PCM and Facility Director confirmed that staffing plan is adequate and there has been no deviation in the past twelve (12) months.

Based on PC and Facility's Director and random staff interviews, policy and staffing plan, PAQ, document reviewed, and observation of the Facility revealed no blind spots, the Facility is meeting standard 115.213

Interviews:

Facility Director
PC/PCM
Documents Reviewed:
Facility Policy H1303
Staffing Plan Assessment
PAQ

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.

Review of CRRC Policy H1402 states the Facility does not conduct cross gender strip searches or cross gender visual cavity searches. The policy further states that staff shall not search or physically examine a transgender or intersex resident for the sole purpose of determining resident genital status Staff interviewed confirmed the policy and staff stated they did not perform cross gender searches.

The facility has a policy 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. Staff and resident interviews confirmed the facility policy is being implemented. All residents interviewed were able to verbalize being able to shower, change clothes in privacy and acknowledge that cross gender announce their presence when entering the housing area. Staff training records/interviews verify staff receiving training on cross gender pat searches and searches on transgender and intersex residents. During the onsite visit there were no female residents or transgender residents housed in the Facility.

The facility policy 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. The 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, staff and resident interviews, document reviews and observation during the onsite visit, the Facility is meeting standard 115.215.

Interviews:

Residents
Random Staff

Documents Reviewed:

Facility Policy H1402
PREA Pre-Audit Questionnaire Training Records
Training Sign-in Sheet Resident Handbook

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.

Review of CRRC policy H1301 confirmed the facility provides interpretation services to residents when needed. The agency does not rely on resident interpreters, resident readers, or other types of resident assistants except in limited circumstances where an extended delay in obtaining an effective interpreter could compromise the resident's safety.

The agency policy, states “in the event of residents, who are limited English proficient, an interpreter will be provided to them at no cost to the resident”. The PC/PCM reported zero incidents in the past 12 months where residents required interpreters.

Interviews with PC/PCM and Facility Director confirmed the practice is being followed. During the onsite visit there were no LEP, Disabled residents housed in the Facility. The facility has not had disabled or LEP residents in the past twelve (12) months.

There was one corrective action; the Facility shall provide PREA brochure in Spanish to give to Spanish speaking residents.

Based on interviews with PC, review of documents, and observation during the onsite visit, and the facility providing the CPA a PREA brochure in Spanish, the Facility is meeting standard 115.216.

Interviews:

PC/PCM

Documents Reviewed:

Facility Policy H1301

Memorandum of Understanding (MOU).
Resident Handbook in English

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.

Review of CRRC 's Policy 4.3 confirm the agency does not hire or promote anyone who may have contact with residents or enlist the services of any contractor who may have contact with residents, who have engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility or other institution, or who has been convicted of engaging or attempting to engage in sexual activity in the community facilitated by force, overt or implied threats of force, or coercion or if the victim did not consent or was unable to consent or refuse or has been civilly or administratively adjudicated to have engaged in the activity described. The 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. The Facility does not hire anyone without a background check.

An interview with Human Resource Director informed the CPA that 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. The agency performs a criminal background record check in coordination with the BOP before enlisting the services of any contractor who may have contact with residents. A process is in place for criminal background checks at least every five years for current staff and contractors who may have contact with residents. According to Facility's policy, all applicants are asked about any prior misconduct involving any sexual activity. In addition, CRRC 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.

Based on the review of policy document, employee files, and interviews with the HR Director the Facility is meeting standard 115.217.

Interviews:

HR Director

Documents Reviewed:

Policy 4.3

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.

Review of CRRC Policy H701 state when designing or acquiring any new facility and in planning any substantial expansion or modification of existing facilities, Agency shall consider the effect of the design, acquisition, expansion, or modification upon the agency's ability to protect residents from sexual abuse. Any substantial expansion or modification of the existing facility shall be reported to the BOP. When installing or updating a video monitoring system, electronic surveillance system, or other monitoring technology, Agency shall consider how such technology may enhance the agency's ability to protect residents from sexual abuse.

The Facility added additional cameras to eliminate any blind spots in the Facility. The Agency considers technology an asset to enhance the Agency's ability to protect residents against sexual abuse and sexual harassment.

During the onsite visit, the CPA observed cameras strategically placed throughout the facility that eliminated blind spots.

Based on the review of policy document, Previous PREA report, and interview with the PC/PCM the Facility is meeting standard 115.218.

Interviews:

PC/PCM

Documents Reviewed:

Policy H701

Observation:
Cameras
Monitoring Room

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.

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

The Facility offers all victims of sexual abuse access to forensic medical examinations at an outside facility, without financial cost, where evidentiary or medical appropriate in accordance with the standard. Any resident alleges a sexual assault is transported to MUSC Emergency Room where an examination is performed by Sexual Assault Forensic Examiners or Sexual Assault Nurse Examiners, where possible. MUSC has a signed a memorandum of agreement (MOU) with the agency concerning emergency medical services including forensic examinations.

The agency also has a Memorandum of Agreement (MOA) with Tri-County Speaks to provide 24-hour hotline and counseling available to victims of sexual assault.

During the onsite visit, the CPA was able to observe posting of Tri-County hotline for rape crisis and PREA reporting. The CPA interviewed PC/PCM who confirmed the MOUs and Agency's policy is being implemented. Interview with MUSC Nurse confirmed availability of SANE/SAFE nurses to conduct forensic examinations. Based on PAQ and PC/PCM no sexual assaults were reported during the past twelve (12) months.

Based on the review of policy document, MOUs, PAQ, Postings, observation of postings, and interview with the PC/PCM the Facility is meeting standard 115.221.

Interviews:

PC/PCM
Telephone interview with Tri-County Speaks Counselor
Telephone interview with MUSC Nurse

Documents Reviewed:

Facility Policy 809
Memorandum of Understanding (MOU) with Tri-County Speaks
Memorandum of Understanding (MOU) with MUSC
Posting of Victim Services
Posting of Hotline

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.

Review of CRRC Policy 3.4 states the facility ensures an administrative or criminal investigation is completed for all allegations of sexual abuse and sexual harassment. The policy also ensures allegations of sexual abuse and sexual harassment are referred for investigation to an agency with the legal authority to conduct criminal investigations unless the allegation does not involve potentially criminal behavior. The agency has published this policy on its website. 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.

Interviews with PC/PCM confirmed the implementation of Policy 3.4. Observation of the Agency's website confirmed PREA information is posted on the website. The website also is a method for reporting PREA allegations. Observation of website confirmed there were no reported allegations on the agency website the past twelve (12) months. Review of PAQ confirmed no PREA allegations were reported during the past twelve (12) months.

Based on the review of policy document, MOUs, PAQ, observation of website, and interview with the PC/PCM the Facility is meeting standard 115.222.

Documents Reviewed:

Facility Policy 3.4
PREA Pre-Audit Questionnaire

Interviews:

Random staff
PC/PC

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.

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

The CPA interviewed ten (10) random staff who were knowledgeable and able to recite some of the PREA training received. Staff interviews were able to confirm receiving training in the following: employees who have contact with residents on: Its zero-tolerance policy for sexual abuse and sexual harassment; How to fulfill their responsibilities under agency sexual abuse and sexual harassment; prevention, detection, reporting and response policies and procedures; Resident's right to be free from sexual abuse and sexual harassment; The right of residents and employees to be free from retaliation for reporting sexual abuse and sexual harassment; The dynamics of sexual abuse and sexual harassment in confinement; The common reactions of sexual abuse and sexual harassment victims; How to detect and respond to signs of threatened and actual sexual abuse; How to avoid inappropriate relationships with residents; How to communicate effectively and professionally with residents, including lesbian, gay bisexual, transgender, intersex or gender nonconforming residents; and How to comply with relevant laws related to mandatory reporting of sexual abuse to outside authorities.

Based on the review of policy document 3.4 training records, staff signatures on training sheet, interviews with the PC/PCM and random staff confirm the Facility is meeting standard 115.231.

Interviews:
Random Staff
Compliance Manager/PREA Coordinator

Documents Reviewed:
Facility Policy 3.4
Training Attendance Record

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.

Review of CRRC Policy 4.27 requires 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.

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

During the onsite visit no volunteers or contractors were providing services in the Facility. No contractors or volunteers provided services in the past 12 months.

Based on the review of policy document 4.27 training records, staff signatures on training sheet, interviews with the PC/PCM the Facility is meeting standard 115.232.

Interviews:

PC/PCM

Documents Reviewed:

Policy 4.27

Training Document

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 action is taken by the facility.

Review of CRRC Policy H1202 states residents shall receive one-on-one individualized orientation during the intake process within 24 to 48 hours of arrival. The CPA interviewed 10 random residents who confirmed they received PREA orientation and education within 24-48 hours of coming into the Facility. The Case Manager who conducts the intake confirmed in an interview that residents receive PREA information during orientation process. PREA education is provided in person. Resident signatures acknowledging orientation were process. Case Managers provide follow-up PREA education to residents within 30 days.

The Facility education and orientation to PREA is accessible to residents who are Limited English Proficient (LEP), deaf, and visually impaired. During the onsite visit there were no LEP, deaf or visually impaired residents housed at the Facility.

Based on the review of policy document H1202, Residence Handbook, residence training records, interviews with the PC/PCM and random residence and observation of posters confirm the Facility is meeting standard 115.233.

Documentation Reviewed:

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

Training Acknowledgement Statements

Interviews:

Human Resource Director Facility Director
PREA Coordinator

Random Residents

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.

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

Specialized training shall include techniques for interviewing sexual abuse victims, proper use of Miranda and Garrity warnings, sexual abuse evidence collection in confinement settings, and the criteria and evidence required to substantiate a case for administrative action or prosecution referral. The Federal Bureau of Prisons has investigators and referral investigators that have the specialized training in accordance with the PREA standard and the agency coordinates all investigations with them.

Based on interview with PC/PCM and review of PAQ, there have been no reports of sexual abuse/sexual harassment within the past twelve (12) months.

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

Interviews:

Facility Director

Charleston Police

Documentation Reviewed:

Facility Policy 4.13
MOU

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 ☐X 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.

CRRC Policy H809 states the agency does not employ any medical or mental health staff. The Agency has a written agreement with MUSC for emergency medical care as well as forensic examination services. The Agency has a written agreement with Tri-County Speaks for hotline and counseling services to victims. The Auditor has viewed and verified MOUs.

The Agency does not employ any medical or mental health staff. The Agency coordinates with MUSC for emergency medical care as well as forensic examination services.

The Agency does not employ any medical or mental health staff. The Agency coordinates with the Medical University of SC (MUSC) located in Charleston, South Carolina, which conducts forensic examinations if needed. The local rape crisis center, Tri-County Speaks 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 the facility's residents.

The Agency does not employ any full-or part-time medical or mental health care practitioners who work in the facility; therefore, this standard is not applicable.

There have been no reports of sexual abuse within the past twelve (12) months.

Documentation Reviewed:

Facility Policy H809, MOU,

Interviews:

Facility Director
PC/PC
Telephone interview with MUSC Nurse

Interview with Tri-County Counselor

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.

Review of CRRC Policy H1202 states and based on interviews with the facility's intake staff and random residents, all residents are assessed during the intake screening and upon transfer to the facility for their risks of being sexually abused by other residents or sexually abusive toward other residents.

Interviews with residents confirmed intake screening takes place within 72 hours of arrival to the facility. CRRC uses an assessment that is an objective screening instrument. During the onsite visit there were no residents admitted. The CPA reviewed the assessment to see how staff used data of victimization and abusiveness during intake.

The intake screening included at minimum, the following criteria to assess residents for risk of sexual victimization: Whether the resident has a mental, physical or developmental disability; The age of the resident; The physical build of the resident; Whether the resident has previously been incarcerated; Whether the resident's criminal history is exclusively nonviolent; Whether the resident has prior convictions for sex offenses against an adult or child; Whether the resident is or is perceived to be gay, lesbian, bisexual, transgender, intersex or gender nonconforming; Whether the resident has previously experienced sexual victimization; and The residents own perception of vulnerability.

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

Only management staff have access to the risk screening form such as Executive Director, Facility Director as well as the PREA Coordinator.

Based on interviews with PC/PCM, Staff Responsible for Screening, review of document policy H1202 and the Risk Assessment the confirm the agency is meeting standard 115.235.

Interviews:

PC/PCM
Staff Responsible for Risk Screening Random Residents

Documents Reviewed:

Facility Policy H1202
Vulnerability Assessment Risk of Victimization and/or Sexual Aggression

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.

Review of CRRC Policy H1202 states the agency shall use information from the risk screening to determine housing, bed, work, education, and program assignments with the goal of keeping separate those residents of high risk of being sexually victimized from those at high risk of being sexually abusive. The agency shall make individualized determinations about how to ensure the safety of each resident. In deciding whether to assign a transgender or intersex resident to a room for male or female residents, and in making other housing and programming assignments, the agency shall consider on a

case-by-case basis whether a placement would ensure the residents health and safety and whether the placement would present management or security problems.

The policy confirms a transgender or intersex resident's own view with respect to his or her own safety shall be given serious consideration. The policy also confirms transgender and intersex residents shall be given the opportunity to shower separately from other residents.

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 to reduce the risk of sexual abuse by or upon a resident. The resident's risk level is reassessed with 30 days and periodically. All residents interviewed could identify specific areas inquired about in the administration of the Vulnerability Assessment.

Interviews with the PC and Staff responsible for intake verified that information taken during screening of residents were being utilized. 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.

No transgender or intersex residents were at the facility during audit to interview.

Based on interviews with PC/PCM, Staff Responsible for Screening, review of document policy H1202 and the Vulnerability Assessment of Victimization and or Sexual Aggression Random Resident Intake Files confirm the Facility is meeting standard 115.242.

Interviews:

PC/PCM
Random Resident
Facility Director
Staff Responsible for Risk Screening and Intake Coordinator

Documents Reviewed:

Facility Policy H1202
Vulnerability Assessment Risk of Victimization and/or Sexual Aggression and Random Resident Intake Files.

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.

Review of CRRC Policy H809 states the agency has multiple internal ways for residents to privately report per the PREA standard. The PC created a reporting form directly on the agency website which is available to all residents, staff, third parties and the public. A documentation review confirmed that the agency has an agreement with an outside advocacy organization, Tri-County Speaks. There is a 24 hour help line that is available to all residents and the public.

Documentation review confirmed that the Agency staff is well trained on accepting resident reports in multiple formats either verbally, in writing, anonymously or from third parties. Based on documentation and interviews Agency staff accept report made verbally, in writing anonymously or from third parties and shall promptly document any verbal reports. The agency provides a method for staff to privately report sexual abuse and sexual harassment of residents. This was further verified with random residents and random staff and PREA Coordinator interviews. There have been no reports of sexual abuse /sexual harassment within the past twelve (12) months.

Based on interviews with PC/PCM, Staff Responsible for Screening, review of document policy H809 and Third-Party reviewing forms, Resident Handbook and observed hotline Repotting Posters, the agency is meeting standard 115.251.

Interviews:

PC/PCM
Random Resident
Facility Director
Staff Responsible for Risk Screening and Intake Coordinator

Documents Reviewed:

Facility Policy H809
Third Party Reporting Forms, Resident Handbooks, Observed Posters and Hotline reporting Posters

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.

Review of CRRC Policy H809 states all the agency's residents are federal inmate transfers from the FBOP in accordance with contractual agreements between the two agencies. Documentation review confirmed that the FBOP maintains ultimate authority over all residents at the Charleston, SC facility. The policy also confirms any form of administrative procedure for dealing with resident grievances regarding sexual abuse will be coordinated with the FBOP. Review of CRRC confirms that there is no time limit imposed regarding when a resident may submit a grievance regarding an allegation of sexual abuse to their liaison officer with the FBOP.

Review of CRRC policy confirmed that a resident is not required to use any informal grievance process, or otherwise attempt to resolve with staff an alleged incident of sexual abuse. Interviews with residents confirmed residents understanding of administrative remedies in reporting grievances.

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 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.

Interviews:

HR Director

PC/PCM

Documents Reviewed:

Policy H809

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.

Review of CRRC Policy H809 states the agency maintains an agreement with an independent outside advocacy agency. The CPA tested the resident telephone access for this outside confidential support service during the onsite portion of the audit and interviewed an employee.

Review of MOU confirms Tri-County Speaks offers victim advocacy services at no cost to the resident or agency. CPA observed that the agency has posters and brochures with Tri-County Speaks contact information. Interviews confirmed that rape crisis information is available to all residents, staff and public. Documentation and random inmate interviews confirmed that the resident telephone calls are not monitored. Interviews with random residents revealed the knowledge of the accessibility of these support services. There have been no reports of sexual abuse within the past twelve (12) months.

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

The PREA Coordinator confirmed the availability and accessibility of outside confidential support services to residents. The Counselor of the advocacy agency stated that an advocate would go to the facility or the hospital upon request.

Based on interviews with random residents, review of document Policy H809, Tri-County Speaks MOU Resident Handbook the agency is meeting standard 115.253.

Interviews:

Random Residents

Documents Reviewed:

Policy H809
MOU,

Resident Handbook
Posted Information

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.

Review of CRRC Policy H809 states the agency has a method to receive third party reports of sexual abuse and sexual harassment through its website reporting process and local advocacy group (Tri-County Speaks). The policy and interviews confirms the agency shall distribute publicly information on how to report sexual abuse and sexual harassment on behalf of a resident. CPA observation confirmed the agency has posters and brochures throughout the facility that are also available to anyone and

explains third-party reporting options and processes. This practice was reviewed by the CPA on the agency's website.

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. There were no third-party reports received during the past 12 months.

Based on interviews with random residents, review of document Policy H809, Third Party Reporting Form confirm the agency is meeting standard 115.254.

Interviews:

Random Staff
Random Residents

Documents Reviewed:

Policy H809
Third Party Reporting Form
Agency Website

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.

Review of CRRC Policy 3.4 states the Agency requires all staff to report sexual abuse and sexual harassment immediately and according to agency policy report any knowledge, suspicion or information regarding an incident of sexual abuse or sexual harassment that occurred at the facility, whether or not it is part of the agency; retaliation against residents or staff who reported such an incident; and any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation.

Documentation review confirmed that the Agency reports all allegations of sexual abuse and sexual harassment including third-party and anonymous reports to the FBOP. Interviews with Case Managers, Intake staff, Facility Director, PREA Coordinator, random staff and residents verified the reporting process. Staff members are instructed to immediately report all allegations of sexual abuse or sexual harassment to a Supervisor or the Facility Director.

The 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. Interview with random staff confirmed there understanding 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.

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.

There were no reports of sexual abuse/sexual harassment within the past twelve (12) months.

Based on interviews with Intake Staff and CM/PCM confirm the agency is meeting standard 115.261.

Interviews:

Intake Staff
Facility Director
Compliance Manager/PREA Coordinator
Case Managers

Documents Reviewed:
Policy 3.4
PREA Questionnaire

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.

Review of CRRC Policy H809 and procedures, FBOP, interviews with CM/PCM and random staff during the on-site portion of the audit confirmed, once the agency staff learns that a resident is subject to a substantial risk of imminent sexual abuse, they will take immediate action to protect the resident. Review of documentation verify that follow-up coordination will occur between the agency and the FBOP to further ensure the resident's safety and security. The interviews of the random staff 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. Random staff indicated the expectation is that any action to protect a resident would be taken immediately. Interviews confirms that reports are private and confidential.

There have been no reports of sexual abuse/sexual harassment within the past twelve (12) months.

Based on interviews with CM/PCM and random staff and review of Policy H809 and Criminal Investigation Checklist Vulnerability Assessment confirm the agency is meeting standard 115.262.

Interviews:

Random Staff
Random Residents

Documents Reviewed:

Policy H809
Criminal Investigation Checklist Vulnerability Assessments

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.

Review of CRRC Policy H809 states the Facility Director will notify and act as soon as possible, but no later than seventy-two hours after receiving an allegation a resident was sexually abused while confined at another facility. The Agency documents such notification and informs the head of the facility and head of the agency where the alleged abuse occurred. Based on interviews with the Facility Director there were no allegations reported by another facility that a resident alleged sexual abuse while at CRRC and there were no allegations made by CRRC residents that he or she was sexually abused while at another facility. However, if such reports were made by residents, they would have reported it immediately.

There have been no reports of sexual abuse while housed at another facility within the past 12 months. Interviews confirms that the Agency will document such notifications to ensure the allegation is investigated in accordance with the PREA standard.

Based on interviews with CM/PCM and random staff and review of Policy H809 confirm the agency is meeting standard 115.263.

Interviews:

Facility Director
Random Staff
Compliance Manager
Telephone Interview (BOP)

Documents Reviewed:

Policy H809
Criminal Investigation Checklist
Vulnerability Assessments

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.

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

Policy review and staff interviews with security and non-security staff confirmed procedures that if the first responder is not a security staff member, the responder shall be required to request the alleged victim not take any actions that could destroy physical evidence, and then notify security staff. Random staff were able to convey provides 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 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 annually.

There has been no report of sexual abuse within the past twelve (12) months.

Based on interviews with random staff, Non-Security Staff and First Responders and review of Policy H809 confirm the agency is meeting standard 115.264.

Interviews:

Random Staff
Non-Security Staff
First Responder

Documents Reviewed:

Policy H809

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.

The Facility has a written institutional plan to coordinate actions taken in response to an incident of sexual abuse, among staff first responders, contract agencies, facility leadership and agency executive leadership. Random staff interviewed was familiar with the roles regarding the response to an allegation of sexual abuse. Review of plan and interviews with residents and staff during the during the onsite visit of the facility confirmed agency procedures.

Forensic medical examinations will be provided free of charge to the victim at MUSC 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. However, interview with Nurse at MUSC indicated that a

SANE Nurse is always available and on call for crisis. The victim will be provided unimpeded access to crisis intervention and medical services.

Based on interviews with Facility Director and random staff and review of Policy H809, MOU, Facility Written Plan confirm the agency is meeting standard 115.265.

Interviews:

Facility Director
Random Staff

Documents Reviewed:

Policy H809
MOU
Facility Written Plan

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.

Review of CRRC Policy H809 and procedures and interview with the Facility Director, confirmed that the facility is not bound by any form of collective bargaining 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. A review of documentation verified the state of South Carolina is considered a right to work state. The CPA specifically reviewed personnel actions taken by the agency. No allegations of sexual abuse were made within the past twelve (12) months.

Based on interviews with Facility Director and random staff and review of Policy H809 confirm the agency is meeting standard 115.266.

Interviews:

Facility Director
Random Staff

Documents Reviewed:

Policy H809

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.

Review of CRRC Policy H809 and procedures and an interview with Facility Director verified the agency policy protects all residents and staff who report sexual abuse or sexual harassment or who cooperate with sexual abuse or sexual harassment investigations from retaliation by other residents or staff. Documentation review verified that the Facility Director serves as the retaliation monitor.

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

Policy requires the monitoring of residents and staff who have reported sexual abuse and sexual harassment or cooperated in a sexual abuse or sexual harassment investigation. Documentation review confirmed the monitoring will take place for a period of ninety (90) days or longer, if needed. Interview with the Facility Director confirmed the Director's role as the monitor to prevent retaliations. Protective measures would include housing changes, transfers, removing alleged abusers, and emotional support services. The Facility Director identified protective measures that are aligned with the Policy and standard, including separating the alleged abuser from the alleged victim.

There were no incidents of retaliation within the past twelve (12) months.

Based on interviews with Facility Director, Retaliation Monitoring Checklist and Policy H809 the agency is meeting standard 115.267.

Interviews:

Facility Director
Retaliation Monitor

Documents Reviewed:

Policy H809
Retaliation Monitoring Checklist

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.

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

Documentation and Interviews confirmed the Agency coordinates with other outside agencies in determining further action and prosecution. The Agency does not compel residents to take a polygraph examination or other truth-telling devices as a condition for proceeding with an investigation.

Investigations are documented in a written report which contains a thorough description of physical, testimonial and all other documentary evidence.

Interviews and documentation review confirmed the Agency retains all written reports for as long as the alleged abuser is housed at the facility or employed by the Agency, plus five (5) years. The departure of the alleged abuser or victim from the employment or control of the agency shall not provide a basis for terminating an investigation. There have been no reports of sexual abuse/sexual harassment within the past twelve (12) months.

Based on interviews with Facility Director, Retaliation Monitoring Checklist and Policy H809 the Agency is meeting standard 115.271.

Interviews:

Telephone Interview North Charleston Detective
Facility Director
Random Staff
Compliance Manager/PREA Coordinator

Documents Reviewed:

Policy 4.13
Retaliation Monitoring Checklist

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.

Review of CRRC Policy 4.13 states the Agency imposes no standard higher than a preponderance of the evidence in determining whether allegations of sexual abuse or sexual harassment are substantiated. The CPA observed Agency and facility practices; reviewed data provided by the facility and interviewed residents and staff during the onsite visit and tour of the facility. Based on Agency policy and procedures along with agency staff and residents' 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.

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.

Substantiated allegations of conduct that appears to be criminal shall be referred for prosecution. Criminal investigations are handled by local law enforcement, North Charleston 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 the residents are under the jurisdiction of the federal Bureau of Prisons.

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. CRRC Policy states staff shall cooperate with any outside investigators and shall remain informed about the progress of the investigation.

Based on interviews and policy reviews the agency is meeting standard 115.272.

Interviews:

Telephone Interview north Charleston Detective
Facility Director
PC/PCM

Documents Reviewed:

Policy 4.13

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.

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

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

indicted on a charge related to sexual abuse within the Agency; or the Agency learns that the alleged abuse has been convicted on a charge related to sexual abuse within the Agency.

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.

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

Based on interviews telephone interview with Facility Director, CM/PCM, and BOP the agency is meeting standard 115.273.

Interviews:

Facility Director
Compliance Manager/PREA Coordinator

Documents Reviewed:

Policy 4.13

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.

Review of CRRC Policy 3.4 states disciplinary sanctions for violations of Agency policies relating to sexual abuse or sexual harassment are commensurate with the nature and circumstance of the acts committed, the staff member's disciplinary history and the sanctions imposed for comparable offenses by other staff histories. Staff shall be subject to disciplinary sanctions up to and including termination for violating Agency sexual abuse or sexual harassment policies.

Policy reviews and interview with HR Director verified 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. 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 the Agency's policy and procedures.

There have been no reports or sanctions on staff within the past twelve (12) months.

Based on interviews telephone interview with Facility Director, HR Director, CM/PCM, the agency is meeting standard 115.276.

Interviews:

Facility Director
HR Director
PC/PCM

Documents Reviewed:

Policy 3.4

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.

Review of CRRC Policy 4.3 and procedures along with an interview with the Facility Director and volunteer state 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.

Documentation review and interview verified the Agency takes appropriate remedial measures and shall consider whether to prohibit further contact with residents, in the case of any other violation of agency sexual abuse or sexual harassment policies by a contractor or volunteer.

There have been no allegations of Sexual abuse and sexual harassment by contractors or volunteers within the past twelve (12) months.

Based on interview with Facility Director and review of policy 3.4 confirm the Agency is meeting standard 115.277.

Interviews:

Facility Director

Documents Reviewed:

Policy 3.4

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

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

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

There have been no reports or sanctions on residents within the past twelve (12) months.

Based on interview with Facility Director and review of policy 3.4 confirm the Agency is meeting standard 115.278.

Interviews:

Facility Director

Documents Reviewed:

Policy H1305

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.

Review of CRRC Policy H809 verified resident victims of sexual abuse receive timely, unimpeded access to emergency medical treatment and crisis intervention services, the nature and scope of which are determined by medical and mental health practitioners according to their professional judgement. If no qualified medical or mental health practitioners are available at the time, a report of recent abuse is made, security staff first responders take preliminary steps to protect the victim and shall immediately notify the appropriate medical and mental health practitioners. Additionally, follow-up services as needed will be provided. The facility houses females and males. However, no female residents were present during the onsite visit or housed in the facility the past 12 months.

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

The CPA reviewed agency agreements and spoke with Counselor at Tri-County Speaks crisis hotline and MUSC Nurse on emergency forensic examination to confirm compliance. There have been no reports of sexual abuse within the past twelve (12) months. Based on interviews with random security staff.

Based on interview with Facility Director and review of policy 3.4 confirm the agency is meeting standard 115.282.

Interviews:

Facility Director
Random Staff
MUSC Nurse
Tri-County Speaks Counselor

Documents Reviewed:

Policy H809
Acknowledgment of PREA Education
MOU

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.

Review of CRRC Policy H809 states the Agency, in coordination with the FBOP, offers medical and mental health evaluations and as appropriate treatment to all residents who have been victimized by sexual abuse. The evaluation and treatment of such victims include, as appropriate, follow-up services, treatment plans, and, when necessary, referrals for continued care following their transfer, or placement in other facilities or their release from custody.

Documentation review and interview verified treatment provides such victims with medical and mental health services consistent with the community level of care. Resident victims of sexual abuse while

housed are offered tests for sexually transmitted infections as medically appropriate. Treatment services are provided to the victim with no financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident.

Staff interview, review of policy and procedures and outside agency agreements confirm the agency offers 24-hour unimpeded access of medical and mental health care per written agreements with outside agencies. There are no medical or mental health practitioners employed by the 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.

There have been no reports of sexual abuse or harassment by residents within the past twelve (12) months. There also have been no identified victim of abuse through screening or other methods in the past12 months.

Based on interview with Facility Director and review of policy H809, MOU confirm the agency is meeting standard 115.283.

Interviews:

Facility Director

Documents Reviewed:

Policy H809
MOU

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.

Review of CRRC Policy 4.13 states the facility shall conduct a sexual abuse incident review at the conclusion every sexual abuse investigation, including where the allegation has not been substantiated, unless the allegation has been determined to be unfounded. The 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. The Policy requires the meeting to be documented, including recommendations and the document provided to the Facility Director. The interview with the 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.

CRRC has a review team in place that consist of PC/PCM, Facility Director, and HR Director. All staff members on the Incident Review Team are upper management staff. The Incident Review Team considers whether the allegation or investigation indicates a need to change policy or practice to better prevent, detect, or respond to sexual abuse, and considers 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. The Review Team examines the area in the facility where the incident allegedly occurred to assess whether physical barriers in the area may enable abuse, assess the adequacy of staffing levels in that area

during different shifts, and assess whether monitoring technology should be deployed or augmented to supplement supervision by staff.

There were no reports within the past twelve (12) months, however the facility has the components for the incident review team in place.

Documents Reviewed:

Facility Policy 4.13

Interviews:

Facility Director
Incident Review Team Member

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.

Review CRRC Policy 4.13 states the Agency collects accurate, uniform data for every allegation of sexual abuse at facilities under direct control using a standardized instrument and set of definitions. The Agency aggregates the incident-based sexual abuse data at least annually. The incident-based data collected shall include, at minimum, the data necessary to answer all questions from the most recent version of the Survey of Sexual Violence conducted by the Department of Justice (DOJ).

The 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.

The Agency maintains, reviews, and collects data from every facility. Upon request, the Agency shall provide all such data from the previous calendar year to the DOJ no later than June 30. There have been no requests by DOJ in the past twelve (12) months. There have been no requests in the past twelve (12) months

Based on interview with PC/PCM, Facility Director, review of Policy 4.13, annual report and website confirm the Facility is meeting standard 115.287.

Documents Reviewed:

Facility Policy 4.13

Annual Report

PAQ

Interviews:

Facility Director
PC/PCM

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.

Review of CRRC Policy 4.13 states the Agency reviews data collected and aggregated to assess and improve the effectiveness of its sexual abuse prevention, detection and response policies, practices, and training. 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. The Agency's annual report approved by the agency head and made readily available to the public through its website.

The report shall include a comparison of the current year's data and corrective actions with those from prior years and shall provide assessment of the agency's progress addressing sexual abuse. The agency redacts specific material from the reports when publication would present a clear and specific threat to the safety and security of a facility but must indicate the nature of the material redacted.

Based on interview with PC/PCM, Facility Director, review of Policy 4.13, annual report and website confirm the Facility is meeting standard 115.288.

Documents Reviewed:

Facility Policy 4.13
Annual Report

Interviews:

Facility Director
PC/PCM

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.

Review of CRRC Policy 4.13 states a review of documents, policy, procedure along with agency PREA compliance manager and coordinator, the Agency ensures that data is collected and securely retained.

The Agency makes all aggregated sexual abuse data, from facilities under its direct control, readily available to the public at least annually through its website. The Agency website is www.alstonwilkessociety.org. The Agency has not posted 2020 annual report, but the CPA received a copy of the 2020 annual report. The report shall be upload before the end of the year.

Before making aggregated sexual abuse data publicly available, the Agency removes all personal identifiers. The Agency maintains sexual abuse data collected for at least ten (10) years after the date of the initial collection. The agency has removed all identifying information in its report.

Based on interview with PC/PCM, Facility Director, review of Policy 4.13, annual report and website confirm the Facility is meeting standard 115.289.

Documents Reviewed:

Facility Policy 4.13

Annual Report

Interviews:

Facility Director
PC/PCM

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.

PREA audits for the Facility have been conducted as required for the initial three-year period. The Facility is completing its requirement for the third three-year period. The CPA has observation on the Agency's website the audit completion from 2020. The CPA has access to and observed all areas of the audited facility. The facility has provided the Auditor with the required documentation which have maintained as required by the standards and the auditing process. The CPA was permitted to conduct private interviews with residents. The CPA was permitted to request and received copies of any relevant documents.

The PC/PCM was cooperative in providing additional information. Residents were permitted to send confidential information or correspondence to the auditor in the same manner as if they were communicating with legal counsel. The CPA's contact information was posted for residents to send confidential information.

Based on interview with PC/PCM, interviews with residents, observation of postings, review of website, the Facility is meeting standard 115.401.

Interviews:

PC/PCM
Resident Interviews in private area

Documents:

Website
Posting

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.

The facility was last PREA audited in 2020, and the CPA confirmed the audit report was posted on the Agency's website as is the practice with the facility. The report does not contain any personal identifying information and there were no conflicts of interest regarding the completion of the audit. The facility policies and other documentation were reviewed regarding compliance with the standards and have been identified in the report.

Based on observation of website the Facility is meeting standard 115.403.

Documents Reviewed:

Website

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.

Demetrius Henderson 12/29/2023

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.