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

☐ **Interim** X☐ **Final**

Date of Report January 27, 2020

Auditor Information

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Company Name: KEA Correctional Consulting LLC	
Mailing Address: P.O. Box 1872	**City, State, Zip:** Castle Rock, CO 80104
Telephone: (484)999-4167	**Date of Facility Visit:** September 11, 12, 2019

Agency Information

Name of Agency: CoreCivic		**Governing Authority or Parent Agency** *(If Applicable)*: NA	
Physical Address: 5501 Virginia Way		**City, State, Zip:** Brentwood, Tennessee 37027	
Mailing Address: SAA		**City, State, Zip:** SAA	
The Agency Is:	☐ Military	X☐ Private for Profit	☐ Private not for Profit
☐ Municipal	☐ County	☐ State	☐ Federal

Agency Website with PREA Information: http://www.corecivic.com/the-prison-rape-elimination-act-of-2003-prea

Agency Chief Executive Officer

Name: Damon Hininger	
Email: damon.Hininger@corecivic.com	**Telephone:** 615-263-3000

Agency-Wide PREA Coordinator

Name: Eric S. Pierson	
Email: eric.pierson@corecivic.com	**Telephone:** 615-263-6915

PREA Coordinator Reports to:	Number of Compliance Managers who report to the PREA Coordinator:
Steve Conry, Vice President, Operations Administration	63

Facility Information

Name of Facility: CoreCivic- Dahlia			
Physical Address: 4511 E. 46th Ave.		**City, State, Zip:** Denver, CO 80216	
Mailing Address (if different from above): SAA		**City, State, Zip:** SAA	
The Facility Is:	☐ Military	X☐ Private for Profit	☐ Private not for Profit
☐ Municipal	☐ County	☐ State	☐ Federal

Facility Website with PREA Information: http://www.corecivic.com/facilities/dahlia-facility

Has the facility been accredited within the past 3 years? ☐ Yes X☐ 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:
X☐ N/A

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

Facility Director

Name: Ericka Gillespie	
Email: ericka.gillespie@corecivic.com	**Telephone:** (303) 377-7200

Facility PREA Compliance Manager

Name: SAA	
Email: SAA	**Telephone:** SAA

Facility Health Service Administrator X☐ N/A

Name:	NA		
Email:	NA	**Telephone:**	NA

Facility Characteristics		
Designated Facility Capacity:	120	
Current Population of Facility:	97	
Average daily population for the past 12 months:	82	
Has the facility been over capacity at any point in the past 12 months?	☐ Yes X☐ No	
Which population(s) does the facility hold?	☐ Females X☐ Males ☐ Both Females and Males	
Age range of population:	37	
Average length of stay or time under supervision	188	
Facility security levels/resident custody levels	Minimum	
Number of residents admitted to facility during the past 12 months		237
Number of residents admitted to facility during the past 12 months whose length of stay in the facility was for *72 hours or more*:		237
Number of residents admitted to facility during the past 12 months whose length of stay in the facility was for *30 days or more:*		232
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)?		X☐ 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 X☐ 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:		21
Number of staff hired by the facility during the past 12 months who may have contact with residents:		9
Number of contracts in the past 12 months for services with contractors who may have contact with residents:		0 (See narrative for 115.232)

Number of individual contractors who have contact with residents, currently authorized to enter the facility:	0 (See narrative for 115.232)
Number of volunteers who have contact with residents, currently authorized to enter the facility:	6
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.**	0
Number of single resident cells, rooms, or other enclosures:	0
Number of multiple occupancy cells, rooms, or other enclosures:	17 rooms with between five and 22 residents
Number of open bay/dorm housing units:	3
Does the facility have a video monitoring system, electronic surveillance system, or other monitoring technology (e.g. cameras, etc.)?	X☐ 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 X☐ No

Medical and Mental Health Services and Forensic Medical Exams	
Are medical services provided on-site?	☐ Yes X☐ No
Are mental health services provided on-site?	☐ Yes X☐ No
Where are sexual assault forensic medical exams provided? Select all that apply.	☐ On-site X☐ Local hospital/clinic ☐ Rape Crisis Center ☐ Other (please name or describe:

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 X☐ 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)	X☐ Local police department ☐ Local sheriff's department ☐ State police ☐ A U.S. Department of Justice component ☐ Other (please name or describe: ☐ 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?	2
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	X☐ 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: ☐ N/A X

Audit Findings

Audit Narrative

The Prison Rape Elimination Act (PREA) on-site audit of Dahlia Facility (DF) was conducted September 11 and 12, 2019, by K. E. Arnold from Castle Rock, CO, a United States Department of Justice Certified PREA Auditor for both juvenile and adult facilities. Pre-audit preparation included review of all materials and self reports electronically uploaded to a program and e-mailed to the auditor's secure e-mail address.

The documentation review included, but was not limited to, Core Civic (CC) facility policies, staff training slides, completed forms regarding both staff and resident training, MOUs, organizational chart(s), CC PREA brochures, victim advocacy brochure, resident education materials, photographs of PREA related materials (e.g. posters, etc.), executed Human Resources documents associated with relevant PREA standard(s), and staff training certifications. This review prompted several questions and informational needs that were addressed with the DF Director/PREA Compliance Manager (DF PCM). The majority of informational needs were addressed pursuant to this process.

Following the on-site audit, the auditor spoke with the Director of Client Services at The Blue Bench. The Blue Bench is an advocacy group who is tied into the reporting format at DF. The Director of Client Services asserts she cannot specifically cite a number associated with receipt of sexual abuse/ harassment reports from residents housed at DF however, she can report they are minimal in view of the fact the facility is not foremost in her mind.

The auditor met with the Director/PCM, the Assistant Facility Director, and the CC Director of PREA Compliance and Investigations at 8:00AM on Wednesday, September 11, 2019. The auditor provided an overview of the audit process and advised all attendees the same would be facilitated in the least disruptive manner possible. Additionally, the auditor advised attendees of the tentative schedule(s) for the conduct of the audit. Between 8:50AM and 10:15AM, the auditor toured the entire facility with the Director and CC Director of PREA Compliance and Investigations.

It is noted the rated capacity of DF is 120 residents and the institutional count on September 11, 2019 was 97 residents.

During the on-site audit, the auditor was provided a conference room from which to review documents and facilitate confidential interviews with staff and residents. The auditor randomly selected (from a resident roster provided by the Director) 17 residents (10 of whom were designated as random resident interviewees) for on-site interviews pursuant to the Resident Interview Questionnaire and specialty interview questionnaires. The auditor notes one potential interviewee refused to be interviewed. Interviewees represented all wings.

According to the Director, there were no resident(s), confined in the facility at the time of the on-site audit, who were blind/low vision or low hearing/deaf, lesbian/bisexual residents, transgender or intersex residents, or residents who reported a sexual abuse at DF. The Director identified one LEP resident however, the auditor determined (pursuant to conversation with the interviewee) he spoke, understood, read English and accordingly, the auditor did not utilize the Disabled Questionnaire with this interviewee.

It is noted the 10 random resident interviewees were generally questioned regarding their knowledge of a variety of PREA protections and their knowledge of reporting mechanisms available to residents for reporting sexual abuse and sexual harassment. Overall, random resident interviewees presented

reasonable knowledge of PREA policies and practices. Of note, the auditor inquired as to the basis for their knowledge and several interviewees advised they had received training by DF staff, as well as, information gleaned pursuant to previous PREA training within State prisons, jails, other CC facilities, and transitional centers.

The auditor notes at the time of the on-site audit, the on-strength staff complement was twenty-one. Twelve security staff, five case managers, one cook supervisor, one operations supervisor, one assistant director, and one Director comprise the DF staff complement. Some staff facilitate multiple PREA functions.

The auditor facilitated 12 random staff interviews, selected by the auditor from a staff roster provided by the Director. The Random Sample of Staff Interview Questionnaire was administered to this sample group of interviewees. Interviewees were questioned regarding PREA training and overall knowledge of the agency's zero tolerance policy, reporting mechanisms available to residents and staff, response protocols when a resident(s) allege abuse, and First Responder duties.

The following specialty staff questionnaires were utilized during this review including:

Agency Head
Director
CC PREA Coordinator (CCPC)
PCM
Designated Staff Charged with Monitoring Retaliation (1)
Incident Review Team (1)
Human Resources (1)
Investigator (1)
SAFE/SANE Staff- (1)
Intake (1)
Staff Who Perform Screening for Risk of Victimization and Abusiveness (1)
Security and Non-Security Staff Who Have Acted as First Responders (1 Security staff and 1 Non-Security staff)
Non-medical Staff Involved in Cross-Gender Strip or Visual Searches (1)
Volunteer (1)

The Contract Administrator interview was not conducted as DF does not employ staff in that capacity.

It is noted CC is the umbrella company for DF.

The following resident interviews were facilitated in addition to the random resident interviews. The interview sets are noted below:

Disabled (2 with mental disabilities, 2 with physical disabilities, 1 with low reading, and 1 with speech impediment)
Gay (1)
Reported Prior Sexual Abuse during Screening (1)

The auditor reviewed 11 Staff Training records, 11 resident files, 10 staff HR files, two PREA investigative files, and other records reflected throughout the following narrative prior to the audit, during the audit, and subsequent to completion of the same.

On September 11, 2019, the auditor was processed into the facility at the control center. The auditor did note PREA third-party notification (telephonic reporting information) posted outside the control center and generously posted throughout the facility.

Similarly, PREA Hotline notification numbers were posted above the resident telephones, in every resident room, and on various walls through the facility. An Ethics Hotline poster (staff private reporting mechanism) was also posted in the staff gathering area(s). PREA Audit Notices were prevalent throughout the facility, inclusive of the housing units, resident rooms, program areas, etc. It is also noted a reminder regarding opposite gender staff announcements is posted on resident room doors throughout the facility.

During the facility tour, the auditor observed, among other features, the facility configuration, location of cameras, staff supervision of residents, unit layout (inclusive of shower areas), placement of PREA posters and informational resources, security monitoring, and resident programming.

The facility is single floor, rectangular in construction, generally configured with resident rooms situated around the external facility walls. The auditor notes there are two large dormitory style rooms wherein up to 18 and 24 residents can be housed. The facility was not full at the time of the on-site audit.

The control center, as well as, the operations supervisor and assistant facility director have access to video surveillance monitoring. A total of 38 cameras are strategically located throughout the facility and all can be monitored.

Sufficient security monitors (staff), given the size of the facility and commensurate with policy as articulated in the narrative at 115.213, supervised the facility throughout periods of time the auditor was present at the facility. Video surveillance and implementation thereof effectively augments staff physical supervision.

The auditor noted camera surveillance are well dispersed throughout the facility. All relevant areas are adequately covered by camera supervision, ensuring observation of entrance into and egress from relevant areas.

No cameras are specifically focused into resident rooms or resident bathrooms. The auditor reviewed camera angles in real time from the control center and found no instances allowing voyeurism, etc.

Toilet areas are adequately shielded. Showers and toilets/urinals are located in such a manner they are not visible unless one physically walks into the bathroom. Urinals are located against a wall opposite from view.

The auditor notes there are windows in all staff offices and resident rooms. Accordingly, supervision pursuant to routine correctional supervision is enhanced.

During the facility tour, the auditor did test the DOC-TIPS Line (external reporting source for residents, staff) and found the same to be operational. Contact with a recorded voice was accomplished and he advised of the test of the Hotline. According to the Director, she did not receive a text, e-mail, or telephone call in follow-up to the test call.

The auditor notes he has tested the DOC-TIPS-Line at two other CC Denver community confinement facilities and the requisite notification to the Director or designee was accomplished. Accordingly, the auditor recommends the Director contact DOC-TIPS Line staff to report this failure in terms of reporting the test to her. Additionally, the auditor recommends the DOC-TIPS Line be tested monthly with results documented.

As a kudo, the auditor learned the assistant facility director closely tracks the conduct of 30-day sexual victimization/aggressor screenings, as required pursuant to 115.241, by spread sheet. This check and balance process is integral to positive outcomes.

An On-site Audit Closeout meeting was facilitated on September 12, 2019 with the Director, the assistant facility director, and the operations supervisor. The auditor expressed his gratitude for the hospitality displayed at the facility, as well as, staff's responsiveness during interviews, information gathering, etc. Additionally, the auditor thanked the Director for her diligence in terms of ensuring prompt reporting of interviewees.

While a rating is not provided during such Closeouts, the auditor complimented the Director regarding staff's general knowledge regarding PREA programs and operations. Additionally, he cited the PREA Victimization and Predator Screening process/implementation of the same as a strength.

Facility Characteristics

DF is located at 4511 East 46th Avenue, Denver, Colorado. From 2001 – 2003, DF was owned and operated as a juvenile secured facility by Correctional Management Inc. (CMI). From 2003 to present, DF has been a community corrections program that houses all male adult residents. In April, 2016, Corrections Corporation of America (CCA) acquired CMI-Dahlia. Corrections Corporation of America's mission has changed and with the change, the name of the agency has been changed to CoreCivic.

DF is a 9,770-square foot single floor building constructed in 1953. Residents are minimum-security level offenders most of them released from the Colorado Department of Corrections. The residents are classified as Condition of Parole, Transition or Diversion clients.

There is a level-based system for residents of DF. Residents entering the program are on level 1 and after certain requirements are met, residents can advance to other levels up to level 4, which affords them more privileges. Residents must abide by certain conditions of placement and residents who violate these conditions are subject to sanctions, which may include a decrease in their level or removal from the program.

As reflected throughout this report, two contractors (contracted by CDOC) and volunteers augment services provided by DF staff. The auditor found no concerns with respect to PREA training provided to these individuals.

The CC Mission Statement reads as follows.

We help government better the public good through:

Core Civic Safety - We operate safe, secure facilities that provide high quality services and effective re-entry programs that enhance public safety.

Core Civic Community - We deliver proven and innovative practices in settings that help people obtain employment, successfully reintegrate into society, and keep communities safe.

Core Civic Properties - We offer innovative and flexible real estate solutions that provide value to government and the people they serve.

Summary of Audit Findings

Standards Exceeded

Number of Standards Exceeded: 4
List of Standards Exceeded: 115.231, 115.267, 115.286, 115.288

Standards Met

Number of Standards Met: 35

Standards Not Met

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

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? X□ Yes □ No

- Does the written policy outline the agency's approach to preventing, detecting, and responding to sexual abuse and sexual harassment? X□ Yes □ No

115.211 (b)

- Has the agency employed or designated an agency-wide PREA Coordinator? X□ Yes □ No

- Is the PREA Coordinator position in the upper-level of the agency hierarchy? X□ 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? X□ Yes □ No

Auditor Overall Compliance Determination

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

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

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

The Director self reports the agency has a written policy mandating zero tolerance toward all forms of sexual abuse and sexual harassment in facilities it operates directly or under contract. The Director self reports the facility has a written policy outlining how it will implement the agency's approach to preventing, detecting, and responding to sexual abuse and sexual harassment.

The Director further self reports the facility has a written policy which includes definitions of prohibited behaviors regarding sexual abuse and sexual harassment. The policy does include sanctions for those found to have participated in prohibited behaviors and a description of agency strategies and responses to reduce and prevent sexual abuse and sexual harassment of residents.

Core Civic (CC) 14-2 CC entitled Sexual Abuse Prevention and Response, pages 1-33 addresses 115.211(a).

Pursuant to the PAQ, the Director self reports the agency employs or designates an upper-level, agency-wide PREA Coordinator who has sufficient time and authority to develop, implement, and oversee agency efforts to comply with the PREA standards in all of its community confinement facilities. The Director reports

the CC PREA Coordinator (CCPC) is in the agency's organizational structure and the auditor verified the same pursuant to review of the CC Organizational Chart.

The auditor notes the Director serves as the PREA Compliance Manager (PCM) at DF. She is likewise included in the facility organizational chart.

Pursuant to interview with the CCPC, the auditor learned he does feel he has sufficient time to manage all of his PREA related responsibilities. Each facility has a PREA Compliance Manager (PCM), numbering in excess of sixty.

As Senior Director, he oversees the Director who facilitates reviews of all PREA investigations. The Director tracks any follow-up regarding reviewed PREA investigations. The Director is now working on an enhanced PREA training program for implementation at the facilities.

The CCPC's primary focus is audit preparation. Specifically, he reviews each Pre-Audit Questionnaire (PAQ) for sufficiency and comprehensiveness prior to forwarding the same to PREA auditors. The CC Quality Assurance Department (QA) currently facilitates mock audits of each facility. The CCPC reviews each mock audit report and coordinates corrective action with Wardens/Facility Directors and facility PCMs. He posts common audit deficiencies on a shared website so stakeholders can assume a proactive approach, as opposed to, reactive in terms of PREA-related matters. Additionally, the CCPC coordinates all corrective action following each PREA audit.

Finally, the CCPC reviews each facility PREA Staffing Plan and signs the same. Assistance with relevant MOU development is also a primary responsibility, with approval being conferred by the CC Legal Department.

In view of the above, the auditor finds DF substantially compliant with 115.211.

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 X□ 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 X□ 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 X□ 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 X□ NA

Auditor Overall Compliance Determination

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

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

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

Pursuant to the PAQ, the Director self reports CC and DF do not contract with other facilities or companies to house residents designated for confinement at DF. The auditor's research and informal interview with the CCPC and Director validate the same.

Given the lack of evidence substantiating non-compliance with 115.212, the auditor finds DF substantially compliant with the same.

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?
- X□ 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? X□ 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? X□ 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? X□ 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? X□ 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 X□ 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? X□ Yes □ No

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

Auditor Overall Compliance Determination

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

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

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

Pursuant to the PAQ, the Director self reports the agency develops and documents a staffing plan that provides for adequate levels of staffing, and where applicable, video monitoring to protect residents against sexual abuse. The Director self reports the average daily number of residents since the last PREA audit is 82 and the average daily number of residents on which the staffing plan is predicated is 90.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 9, section D(1 and 2)(a-d) addresses 115.213(a). Page 32 of the Colorado Community Corrections Standards. section OMA-020 also addresses the minimum staffing guidelines for community confinement facilities. A minimum of two staff, whose primary duties entail client supervision, must be on shift within the facility at all times.

Page 6, paragraphs 28 and 29 of the MOU between the Denver Community Corrections Board and Correctional Management Inc. (CMI- the last owner of the facility) confirms the verbiage discussed above. Additionally, minimal staffing of three is required during daytime hours (8:00AM- 10:00PM) in those facilities housing 90 or more residents. Accordingly, requisite staffing at DF is three during daytime hours (8:00AM-10:00PM).

Pursuant to the Director, the facility does have a staffing plan. Adequate staffing levels to protect residents against sexual abuse and video monitoring are considered in the plan. Generally, two staff members are on each shift however, three monitors are on site between the hours of 8:00AM and 10:00PM. The staffing plan is documented and maintained electronically/hard copy in the Director's Office.

When assessing adequate staffing levels and the need for video monitoring, the facility plan considers the following:

a. The facility is configured in a large rectangle. The number of staff required to effectively monitor the facility, by shift, is the primary consideration. Camera surveillance addresses barriers and blind spots. Three monitors are required on day and swing shifts while two staff are required for graveyard shift. One monitor is required in the control center at all times. The third staff member may facilitate transports or process intakes.
b. The resident population is normalized at DF. There are no prevalent racial issues, nor are there any gang issues. Some gang members or gang affiliates are housed at DF however, there are no apparent "turf battles". There are no LGBTI issues, as observed by the auditor and gleaned pursuant to resident interviews. Positive and tenured prison inmates are sometimes used as role models (strategically placed throughout the facility).
c. PREA incidents have not been issue during this audit period. PREA is stressed all of the time with both staff and residents.
d. There are no other relevant factors under consideration at DF at this time.

In regard to daily checks for compliance with the staffing plan, the operations supervisor forwards a daily roster to the Director for review. All posts are covered on a daily basis. The operations supervisor reports any potential vacancies to the Director, Assistant Director, and on-call. All parties are responsible for ensuring coverage, inclusive of filling the post by the on-call.

The auditor notes the Director is also self-designated as the PCM at DF.

Pursuant to the PAQ, the Director self reports in circumstances where the staffing plan is not complied with, the facility documents and justifies all deviations from the plan. According to the Director's self report in the PAQ, there were no instances of deviation from the staffing plan during the last year.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 9, section D(3) addresses 115.213(b).

The Director asserts all instances of non-compliance with the PREA Staffing Plan would be documented. Specifically, the deviation would be documented in a 5-1 packet as a Reportable Incident and forwarded to the CCPC within seven days of occurrence. The Senior Director for Division 7 is alerted immediately.

The Director self reports there were no instances of deviation from the Staffing Plan during the last 18 months. The auditor's observation of staffing during the facility tour and during non-regular business hours reveals substantial compliance with 115.13. Three monitors are assigned to the shift during day and swing shifts and they are visible throughout the facility.

The auditor did note camera surveillance is sufficient to augment staffing, thereby serving to facilitate resident sexual safety. Camera placements are addressed in the first few pages of this report.

Pursuant to the PAQ, the Director self reports at least once every year, the facility reviews the staffing plan to see whether adjustments are needed to:

The staffing plan;
Prevailing staffing patterns;
The deployment of video monitoring systems and other monitoring technologies; and
The allocation of facility/agency resources to commit to the staffing plan to ensure compliance with the same.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, pages 9 and 10, section D(5)(a) and (b)(i-iv) address 115.213(c). Additionally, Colorado Community Corrections Standards, section OMA-020 addresses 115.213 as referenced in the narrative for 115.213(a) addresses 115.213(c).

According to the DF PCM, the facility staffing plan is reviewed at least once each year. As both Director and PCM, she develops the same.

The auditor's review of the October 23, 2018 and May 5, 2019, Annual PREA Staffing Plan Assessments reveals substantial compliance with 115.213(c). The plans address the four requisite consideration factors and reflect all requisite signatures.

In addition to the above, the auditor's review of the Colorado Community Corrections Standards reveals the requisite minimum three staff verbiage (daytime) as previously articulated in the 115.213(a) narrative, is present.

In view of the above, the auditor finds DF substantially compliant with 115.213.

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?
  X□ 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 X□ 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 X□ NA

115.215 (c)

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

Auditor Overall Compliance Determination

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

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

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

Pursuant to the PAQ, the Director self reports cross-gender strip searches or cross-gender visual body cavity searches of the anal or genital opening are not conducted at DF. The Director further self reports 0 strip or cross-gender visual body cavity searches of residents were conducted at DF during the last 12 months.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 14, section K(1)(a) addresses 115.215(a). Such searches can be completed in exigent circumstances. Exigent circumstances are defined in this policy provision, as well as, the specifics of provision requirements.

According to the non-medical staff involved in a cross-gender strip or visual search interviewee, cross-gender strip searches or cross-gender visual body cavity searches are not conducted at DF. The auditor notes the interviewee's assertion coincides with the auditor's findings. However, she asserts a resident

carrying dangerous contraband in his rectum constitutes an exigent circumstance warranting the conduct of such cross gender searches.

The auditor has found no evidence of cross-gender strip or visual searches conducted by non-medical staff, at DF during the last 12 months.

Pursuant to the PAQ, the Director self reports the facility does not permit cross-gender pat-down searches of female residents, absent exigent circumstances. The Director further self reports the facility does not restrict female resident's access to regularly available programming or other outside opportunities in order to comply with this provision. Given the fact female residents are not housed at DF, the auditor finds 115.215(b) not applicable to the facility. In the past 12 months, no female pat-down searches were conducted by male staff.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 14, section K(1)(b) addresses 115.215(b). Exigent circumstances are defined in this policy provision, as well as, the specifics of provision requirements.

The auditor notes female residents are not housed at DF.

Pursuant to the PAQ, the Director self reports facility policy requires all cross-gender strip searches and cross-gender visual body cavity searches be documented. As female residents are not housed at DF, such policy is not applicable to cross-gender pat searches of female residents.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, pages 14, section K(1)(c) addresses 115.215(c).

Pursuant to the PAQ, the Director self reports the facility has implemented policies and procedures that enable residents to shower, perform bodily functions, and change clothing without non-medical 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 (this includes viewing via video camera). The Director further self reports policies and procedures require staff of the opposite gender to announce their presence when entering a resident housing unit.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 15, section K(5 and 6) addresses 115.215(d). This policy provision addresses the requirements of the provision and a definition of exigent circumstances.

Eight of 10 random resident interviewees self report female staff announce their presence, by gender, when entering their housing area. One interviewee who responded in the negative assessed female staff consistency in announcing as 98% while the other assessed consistency as 70%. All 10 interviewees self report they are never naked or in full view of female staff (not including medical staff such as doctors, nurses) when toileting, showering, or changing clothing.

All 12 random staff interviewees self report female staff announce their presence, by gender, when entering housing areas at DF. Similarly, all interviewees self report residents are able to dress, shower, and toilet without being viewed by staff of the opposite gender.

During the facility tour, the auditor noted a sign on every resident room door reading, "Opposite Gender Must Announce Upon Entry". The auditor noted no instances either during the facility tour or throughout the duration of the audit wherein female staff failed to announce their presence (by gender) whenever they entered a housing area.

Pursuant to the PAQ, the Director self reports the facility has a policy prohibiting staff from searching or physically examining a transgender or intersex resident for the sole purpose of determining the resident's genital status. According to the Director, no such searches were facilitated during the last 12 months.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, pages 14 and 15, section K(2) addresses 115.215(e).

All 12 random staff interviewees self report the facility prohibits staff from searching or physically examining a transgender or intersex resident for the sole purpose of determining the resident's genital status and that they are aware of the relevant policy.

The Director asserts there were no transgender/intersex residents housed at DF during the on-site audit and accordingly, the appropriate questionnaire could not be administered.

Pursuant to the PAQ, the Director self reports 100% of all security staff have received training on conducting cross-gender pat-down searches and searches of transgender/intersex residents in a professional and respectful manner, consistent with security needs.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 7, section b(i) addresses 115.215(f).

The auditor's review of the training module regarding the conduct of cross-gender pat down searches and searches of transgender/intersex residents in a professional and respectful manner training reveals substantial compliance with 115.215(f). Cross-gender pat-down searches and searches of transgender/ intersex residents in a professional and respectful manner are facilitated in the PREA Overview session during Pre-Service and annual In-Service training.

In addition to the above, the auditor's review of Training Activity Enrollment/Attendance Rosters dated June 21 and 29, 2019 reveals 17 staff completed a PREA: Cross Gender/Transgender Pat Searches class.

The auditor's on-site review of 11 random staff interviewee training files reveals the afore-mentioned and described training was provided during Pre-Service, In-Service, or both training sessions throughout the audit period.

All 12 random staff interviewees self report they are aware of the policy prohibiting staff from searching or physically examining a transgender or intersex resident for the sole purpose of determining that resident's genital status and all interviewees self report they received the requisite training either during Pre-Service, In-Service training, or both. The training was provided in a video/power point format and in some cases, a demonstration.

In view of the above, the auditor finds DF substantially compliant with 115.215.

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? X□ 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? X□ 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? X□ 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? X□ 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? X□ 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.) X□ Yes □ No

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

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

Auditor Overall Compliance Determination

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

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

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

Pursuant to the PAQ, the agency has established procedures to provide disabled residents equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and harassment.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, pages 13 and 14, section I(5)(a) and (b) addresses 115.216(a).

According to the Agency Head interviewee, the agency has established procedures to provide residents with disabilities and residents who are Limited English Proficient (LEP) 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. Specifically, Language Line is used, when necessary, to communicate with LEP residents. Generally speaking, staff translators can also be used. TTY units are available in every facility and Braille is available in some facilities.

According to the PCM, no limited English proficient residents were housed at DF at the time of the on-site audit. Accordingly, this interview could not be conducted. The two Disabled (Mental Health), two physically disabled, one low reading, and one speech impediment interviewees self report the facility provides information about sexual abuse/harassment that they are able to understand.

During the facility tour, the auditor noted posters are positioned in such a manner disabled residents can read the same. Materials are in sufficient supply to enable residents ample access to PREA program information, etc. During the facility tour, three random resident interviewees advise they have experienced no difficulty in terms of program understanding.

The Director asserts low functioning residents can be aided by a Mental Health Therapist. Access to Braille services is accommodated through the State of Colorado. When needed, staff read materials to blind residents and deaf or hard of hearing residents read materials themselves. Residents sign and date a document stipulating they understand the subject-matter presented.

Pursuant to the PAQ, the Director self reports the agency has established procedures to provide inmates with limited English proficiency 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.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, pages 13 and 14, section I(5)(a) and (b) addresses 115.216(b).

The auditor's review of the Language Line Interpreter Services contract reveals substantial compliance with 115.216(b). Additionally, the auditor's review of an MOU with the Spring Institute for Intercultural Learning reveals the same level of compliance. Finally, the auditor's review of the PREA: A Guide to the Prevention and Reporting of Sexual Misconduct is presented in both English and Spanish.

Pursuant to the PAQ, the Director self reports agency policy prohibits use of resident interpreters, resident readers, or other types of resident assistants except in limited circumstances where an extended delay in obtaining an effective interpreter could compromise the resident's safety, the performance of first-response duties, or the investigation of the resident's allegations. The Director further self reports the facility documents the limited circumstances in individual cases where resident interpreters, readers, or other types of resident assistants are used. Finally, in the last 12 months, there were no instances where resident interpreters, readers, or other types of resident assistants have been used and it was not the case that an extended delay in obtaining another interpreter could compromise the resident's safety, the performance of first response duties, or the investigation of the resident's allegations.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 14, section I(5)(c) addresses 115.216(c).

Eleven of 12 random staff interviewees were aware of at least one condition under which a resident translator, interpreter, reader, or assistant can be used to assist with translation in the event a disabled or Limited English Proficient (LEP) resident attempts to report sexual abuse. The auditor notes interviewees quickly identified the condition(s) following dissection of a scenario. All 12 interviewees self report no such instances of using translators pursuant to the circumstances articulated in 115.216(c) have presented during the last 12 months.

Throughout the on-site audit, the auditor found no evidence of staff use of other residents as prescribed in 115.216(c).

In view of the above, the auditor finds DF substantially compliant with 115.216.

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)? X□ 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? X□ 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? X□ 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)? X□ 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? X□ 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? X□ 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? X□ 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? X□ Yes □ No

115.217 (c)

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

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

115.217 (g)

- Does the agency consider material omissions regarding such misconduct, or the provision of materially false information, grounds for termination? X□ 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.) X□ Yes □ No □ NA

Auditor Overall Compliance Determination

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

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

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

Pursuant to the PAQ, the Director self reports agency policy prohibits hiring or promoting anyone who may have contact with residents and prohibits enlisting the 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;
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 in the above paragraph.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 5, section B(1)(a-c) addresses 115.217(a).

It is noted the auditor's on-site random review of three HR files regarding staff promoted during the last 18 months reveals two staff completed the 14-2H CC (includes the three questions as articulated above, plus sexual harassment) in a timely manner while the other did not complete the same in a timely manner. As reflected in the narrative for 115.232, there are no contractors who executed contracts with DF. The contracts are executed between CDOC and the contractor(s).

The auditor's review of two completed 14-2H CC forms (executed by the contractors) dated September 23 and 25, 2019 reveals substantial compliance with 115.217(a) and (b). Additionally, the auditor's review of criminal background record checks dated June 13, 2019 and July 1, 2019 validates non-existence of the 115.217(a) and (b) issues. Contractor criminal background record checks are addressed in the 115.217(d) narrative.

The auditor's on-site random review of six Human Resources (HR) files for staff hired at DF between 2017 and 2019 reveals the requisite 14-2H CC form was completed by the applicant either prior to the date of hire, on the date of hire, or within days thereafter. One random file review pertained to an employee who was hired pursuant to the previous contract. Accordingly, compliance with 115.217(a) and (b) is demonstrated.

Contact with HR staff reveals a criminal background records check is not completed for internal promotions as the initial background check, in addition to the completion of the annual 14-2H CC document, provides continuity to determine the existence of the afore-mentioned behaviors. A criminal background record check is completed prior to the "start date" for all new employees thus, ensuring comprehensive knowledge of background history.

Pursuant to conversation with the HR interviewee, the auditor finds CC acquired DF on or about January 1, 2017. Many staff, who were hired or worked under the previous company (CMI), remained subsequent to the acquisition. In regard to the auditor's review of random staff HR files, many of the same were hired by the previous company and subsequent to acquisition (as previously referenced), their files were given a CC hire date of January 1, 2017.

The auditor's review of 10 random staff HR files reveals a timely criminal background record check or 5-year reinvestigation is present in all files. Given the above explanation, it appears all pre-hire criminal background record checks are timely.

Of note, the HR interviewee asserts criminal record background checks are conducted by staff working for the Colorado Division of Criminal Justice (CDCJ). Additionally, a fingerprint check is completed as another source of criminal history exploration. Pursuant to contract, upon completion of these checks, CDCJ simply provides an affirmative response (it is okay to hire this individual) or negative response (it is not okay to hire this individual). Specifics regarding the particular criminal history are not provided to CC.

The HR interviewee asserts the 14-2H CC is also completed by potential contractors with both name and date affixed thereto. This document, in addition to the completion of a criminal background records check, provides reasonable assurance of compliance with 115.217(a) and (b).

Pursuant to the PAQ, the Director self reports agency policy requires the consideration of 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.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 5, section B addresses 115.217(b).

As articulated in the narrative for 115.217(a), the Form 14-2H CC contains a separate question as to whether a substantiated allegation of sexual harassment had been made against the individual. Additionally, the Form 3-20-2B entitled PREA Questionnaire for Prior Institutional Employers reflects the same question. Previous institutional employers are requested to complete the same however, there is no obligation. There is an expectation of response regarding PREA issues.

As criminal background record checks do not address sexual harassment, the latter form is the only document available to validate the 14-2H CC.

The HR interviewee asserts the facility does consider prior incidents of sexual harassment when determining whether to hire or to promote anyone, or to enlist the services of any contractor, who may have contact with residents. New hires/promotions complete the 14-2H CC. Prior Institutional Employer Checks validate any incidence of sexual harassment when the receiving party completes the mailed form.

The auditor notes there is no evidence of prior institutional employment with respect to the 10 random staff HR files reviewed.

Pursuant to the PAQ, the Director self reports agency policy requires before it hires any new employees who may have contact with residents, it conducts criminal background record checks, and (b) consistent with federal, state, and local law, makes its best efforts to contact all prior institutional employers for information on substantiated allegations of sexual abuse or any resignation during a pending investigation of an allegation of sexual abuse. The Director further self reports nine persons were hired who may have contact with residents and all have had criminal background record checks, during the last 12 months.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, pages 5 and 6, section B(3)(a)(i and ii) addresses 115.217(c).

The HR interviewee asserts CC HR requests performance of criminal background record checks or considers pertinent civil or administrative adjudications for all newly hired employees who may have contact with residents.

The practice as described by the HR interviewee is clearly articulated in the narrative for 115.217(a). This narrative also addresses procedural processing of criminal background record checks regarding promotions.

This same procedure applies to contractors.

The auditor notes the Director/PCM self reports 0 contractors have been employed at DF during the last 12 months. Further elaboration regarding this issue is addressed in the narrative for 115.217(a).

Criminal background record checks and previous institutional employer checks (referencing the on-site review of 10 random staff HR files) are addressed in the narrative for 115.217(a).

Pursuant to the PAQ, the Director self reports agency policy requires a criminal background record check is completed before enlisting the services of any contractor who may have contact with residents. The Director self reports there were 0 contracts for services where criminal background record checks were conducted during the past 12 months. However, as reflected in the narrative for 115.217(a), the auditor finds there are two contractors who provide services to residents at DF. The status of their criminal background record checks is likewise addressed in that narrative.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 6, section B(3)(b) addresses 115.217(d).

Pursuant to the PAQ, the Director self reports agency policy requires that either criminal background record checks are conducted at least every five years for current employees and contractors who may have contact with residents or a system is in place for otherwise capturing such information for current employees.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 6, section B(3)(c) addresses 115.217(e).

The auditor's review of one PAQ five-year reinvestigation reveals substantial compliance with 115.217(e).

Of the previously referenced on-site random review of staff HR files, three required 5-year criminal background record checks and all three were conducted in a timely manner. No issues with respect to continued employment status were identified in these re-investigations.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 5 section B(2) and (b) addresses 115.217(f).

The auditor is aware the equivalent of the Form 14-2H CC is completed annually by all staff. Additionally, the document is completed as a staff applicant and prior to hire. Finally, the same is completed by staff who are promoted.

The auditor's on-site random review of 10 staff HR files reveals at least two years of annual staff completions of the 14-2H CC form (as applicable to hiring date) were available in each file.

According to the HR interviewee, the facility asks all applicants and employees who may have contact with residents about previous misconduct described in 115.217(a) in written applications for hiring, prior to hire, and during the promotion phase. The 14-2H CC is completed annually as of calendar year 2018, to encompass the performance evaluation process and affirmative duty to report. Of note, the affirmative duty to report caveat is also reflected on the 14-2H CC.

Pursuant to the PAQ, the Director self reports agency policy states material omissions regarding such misconduct, or the provision of materially false information, shall be grounds for termination.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 5 section B(1)(NOTE:) addresses 115.217(g).

The auditor's review of the Form 14-2H CC reflects a caveat about material omissions regarding such misconduct, or the provision of materially false information, being grounds for termination. This document is signed and dated by the employee on an annual basis.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 6 section B(3)(d)addresses 115.217(h).

According to the Director, during the last 24 months, no requests for information were received from an institutional employer, to whom a CC or ex-CC employee has applied to work, relative to substantiated allegations of sexual abuse or sexual harassment.

The HR interviewee asserts when a former employee applies for work at another institution, upon request from that institution, the facility provides information on substantiated allegations of sexual abuse/sexual harassment involving the former employee, unless prohibited by law.

In view of the above, the auditor finds DF substantially compliant with 115.217.

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 X□ 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 X□ NA

Auditor Overall Compliance Determination

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

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

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

Pursuant to the PAQ, the Director self reports the facility has not acquired a new facility or made a substantial expansion or modification to existing facilities since the date of the last PREA audit.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 33, section V(1) addresses 115.218(a).

Pursuant to the PAQ, the Director self reports the facility has not installed or updated a video monitoring system, electronic surveillance system, or other monitoring technology since the last PREA audit.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 33, section V(2) addresses 115.218(b).

Since there is no evidence of non-compliance with 115.218, the auditor finds DF substantially compliant with the same.

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.) X□ 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.) X□ 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.) X□ 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? X□ Yes □ No

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

- Has the agency documented its efforts to provide SAFEs or SANEs? X□ Yes □ No

115.221 (d)

- Does the agency attempt to make available to the victim a victim advocate from a rape crisis center? X□ 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 X□ NA

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

- As requested by the victim, does this person provide emotional support, crisis intervention, information, and referrals? X□ 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.) X□ 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.) X□ Yes □ No □ NA

Auditor Overall Compliance Determination

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

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

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

Pursuant to the PAQ, the Director self reports the facility is responsible for conducting administrative sexual abuse investigations (including resident-on-resident sexual abuse or staff sexual misconduct). The Director further self reports the Denver Police Department (DPD) facilitates criminal investigations. When conducting a sexual abuse investigation, the agency investigators follow a uniform evidence protocol.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 25, section 4 and A addresses 115.221(a).

All 12 random staff interviewees assert they know and understand the agency's protocol for obtaining usable physical evidence if a resident alleges sexual abuse. The responses regarding first responder duties essentially encompass evidence preservation. DPD conducts criminal investigations and they are responsible for physical evidence collection while all staff are responsible to secure the crime scene and guard against destruction of physical evidence by the victim and perpetrator.

None of the 12 random staff interviewees were able to correctly identify all four tasks as cited at 115.264(a). The majority of interviewees assert they must ensure both the victim and perpetrator do not destroy physical evidence or ask both to refrain from destruction of physical evidence, as opposed to, requesting the victim not destroy physical evidence and ensuring the perpetrator does not destroy physical evidence. Additionally, some interviewees assert they would only tell the victim not to destroy physical evidence.

While policy is clearly scripted in accordance with 115.264(a) and each interviewee was in possession of a CC First Responder card, given the above, the auditor finds DF non-compliant with 115.221 and

115.264. He is imposing a 180-day corrective action period wherein DF must demonstrate institutionalization of standards requirements with a corrective action completion date of May 20, 2020.

To accomplish institutionalization, DF staff or Division 7 staff will re-train all DF staff regarding first responder duties, accentuating the nuances (request the victim not destroy physical evidence vs. ensure the perpetrator does not destroy physical evidence) of required steps. The auditor notes all DF staff receive the same first responder training.

The PCM will provide a roster of all staff to the auditor and he will randomly select staff names. The PCM will provide training certifications substantiating provision of the relevant training for each selectee. Additionally, the PCM will provide a copy of the training syllabus to the auditor for inclusion in the audit file. The auditor recommends a test regarding the subject-matter be given to each staff member.

January 27, 2020 Update:

Pursuant to the auditor's review of the training plan regarding first responder duties, the same is clearly commensurate with 115.264(a). The Training/Activity Attendance Roster relative to this training reflects the printed/signed names of participants/title, as well as, the "I understand the training I received" caveat, of 21 DF staff. Accordingly, the auditor finds corrective action is complete.

In view of the above, the auditor finds DF substantially compliant with 115.221.

Eleven of 12 random interviewees assert the Director (seven) or Assistant Facility Director (four) facilitate administrative sexual abuse/harassment investigations and all 12 interviewees assert Denver Police Department (DPD) facilitates criminal investigations.

Pursuant to the PAQ, the Director self reports no youth are housed at DF and accordingly, that component of 115.221(b) is not applicable. The Director self reports the protocol was adapted from or otherwise based on the most recent edition of the DOJ'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.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 25, section 4(b) addresses 115.221(b).

The auditor's review of a letter dated September 25, 2015 from the Director, Division of Community Corrections, City and County of Denver, reveals criminal sexual abuse investigations are conducted by DPD Sex Crimes Unit investigators.

Pursuant to the PAQ, the Director self reports the facility offers to all residents who experience sexual abuse access to forensic medical examinations. Forensic medical examinations are offered without financial cost to the victim. Where possible, examinations are conducted by SAFE/SANE Nurse Examiners. When SAFE/SANE Nurses are unavailable, a qualified medical practitioner performs forensic medical examinations.

All of the above is clearly articulated in an MOU between CMI and St. Anthony North Neighborhood Health Center. According to the Director, no forensic medical examinations were conducted during the last 12 months.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 25, section 4(c) addresses 115.221(c).

The SANE Nurse interviewee asserts she is one of a team of SANE nurses responsible for conducting all forensic medical examinations. The interviewee provides the 80-hour SANE training to staff, much of the same is clinical. SANE Nurses are available twenty-four hours per day, seven days per week and staff are on-call to ensure coverage.

The auditor's review of an MOU Between CMI and St. Anthony North Neighborhood Health Center dated June 8, 2015 reveals substantial compliance with 115.221(c).
Pursuant to the PAQ, the Director self reports the facility attempts to make a victim advocate from a rape crisis center available to the victim, either in person or by other means, and these efforts are documented. The Director further self reports the facility provides victim advocate services pursuant to an MOU between CMI and the Blue Bench (BB) dated August 15, 2016. A revised MOU between CoreCivic of Tennessee and The Blue Bench, dated October 7, 2019, has recently been issued.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 25, section 4(d)(i and ii) addresses 115.221(d).

The auditor's review of the afore-mentioned MOU reflects substantial compliance with 115.221(d).

According to the PCM, victim advocacy services are available to DF residents pursuant to an MOU with Blue Bench. She asserts she has been involved in the plenary session with representatives from Blue Bench regarding MOU development. She also asserts victim advocate (VA) qualifications are addressed on the Blue Bench website.

The Director reports no residents who reported a sexual abuse were housed at DF during the on-site audit.

Pursuant to the PAQ, the Director self reports if requested by the victim, a victim advocate accompanies and supports the victim through the forensic medical examination process and investigatory interviews and provides emotional support, crisis intervention, information, and referrals.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 25, section 4(e) addresses 115.221(e).

The PCM asserts, if requested by the victim, a victim advocate is accessed through Blue Bench to accompany the victim and provide emotional support, crisis intervention, information, and referrals during the forensic medical examination process and investigatory interviews.

As reflected throughout this narrative, the DF PREA Investigator (Director or Assistant Facility Director) facilitates administrative investigations. Accordingly, the auditor finds 115.221(f) to be not-applicable to DF.

In view of the above, the auditor finds DF substantially compliant with 115.221.

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? X□ Yes □ No

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

- Does the agency document all such referrals? X□ 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).) X□ 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*)

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

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

Pursuant to the PAQ, the Director self reports the agency ensures an administrative or criminal investigation is completed for all allegations of sexual abuse and sexual harassment (including resident-on-resident sexual abuse and staff sexual misconduct). In the past 12 months, one allegation of sexual abuse and one sexual harassment allegation were received. The allegations were investigated both administratively and reviewed by criminal investigators. All investigations were reportedly completed, according to the Director. The auditor's review of PAQ evidence validates completion of the investigations.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 23, section O addresses 115.222(a).

According to the Agency Head interviewee, an administrative or criminal investigation is completed for all allegations of sexual abuse or sexual harassment. Administrative investigations are completed by a PREA trained investigator and whenever the Inspector General (IG) arm of the partner is tasked with facilitation of criminal investigations, they are generally PREA trained pursuant to the contract.

In regard to the protocol relative to administrative/criminal sexual abuse or sexual harassment investigations, the Agency Head interviewee asserts the allegation triggers the rest of the investigative process. Medical examination and allegations the victim incurred physical harm may trigger a forensic examination as ordered by medical professionals. The allegation is generally reported to the Director, Assistant Director, Operations Supervisor, and PCM. Notifications to the facility Investigator and/or criminal investigating agency would ensue.

The Agency Head interviewee continued, stating First Responders ensure the victim and perpetrator are separated and perpetrator, if known, is isolated. The victim would likewise remain under staff's physical supervision. Generally, physical evidence is collected by the criminal investigator in a criminal matter. If criminal, the criminal investigator determines interview status and whether the facility Investigator assists. CC investigative staff would assist the criminal investigator in any way needed, inclusive of research and preservation of camera footage, resident/staff file reviews, review of reports submitted by staff, review of resident statements (if applicable), and coordination of investigative activities. Additionally, CC officials would support prosecution efforts of both staff and residents.

The administrative investigation is generally completed by the facility Investigator. He/she employs essentially the same protocol however, he/she does interview witnesses and assesses victim, perpetrator, witness credibility. Finally, the Investigator writes an investigative report.

The auditor's review of the administrative investigations alluded to above, reveals substantial compliance with 115.222(a). The investigation takes the form of an electronically generated CC Incident Report and the same encompasses all investigative steps and informational requirements articulated by the Agency Head interviewee, as reflected above.

Pursuant to the PAQ, the Director self reports the agency has a policy that requires allegations of sexual abuse or sexual harassment be referred for investigation to an agency with the legal authority to conduct criminal investigations, including the agency if it conducts its own investigations, unless the allegation does not involve potentially criminal behavior. The Director further self reports agency policy regarding the referral of allegations of sexual abuse or sexual harassment for criminal investigation is published on the agency website. The agency documents all referrals of allegations of sexual abuse or sexual harassment for criminal investigation.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 23, section O and pages 24 and 25, section O(3)(a) and (b) address 115.222(b).

The investigative staff interviewee asserts agency policy requires allegations of sexual abuse/ harassment be referred for investigation to an agency with the legal authority to conduct criminal investigations, unless the allegation does not involve potentially criminal behavior. The two allegations referenced in the narrative for 115.222(a) were referred for criminal investigation and/or review and the same were completed by DPD investigators. The interviewee asserts that generally, sexual abuse allegations are considered criminal matters.

The auditor's review of the CC and DF websites reveals the appropriate policy regarding criminal referrals and the investigative responsibilities for administrative and criminal investigative entities is posted on the same.

The auditor's review of several forms of correspondence between the DF Director and DPD clearly validates documentation of these two referrals/reviews to that agency for follow-up. Responsive communication from DPD also validates the decision-making practice and completion of the matters.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 23, section O and pages 24 and 25, section O(3)(a) and (b) address 115.222(c).

In view of the above, the auditor finds DF substantially compliant with 115.222.

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? X□ 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? X□ 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 X□ 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? X□ 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? X□ 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? X□ 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? X□ Yes □ No
- Does the agency train all employees who may have contact with residents on: How to avoid inappropriate relationships with residents? X□ 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? X□ 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? X□ Yes □ No

115.231 (b)

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

115.231 (c)

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

115.231 (d)

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

Auditor Overall Compliance Determination

X☐ **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*)

Pursuant to the PAQ, the Director self reports the agency trains all employees who may have contact with residents on:

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

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, pages 6 and 7, section C(1)(a)(i-xiii) addresses 115.231(a).

The auditor's review of the PREA Overview Curriculum and accompanying training slides reveals substantial compliance with 115.231(a). The PREA Teach back Topics document also suggests significant interactive learning between facilitator and students and content appears to be comprehensive.

The auditor's review of Pre-Service and In-Service CORECIVIC PREA ACKNOWLEDGMENT AND/OR TRAINING ACKNOWLEDGMENT forms dated May 21, 2018 and April 17, 2019 respectively reveal

compliance with provision of PREA training in accordance with 115.231. These documents include the "I understand the subject-matter presented" caveat and are signed/dated by the employee participant.

All 12 random staff interviewees self report they received training regarding the afore-mentioned 10 PREA topics either during Pre-Service and/or In-Service training.

Taking into consideration the date of CC assumption of DF (January 1, 2017) and the fact all staff previously hired under the old contract were re-trained regarding PREA, the auditor's review of randomly selected staff files, in addition to those referenced in the preceding paragraph, reveals substantial compliance with 115.231(a). Of the 11 on-site randomly selected staff training files, five pertained to staff hired under the previous contract. All of these staff completed the initial post contract award PREA training and annual In-Service PREA training. Of the six remaining files relevant to staff selected during 2018 and 2019, all Pre-Service and In-Service PREA training has been provided. Of note, all Pre-Service training for this latter group was provided on the hire date.

In view of the above, requisite PREA training was clearly provided and completed prior to contact with residents.

Pursuant to the PAQ, the Director self reports training is tailored to the gender of the residents at the facility. Employees who are reassigned from facilities housing the opposite gender are given additional training. The Director relates there were no staff transfers to DF from facilities wherein female residents are housed, during the last 24 months.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 6, section C(1)(a) and page 8, section c addresses 115.231(b).

The auditor's review of the afore-mentioned training curriculum reveals the same is commensurate with 115.231(b).

Pursuant to the PAQ, the Director self reports 21 staff, who may have contact with residents, were trained or retrained in PREA requirements. This equates to 100% of the staff complement. If there are any policy updates in regard to PREA matters, staff would be trained on the policy during staff meetings. Employees who may have contact with residents receive PREA training on an annual basis.

Given the fact 115.231(c) requires refresher training every two years to ensure all employees know the agency's current sexual abuse/harassment policies and procedures and the fact DF facilitates annual PREA refresher training, the auditor finds DF to exceed standard expectations with respect to this provision.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 6, section C(1)(a) addresses 115.231(c).

Pursuant to the PAQ, the Director self reports the agency documents that employees, who may have contact with residents, understand the training they received through employee signature or electronic verification.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 8, section d addresses 115.231(d).

The auditor's on-site review of staff training files, as reflected in the narrative for 115.231(a), reveals staff signed and dated the requisite Core Civic PREA Policy Acknowledgment and/or Training Acknowledgment forms, acknowledging their understanding of the subject-matter presented for 2017, 2018, and/or 2019. Accordingly, the auditor finds DF substantially compliant with 115.231(d).

In view of the above, the auditor finds DF exceeds standard with respect to 115.231.

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? X□ 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)? X□ Yes □ No

115.232 (c)

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

Auditor Overall Compliance Determination

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

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

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

Pursuant to the PAQ, the Director self reports all volunteers and contractors who have contact with residents are trained on their responsibilities under the agency's policies and procedures regarding sexual abuse/harassment/prevention, detection, and response. The Director further self reports zero contractors and six volunteers provide services at DF who have contact with residents. Pursuant to observation and follow-up at another CC Denver community confinement center, the auditor has determined two contractors (engaged in contracts with CDOC) provide services to residents at DF. The auditor's review of documents, as described below, reveals all contractors received the requisite training.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 8, section 2(a) addresses 115.232(a).

The auditor's review of the CCA Volunteer Orientation and PREA Training- Student Volunteer Handout reveals substantial compliance with 115.232. The curriculum is broad, providing excellent information to volunteers enabling them to meet PREA responsibilities.

The auditor has been provided a Training Activity Enrollment/Attendance Roster dated June 10, 2019 wherein the names of the two contractors are both printed and written, specifying they received requisite PREA training. The auditor's review of CoreCivic PREA Policy Acknowledgment and/or Training Acknowledgment forms signed and dated June 10, 2019 by both contractors, reveals they received requisite training. The contractors attest to both their understanding of policy and the training.

According to the volunteer who has contact with residents interviewee, he self reports he has been trained in his responsibilities regarding sexual abuse and sexual harassment prevention, detection, and response per agency policy and procedure. He receives such training on an annual basis.

The auditor's review of a completed CORECIVIC PREA POLICY ACKNOWLEDGMENT AND/OR TRAINING ACKNOWLEDGMENT document reveals provision of requisite training as articulated in 115.232(a) and the "I understand" caveat. The PREA Policy and Training Acknowledgment also minimally reflects the volunteer's printed name/signature/date and the "I understand" caveat. Of note, one document addresses completion of Pre-Service and the other addresses completion of In-Service training.

Pursuant to the PAQ, the Director self reports the level and type of training provided to volunteers and contractors is based on the services they provide and level of contact they have with residents. The Director further self reports volunteers and contractors, who have contact with residents, have been notified of the agency's zero-tolerance policy regarding sexual abuse and sexual harassment and informed how to report such incidents.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 8, section 2(b) addresses 115.232(b).

The volunteer interviewee self reports the PREA training he received focused on zero tolerance towards sexual abuse/harassment of residents, reporting sexual abuse/harassment of residents, and inappropriate actions between staff and residents. The training included review of multiple videos, receipt and review of a policy packet, and a test.

Pursuant to the PAQ, the Director self reports the agency maintains documentation confirming that volunteers/contractors understand the training they have received.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 8, section 2(c) addresses 115.232(c).

In view of the above, the auditor finds DF substantially compliant with 115.232.

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? X□ Yes □ No

- During intake, do residents receive information explaining: How to report incidents or suspicions of sexual abuse or sexual harassment? X□ Yes □ No

- During intake, do residents receive information explaining: Their rights to be free from sexual abuse and sexual harassment? X□ Yes □ No

- During intake, do residents receive information explaining: Their rights to be free from retaliation for reporting such incidents? X□ Yes □ No

- During intake, do residents receive information regarding agency policies and procedures for responding to such incidents? X□ Yes □ No

115.233 (b)

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

115.233 (c)

- Does the agency provide resident education in formats accessible to all residents, including those who: Are limited English proficient? X□ Yes □ No

- Does the agency provide resident education in formats accessible to all residents, including those who: Are deaf? X□ Yes □ No

- Does the agency provide resident education in formats accessible to all residents, including those who: Are visually impaired? X□ Yes □ No

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

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

115.233 (d)

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

Auditor Overall Compliance Determination

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

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

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

Pursuant to the PAQ, the Director self reports residents receive information at time of intake about the zero-tolerance policy, how to report incidents or suspicions of sexual abuse or harassment, their rights to be free from sexual abuse and sexual harassment and to be free from retaliation for reporting such incidents, and regarding agency policies and procedures for responding to such incidents. The Director self reports 237 residents were provided requisite information at intake during the last 12 months. The Director further self reports 100% of residents were provided requisite information at intake during the last 12 months.

The auditor's review of the CoreCivic PREA- A Guide to the Prevention and Reporting of Sexual Misconduct pamphlet reveals verbiage regarding the resident's right to be free from sexual abuse/harassment and retaliation for reporting the same. The pamphlet is presented in both English and Spanish. Additionally, strategies to avoid sexual abuse/sexual harassment are addressed in this document.

The PREA Advisement is likewise printed in both English and Spanish. The same is completed at intake and includes topics as follows: zero tolerance towards sexual abuse/harassment; all sexual behavior is prohibited; disciplinary action will be imposed in appropriate cases; and reporting options are articulated. An "I understand the subject-matter" caveat is included in the same.

A PREA Orientation form confirms the resident's completion of PREA Orientation and includes viewing of the PREA video. The completed example included in the PAQ reveals PREA Orientation was completed on the date of intake.

A document entitled PREA Resident Orientation Process is completed by staff, capturing the date on which the component was completed and the employee's signature. The PAQ example again pertained to the same resident as referenced throughout this narrative for 115.233(a).

Review of the CoreCivic Client Handbook reveals provision of information regarding the zero tolerance policy, as well as, reporting options.

A Colorado Community Corrections generated video entitled Responses to Sexual Activity in Community Corrections is presented to new arrivals.

The intake staff interviewee self reports he provides residents with information about the CC and DF zero-tolerance policy and how to report incidents or suspicions of sexual abuse or sexual harassment at intake. Specifically, the Client Handbook and PREA pamphlet are provided for reading and these topics are addressed in the same. The interviewee also provides verbal instruction during Intake regarding Blue Bench and reporting options. Orientation instruction is generally provided on the date of arrival or within 24 hours of arrival, as well as, residents view the PREA video.

All 10 random resident interviewees self report they received information about the facility's rules against sexual abuse/harassment during Intake. Similarly, nine of 10 random resident interviewees self report they were told about the following when they arrived at DF:

a. Their right not to be sexually abused or sexually harassed;
b. How to report sexual abuse or sexual harassment;
Their right not to be punished for reporting sexual abuse or sexual harassment; and
c. Their right not to be punished for reporting sexual abuse or sexual harassment.
Six of the 10 interviewees self report they received the latter information within the week following intake. The remaining four interviewees assert they received the same on the date of arrival. Interviewees confirmed the materials provided to them were consistent with staff assertions as reflected above.

The auditor's on-site random review of 11 resident files reveals requisite information was provided at Intake in each case. In one of 11 cases, the secondary Orientation information was provided on the day following intake. Provision of requisite information is both timely and comprehensive.

The auditor notes the resident and a staff witness sign and date the PREA Advisement.

Pursuant to the PAQ, the Director self reports the facility provides residents who are transferred from a different community confinement facility with refresher information as referenced above.
The Director further self reports four residents were transferred to DF from a different community confinement facility within the last 12 months and all have received refresher training. Residents receive the same PREA information when they transfer from one facility to another facility.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 13, section I(1)(a-d) and (4) addresses 115.233(a) and (b).

The intake staff interviewee self reports residents are made aware of the rights articulated in the narrative for 115.233(a) within the first day of admission. Generally, education occurs within hours of admission to DF. However, additional information, inclusive of the PREA video and a staff narrative, is provided during the Orientation presentation within 24 hours of arrival.

Nine of 10 random resident interviewees reported being transferred to DF from state correctional facilities, county jail(s), or private re-entry facilities. The auditor's review of the previously referenced files included three of the random resident interviewees and all files reflected the resident received proper training.

Pursuant to the PAQ, the Director self reports resident PREA education is available in accessible formats for all residents including those who are limited English proficient, deaf, visually impaired, otherwise disabled, as well as, to residents who have limited reading skills.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, pages 13 and 14, section I(5) addresses 115.233(c).

Resident education formats and accessibility of the same to the resident population are addressed in the narrative for 115.216, above.

Pursuant to the PAQ, the Director self reports the agency maintains documentation of resident participation in PREA education sessions.

Substantiating documentation is referenced in the narrative for 115.33(a) above. Multiple documents discussed in the narrative for 115.233(a) substantiate compliance with this provision. Executed documents, as discussed above, are applicable to one resident and those on-site randomly selected resident files.

According to the Director, the majority of PREA education is accomplished during intake.

Pursuant to the PAQ, the Director self reports the agency ensures key information about the agency's PREA policies is continuously and readily available or visible through posters, resident handbooks, or other written formats.

The PCM provided the auditor with two posters, one printed in English and one in Spanish, in the PAQ packet. The posters reveal methods and telephone numbers for residents to privately report sexual abuse/ harassment, inclusive of an entity not affiliated with the facility. Additionally, the PCM provided a copy of House notes dated November 28, 2018 regarding the facilitation of a House Meeting. PREA Awareness was addressed during the meeting and residents were provided an opportunity to ask questions.

During the facility tour, the auditor noted numerous PREA posters in various areas. It is apparent there is an effort to continuously educate residents regarding PREA issues throughout their confinement at DF.

In addition to the above, the auditor's review of three posters contained within the PAQ reveals substantial efforts to inform residents regarding the zero tolerance policy and reporting options.

In view of the above, the auditor finds DF substantially compliant with 115.233.

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).)

  X□ 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).) X□ 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).) X□ 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).) X□ 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).)
  X□ 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).)
  X□ 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*)

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

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

Pursuant to the PAQ, the Director asserts agency policy requires that investigators are trained in conducting sexual abuse investigations in confinement settings.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 7, section b(i) addresses 115.234(a).

The auditor's review of the training syllabus for the National Institute of Corrections (NIC) course entitled PREA: Investigating Sexual Abuse in a Confinement Setting addresses the requirements of 115.234(b). Additionally, the two PREA Investigator's certificates relative to the afore-mentioned course substantiate completion of the same.

According to the investigative staff interviewee, in 2015, she completed the on-line NIC Course entitled "Investigating Sexual Abuse in a Confinement Setting". This on-line course included topics such as interviewing techniques relative to victims and perpetrators in a confinement setting, execution of Miranda and Garrity warnings, evidence collection in sexual abuse cases, and the evidence standard necessary to substantiate a case for administrative action or prosecution referral.

The auditor's review of two certificates as described above reveals the Director and Assistant Facility Director have completed the National Institute of Corrections (NIC) training entitled PREA: Investigating Sexual Abuse in a Confinement Setting specialty training.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 7, section b(i) addresses 115.234(b).

According to the investigative staff interviewee, the specialized training referenced above addressed 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.

Pursuant to the PAQ, the Director self reports the agency maintains documentation showing that investigators have completed the required training. As previously indicated, the Director also self reports the agency maintains documentation showing that two investigators have completed the required training.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 7, section b(i) addresses 115.234(c).

In view of the above, the auditor finds DF substantially compliant with 115.234.

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 X□ 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 X□ 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 X□ 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 X□ 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 X□ 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 X□ 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 X□ NA

Auditor Overall Compliance Determination

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

Pursuant to the PAQ, the Director self reports the agency has a policy related to the training of medical and mental health practitioners who work regularly in its facilities. However, no Medical or Mental Health staff work at DF. The Director further self reports that 0 Medical/Mental Health practitioners who work regularly at the facility received the training.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, pages 7 and 8, section b(i) addresses 115.235(a).

According to the Director and pursuant to the auditor's observation and review of the DF Organizational Chart, medical and mental health staff are not employed at DF. Accordingly, such interviews could not be conducted. Of note, none of the provisions of 115.235(a) are applicable to DF however, as the auditor finds no evidence of non-compliance, DF is compliant with the standard.

Pursuant to the PAQ and in view of the above, the Director self reports facility medical staff do not conduct forensic examinations at DF. Accordingly, the auditor finds 115.235(b) not-applicable to DF.

Pursuant to the PAQ, the Director asserts documentation is not maintained, at DF showing that medical and mental health practitioners completed the requisite training as no medical/mental health practitioners are employed at DF. Medical/Mental Health care is provided in community health facilities.

As mentioned throughout the narrative for this standard, no medical/mental health practitioners are employed at DF.

In view of the above, the auditor finds DF substantially compliant with 115.235.

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? X□ 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? X□ Yes □ No

115.241 (b)

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

115.241 (c)

- Are all PREA screening assessments conducted using an objective screening instrument? X□ 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? X□ 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? X□ 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? X□ 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? X□ 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? X□ 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? X□ 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)? X□ 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? X□ 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? X□ 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? X□ 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? X□ 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? X□ 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? X□ Yes □ No

115.241 (g)

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

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

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

Auditor Overall Compliance Determination

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

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

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

Pursuant to the PAQ, the Director self reports the agency has a policy that requires screening (upon admission to a facility or transfer to another facility) for risk of sexual abuse victimization or sexual abusiveness toward other residents.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 12, section H(1) addresses 115.241(a).

The staff who perform screening for risk of victimization and abusiveness interviewee self reports she does screen residents upon admission to DF or transfer from another facility for risk of sexual victimization or sexual abusiveness toward other residents. Additionally, she reports new commitments are screened within 72 hours of Intake. As a matter of fact, new commitments are screened within 24 hours of intake.

Eight of 10 random resident interviewees self report when they first arrived at DF, they were asked questions like whether they had been in jail or prison before, whether they have ever been sexually abused, whether they identify as being LGBTI, and whether they think they may be in danger of being sexually abused at DF. Seven of 10 interviewees self report they were asked these questions on the date of arrival.

The auditor's review of (resident files) for one of the two random resident interviewees who reported they were not asked the afore-mentioned questions upon intake reveals he was asked the requisite questions in a thorough and comprehensive manner. The auditor notes the other file was not reviewed.

The auditor's on-site review of 11 random resident files reveals sexual victimization/sexual abusiveness screening was conducted in a timely and comprehensive manner in all cases.

The auditor observed the staff office(s) wherein new commitments are screened and noted there are blinds on the windows.

Pursuant to the PAQ, the Director self reports intake screening shall ordinarily take place within 72 hours of arrival at the facility. The below policy requires screening be conducted within 24 hours of arrival at DF. The Director self reports that during the last 12 months, 237 residents entering the facility (either through Intake or transfer) whose length of stay in the facility was 72 hours or more, were screened for risk of sexual victimization or risk of sexually abusing other residents, within 72 hours of their entry into the facility. This equates to 100% of residents admitted to the facility during the last 12 months, for 72 hours or more.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 12, section H(1)(b) and (c) addresses 115.241(b).

The auditor's review of one initial assessment, conducted on November 1, 2017 and reassessment conducted on November 28, 2017 (same resident) reveals substantial compliance with 115.241(b). CoreCivic policy requires completion of the initial assessment within 24 hours of arrival and the same was comprehensive/timely. The reassessment was likewise comprehensive and timely.

Pursuant to the PAQ, the Director self reports risk assessment is conducted using an objective screening instrument.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 12, section H(1)(a) addresses 115.241(c).

The auditor's review of the CC 14-2B CC, Sexual Abuse Screening Tool, reveals the same is an objective screening tool.

The auditor's review of the Sexual Abuse Screening Tool reflects substantial compliance with 115.241(d). Specifically, the document reflects the following issues:

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

The staff who performs screening for risk of victimization and abusiveness interviewee self reports the following factors are considered in the sexual victimization/abusiveness screening:

History of sexual abuse in both confinement and community settings, violent or non-violent criminal history, resident self-identification or appearance of LGBTI status, medical/mental health issues, and history of confinement.

According to the interviewee who conducts such assessments, a pre-screening packet is reviewed by the screener prior to the conduct of the screening. If there are discrepancies between the resident's statements and the pre-screening packet, the same will be reconciled to the degree possible. The client is taken to her office behind closed door and with window blinds open. The PREA video is first played an she subsequently asks the questions and checks the residents understanding of the same. Once the assessment tool is completed, the paper instrument is scanned into the resident's electronic file.

The auditor's review of the Sexual Abuse Screening Tool reveals substantial compliance with 115.241(e). Specifically, the same addresses prior acts of sexual violence, prior convictions for violent offenses, and history of prior institutional violence or sexual abuse.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 12, section H(1)(a-c) addresses 115.241(e).

The auditor notes pursuant to review of the requisite screening tool and all documents referenced in the narrative for 115.241(a), requisite questions are addressed in the same.

Pursuant to the PAQ, the Director self reports policy requires the facility reassesses each resident's risk of victimization or abusiveness within a set time period, not to exceed 30 days after the resident's arrival at the facility, based upon any additional, relevant information received by the facility since the intake screening. The Director self reports during the last 12 months, 232 residents entering the facility (either through Intake or transfer) were reassessed for their risk of sexual victimization or of being sexually abusive, within 30 days after their arrival at the facility based upon any additional, relevant information received since intake. The Director further self reports this represents 100% of residents entering the facility for more than 30 days.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 12, section H(2)(a) addresses 115.241(f).

According to the staff who performs screening for risk of victimization and abusiveness interviewee (reassessments), the same are conducted within 30 days of arrival at DF.

One of 10 random resident interviewees report they were asked the questions reflected in the narrative for 115.241(a) above since arrival at DF. The questions were allegedly asked within 90-days of arrival at DF.

The auditor's on-site review of 11 random resident files, three of which were those of random resident interviewees, reveals ten of the 30-day Reassessments were complete, thorough, and timely. Two of the three reassessments, relative to the afore-mentioned random resident interviewees, were complete, thorough, and timely.

Pursuant to the PAQ, the Director self reports the policy requires that a resident's risk level be 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.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 13, section H(2)(b) addresses 115.241(g).

According to the Director, additional sexual abuse or sexual victimization information has not been received regarding residents which triggered a re-assessment. However, she did include within the PAQ packet two annual reassessments (same resident as previously referenced) dated October 29, 2018 and January 31, 2019 respectively. Both reassessments are timely and comprehensive.

The staff responsible for risk screening interviewee relates the case managers reassess within 30 days of arrival. She also facilitates reassessments as needed 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.

Pursuant to the PAQ, the Director self reports the policy prohibits disciplining residents for refusing to answer (or for not disclosing complete information related to) questions regarding:

Whether or not the resident has a mental, physical, or developmental disability;
Whether or not the resident is or is perceived to be lesbian, gay, bisexual, transgender, intersex, or gender nonconforming;
Whether or not the resident has previously experienced sexual victimization; or
The resident's own perception of vulnerability.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 13, section H(3)(a-d) addresses 115.241(h).

According to the staff who perform screening for risk of victimization and abusiveness interviewee, residents are not disciplined in any way for refusing to respond to (or for not disclosing complete information related to):

Whether or not the resident has a mental, physical, or developmental disability;
Whether or not the resident is or is perceived to be lesbian, gay, bisexual, transgender, intersex, or gender nonconforming;
Whether or not the resident has previously experienced sexual victimization; and
The resident's own perception of vulnerability.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 13, section H(4) addresses 115.241(i).

According to the DF PCM, the agency has outlined who should have access to a resident's risk assessment within the facility in order to protect sensitive information from exploitation. Initial PREA Assessment information is available to all staff on the DF via the shared drive. Access to this system is password protected. The Director advises she feels comfortable with this distribution and the ability to protect sensitive information from exploitation as the information is germane to staff's responsibilities.

The staff who performs screening for risk of sexual victimization and abusiveness confirms the PCM's response.

In view of the above, the auditor finds DF substantially compliant with 115.241.

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? X□ 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? X□ 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? X□ 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? X□ 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? X□ Yes □ No

115.242 (b)

- Does the agency make individualized determinations about how to ensure the safety of each resident? X□ 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)? X□ 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? X□ 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? X□ Yes □ No

115.242 (e)

- Are transgender and intersex residents given the opportunity to shower separately from other residents? X□ 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.) X□ 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.) X□ 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.) X□ Yes □ No □ NA

Auditor Overall Compliance Determination

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

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

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

Pursuant to the PAQ, the Director self reports the facility uses information from the risk screening to inform housing, bed, work, education, and program assignments with the goal of keeping separate those residents at high risk of being sexually victimized from those at high risk of being sexually abusive.
CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 12, section H(1) addresses 115.242(a).

According to the PCM, the agency uses information gleaned from the risk screening during intake to keep residents safe from being sexually victimized or sexually abusive. This information is used primarily with housing decisions as the facility is open in terms of structure, etc. Potential and known victims (PVs/KVs) are separated from potential and known abusers (PAs/KAs). Residents classified as "Unrestricted" may be placed with PVs/KVs or PAs/KAs.

According to the staff who performs screening for risk of victimization and abusiveness interviewee, the operations supervisor makes bed assignments on a printed housing grid. This housing grid is available to monitors, as needed.

PVs/KVs are physically separated (housing only) from PAs/KAs in terms of housing. Specific rooms may be used for housing victims. Only Vs and non-Vs are housed in these rooms.

The auditor's review of a memorandum identifies those residents who are either potential/known victims and potential/known abusers. Another memorandum reveals the housing schematic to ensure victims and predators are not housed together. Finally, the auditor's review of a roster reveals housing assignments.

Pursuant to the PAQ, the Director self reports the facility makes individualized determinations about how to ensure the safety of each resident.

With respect to applicable policy related to 115.242(b), relevant policy provisions are addressed in the narrative for 115.242(a) above.

Pursuant to the PAQ, the Director self reports the facility makes housing and program assignments for transgender or intersex residents in the facility on a case-by-case basis.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 14, section J(1)(a) addresses 115.242(c).

The PCM asserts all incoming residents are placed in a sexually safe situation based on screening results. Residents, aside from victims as articulated in the narrative for 115.242(a), are not placed in specific rooms.

The agency does consider whether the placement will ensure the resident's health and safety. Similarly, the agency does consider whether the placement would present management or security problems.

The PCM asserts 0 transgender/intersex residents were housed at DF during the on-site audit. Accordingly, such interview(s) could not be conducted.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 14, section J(1)(a) addresses 115.242(d).

The PCM asserts the transgender or intersex resident's own views with respect to her own safety are given serious consideration in placement and programming assignments. The staff who conduct screening for risk of victimization and abusiveness interviewee confirms the PCM's statement in this regard.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 15, section K(7) addresses 115.242(e).

According to the PCM, transgender and intersex residents are given the opportunity to shower separately from other residents. Procedurally, security staff clear the bathroom for such shower(s) and subsequently monitors camera(s) in the control center. There is no established time frame for transgender/intersex resident showers.

The staff who performs screening for risk of victimization and abusiveness interviewee confirms the PCM's assertion.

The Director asserts when a transgender/intersex resident, who has requested to shower separately from other residents, desires to shower, she will report to the security office and staff will clear the bathroom and shower for them. The area will remain closed until the resident has completed their shower.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 14, section J(1)(b) addresses 115.242(f).

The PCM asserts the facility is not subject to a consent decree, legal settlement, or legal judgment requiring that it establish a dedicated facility, unit, or wing for LGBTI residents. The PCM further asserts the screening dictates room assignments. Room assignments are made by case managers. Staff assign beds based on screening.

In view of the above, the auditor finds DF substantially compliant with 115.242.

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? X□ 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? X□ 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? X□ 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? X□ 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? X□ Yes □ No
- Does that private entity or office allow the resident to remain anonymous upon request? X□ 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? X□ Yes □ No
- Do staff members promptly document any verbal reports of sexual abuse and sexual harassment? X□ Yes □ No

115.251 (d)

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

Auditor Overall Compliance Determination

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

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

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

Pursuant to the PAQ, the Director self reports the agency has established procedures allowing for multiple internal ways for residents to report privately to agency officials about:

Sexual abuse or sexual harassment;
Retaliation by other residents or staff for reporting sexual abuse and sexual harassment; and
Staff neglect or violation of responsibilities that may have contributed to such incidents.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, pages 15 and 16, section L(1)(a)(i-vii) address 115.251(a).

The auditor's review of the CoreCivic Client Handbook, PREA Advisement, and CoreCivic PREA- A Guide to the Prevention and Reporting of Sexual Misconduct pamphlet reveals multiple methods for private resident reporting of sexual abuse and sexual harassment incidents.

All 12 random staff interviewees are able to cite at least two methods available to residents for reporting sexual abuse/harassment, retaliation by other residents/staff for reporting sexual abuse/harassment, or staff neglect/violation of responsibilities that may have contributed to an incident of sexual abuse/harassment. Methods of reporting include the Hotline (DOC TIPS Hotline), submission of letter, report to staff, and Ethics Hotline.

All 10 random resident interviewees are able to cite at least one method available to them to report. Options include talking to staff, dialing the Hotline (DOC TIPS), submit a kite to staff, third-party report, anonymous report, submit a grievance, and report to family.

As previously addressed in the narrative for 115.233, posters (regarding procedures for reporting sexual abuse/harassment of residents) are available throughout the facility, inclusive of resident rooms.

Pursuant to the PAQ, the Director self reports the agency provides 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.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, pages 15 and 16, sections L(1)(a)(i, v, vi, and vii) addresses 115.251(b).

Pursuant to the auditor's review of the resources mentioned in the narrative for 115.251(a), the DOC-TIPS-LINE is the most prevalent validation of compliance with 115.251(b).

According to the PCM, the DOC-TIPS Line serves as one way for residents to report sexual abuse/ harassment to a public or private entity or office that is not part of the agency. The PCM asserts the Director or CDOC Liaison is notified within 24 hours, generally by telephone call. This service is offered pursuant to CDOC contract.

Eight of 10 random resident interviewees assert they are allowed to make a report without having to give their name.

The auditor did test the DOC-TIPS-Line (CDOC) during the facility tour, making contact with a recorded voice. He advised of the test of the Hotline. According to the Director, she did not receive a text, e-mail, or telephone call in follow-up to the test call.

The auditor notes he has tested the DOC-TIPS-Line at two other CC Denver facilities and the requisite notification to the Director or designee was accomplished. Accordingly, the auditor finds this scenario to be the exception, as opposed to, the rule.

The auditor highly recommends the Director/PCM or designee facilitate a monthly test of the DOC-TIPS Line, ensuring the Director receives timely notification. He further recommends these tests and results be documented.

Pursuant to the PAQ, the Director self reports the agency has a policy mandating that staff accept reports of sexual abuse and sexual harassment made verbally, in writing, anonymously, and from third parties. The Director further self reports staff are required to document verbal reports. The time frame in which staff are required to document such verbal reports is "immediately".

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 16, section 2 addresses 115.251(c). This policy stipulates verbal reports must be documented promptly.

All 12 random staff interviewees assert when a resident alleges sexual abuse, he can do so verbally, in writing, anonymously, and from third parties. Nine of 12 interviewees assert they immediately document any verbal reports of sexual abuse/harassment received from residents while two interviewees assert they document such allegations prior to the end of the shift following receipt of the allegation and one asserts he/she reports as soon as possible following receipt of the report.

All 10 random resident interviewees assert reports of sexual abuse/harassment can be made both in person and in writing. Eight of the 10 interviewees assert a friend or relative can make the report for the resident without giving his name.

Pursuant to the PAQ, the Director self reports the agency has established procedures for staff to privately report sexual abuse and sexual harassment of residents. Of note, the telephone number for DOC TIPS Line is listed in the following policy. The auditor's review of the CC website reveals staff reporting information. The same can be generally accomplished through reporting to the Ethics Hotline. Staff are alerted to reporting procedures pursuant to Pre-Service and In-Service training.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 17, section 2(d) addresses 115.251(d).

One staff-related poster was observed during the facility tour regarding The Ethics Hotline. The Ethics Hotline is specifically referenced in the above policy as a resource for staff private reporting in accordance with 115.251(d).

All 12 random staff interviewees are able to cite at least two methods of privately reporting sexual abuse/harassment of residents. Methods cited are placement of a telephone call to a supervisor/Director/Assistant Director, closed door meeting, report to Director via her cell phone during non-regular business hours (phone list is available on Sharepoint), Ethics Hotline, resident Hotline, contact Blue Bench, written report, or write an e-mail.

In view of the above, the auditor finds DF substantially compliant with 115.251.

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. X□ 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 X□ 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 X□ 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 X□ 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 X□ 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 X□ 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 X□ 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 X□ 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 X□ 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 X□ 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 X□ 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 X□ 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 X□ 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 X□ 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 X□ 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 X□ 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 X□ 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 X□ 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 X□ NA

Auditor Overall Compliance Determination

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

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

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

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 16, section L(1)(b) addresses 115.252. This policy stipulates as follows:

Unless otherwise mandated by contract, alleged PREA incidents will not be processed through the facility's inmate/detainee grievance process. Should a report be submitted and received as an inmate/detainee grievance, whether inadvertently or due to contracting agency requirements, it will immediately be referred to the facility investigator or Administrative Duty Officer (ADO).

The Director relates there has been no residents, within the last 12 months, who filed or attempted to file a PREA-related issue pursuant to the facility grievance policy.

In view of the above, the auditor finds DF substantially compliant with 115.252 as the facility is exempt and there is no evidence of deviation from standard requirements.

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? X□ Yes □ No

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

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

Auditor Overall Compliance Determination

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

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

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

Pursuant to the PAQ, the Director self reports the facility provides 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) for local, state, or national victim advocacy or rape crisis organizations; and
Enabling reasonable communication between residents and these organizations in as confidential manner as possible.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 10, section F(2) addresses 115.253(a).

The auditor's review of the afore-mentioned brochure identified in the narrative for 115.251 establishes compliance with 115.253. This brochure is provided to residents at intake. Additionally, information is provided in the Blue Bench brochure.

The Director asserts an informative pamphlet from Blue Bench is available to residents in a designated area and the same is posted on the bulletin boards (walls) in the housing areas. Accordingly, residents have substantial access to information provided in the same. The auditor confirmed the Director's assertion pursuant to observation during the facility tour.

Seven of 10 random resident interviewees assert there are services available outside the facility for dealing with sexual abuse, if the resident needed it. With the exception of three interviewees, the seven remaining interviewees assert they are either unaware of the name(s)/nature of such services or the information is not provided. Two interviewees assert there are counseling and Crisis Center options while one interviewee spoke of a Prison to Community program to assist with sexual abuse traumatization. Two interviewees assert such information is available in the CC PREA pamphlet(s), or review of posters throughout the facility. Four of the 10 interviewees assert the numbers are free to call. Six of 10 random resident interviewees assert these services can be accessed at any time, three interviewees assert such calls can be made immediately, and one interviewee identified a specific time frame for calling.

According to the PCM, no residents who reported a sexual abuse were housed at DF at the time of the on-site audit and accordingly, this interview could not be conducted.

The Director asserts a pamphlet from Blue Bench is posted on the bulletin boards in the housing areas and individual copies are available to residents on a table in the same area. The auditor's observations validate the same.

Pursuant to the PAQ, the Director self reports the facility informs residents, prior to giving them access to outside support services, of the extent to which such communications will be monitored. The Director further self reports the facility informs residents, prior to giving them access to outside support services, of the mandatory reporting rule governing privacy, confidentiality, and/or privilege that apply to disclosures of sexual abuse made to outside victim advocates, including any limits to confidentiality under relevant federal, state, or local law.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 10, section F(3) addresses 115.253(b).

The auditor's review of the CoreCivic PREA- A Guide to the Prevention and Reporting of Sexual Misconduct brochure reveals compliance with 115.253(b).

All 10 random resident interviewees assert that what is said to people from the outside services remains private. Seven interviewees assert such conversations could be told to or listened to by someone else. Seven interviewees identified the following reasons for such sharing of information or monitoring of calls by the designated community provider(s); if someone is in danger (law enforcement concern), and the threat of self harm or a potential criminal matter.

At the conclusion of each interview wherein the interviewee was unaware of the appropriate responses to these questions, the auditor provided correct response(s) and directed the interviewee(s) to resources for further review.

Pursuant to the PAQ, the Director self reports the facility maintains memoranda of understanding (MOUs) or other agreements with community service providers that are able to provide residents with emotional support services related to sexual abuse. The Director further self reports the facility maintains copies of the agreement.

The auditor's review of the MOU with The Blue Bench reveals the same is commensurate with 115.253(c). The same is also addressed in the narrative for 115.221 above.

In view of the above, the auditor finds DF substantially compliant with 115.253.

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? X□ Yes □ No

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

Auditor Overall Compliance Determination

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

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

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

Pursuant to the PAQ, the Director self reports the facility provides a method to receive third-party reports of resident sexual abuse or sexual harassment. The CC website provides information regarding third-person reporting options.

According to the Director, PREA posters are posted throughout the facility for the 1-877-DOC-TIPS line. Additionally, the auditor's review of a Visitation Log narrative reveals substantial information regarding

third-party reporting options. This narrative is scripted at the very top of the page for all DF entrants to read. The auditor also observed the DOC-TIPS Line poster as he entered the facility adjacent to the control center.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 17, section L(4) addresses 115.254.

In view of the above, the auditor finds DF substantially compliant with 115.254.

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? X□ 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? X□ 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? X□ 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? X□ 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? X□ 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 X□ 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? X□ 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? X□ Yes □ No

Auditor Overall Compliance Determination

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

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

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

Pursuant to the PAQ, the Director self reports the agency requires all staff to report immediately and according to agency policy:

Any knowledge, suspicion, or information they receive regarding an incident of sexual abuse or sexual harassment that occurred in a facility, whether or not it is part of the agency;
Any retaliation against residents or staff who reported such an incident; and/or
Any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 16, section 2(a)(i-iii) addresses 115.261(a).

All 12 random staff interviewees assert the agency requires all staff to report any knowledge, suspicion, or information regarding any incident of sexual abuse or sexual harassment that occurred in a facility; 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. All 12 interviewees assert policy requires immediate reporting to a supervisor, Director, On-Call, or highest ranking management official at the facility at the time.

Pursuant to the PAQ, the Director self reports apart from reporting to designated supervisors or officials and designated state or local service agencies, agency policy prohibits staff from 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.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, pages 16 and 17, section 2(c) addresses 115.261(b).

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 17, section 2(e) addresses 115.261(c).

As previously indicated, there are no medical/mental health staff on board at DF.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 17, section 2(f) addresses 115.261(d).

According to the Director/PCM, no residents under the age of 18 are housed at DF. With respect to a vulnerable adult being subjected to sexual abuse or sexual harassment, an investigation would be immediately initiated, as is the case with any allegation, and the same would be referred to DPD, if warranted, and CDOC.

The auditor has not been provided any information relative to allegation(s) received from vulnerable adults, nor has he discovered any such allegations pursuant to random and specialized staff interviews.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 16, section 2 addresses 115.261(e).

The Director asserts all allegations of sexual abuse and sexual harassment, including those from third-party and anonymous sources, are reported directly to the designated facility investigator. The Director asserts staff generally contact her immediately. Both she and the Assistant Facility Director are trained PREA investigators. The message regarding opening of an investigation is coordinated by the Director.

The auditor's review of one sexual harassment and one sexual abuse allegation, allegedly perpetrated during the last year, reveals both allegations were quickly directed to the Director, the primary investigator. Timely initiation of investigations was implemented in rapid fashion.

In view of the above, the auditor finds DF substantially compliant with 115.261.

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? X□ Yes □ No

Auditor Overall Compliance Determination

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

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

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

Pursuant to the PAQ, the Director self reports when the agency or facility learns that a resident is subject to a substantial risk of imminent sexual abuse, it takes immediate action to protect the resident (i.e., it takes some action to assess and implement appropriate protective measures without unreasonable delay). The Director further self reports in the past 12 months, there were 0 times the facility determined a resident was subject to substantial risk of imminent sexual abuse.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 1, section entitled Policy and pages 16 and 17, section 2(c) address 115.262(a).

The auditor's review of the CC PREA Overview Facilitator Guide reveals removal of the resident victim from the danger zone is paramount to assurance of the potential victim's safety.

The Agency Head interviewee advises immediate isolation of the potential victim is the initial response to a report of substantial risk of imminent sexual abuse. It may be feasible to move the potential victim to another housing unit within the facility, dependent upon the circumstances. The potential perpetrator may also be placed under direct staff supervision status. The contractual requirements of the Governmental partner will dictate the ability to transfer both the potential victim and potential perpetrator. Minimally, we would work with on-site contract monitors to make the best decision under the circumstances.

The Director asserts when staff learn a resident is at risk of imminent sexual abuse, he is removed from the danger zone and placed under staff supervision. If necessary, the victim may be moved to another Denver facility pursuant to Director-to-Director agreement. There are limited viable options to separate the potential victim from the potential perpetrator in view of facility configuration.

All 12 random staff interviewees corroborate the assertions of the Agency Head interviewee and the Director to the extent the potential victim would be immediately removed from the danger zone.

In view of the above, the auditor finds DF substantially compliant with 115.262.

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? X□ Yes □ No

115.263 (b)

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

115.263 (c)

- Does the agency document that it has provided such notification? X□ 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? X□ Yes □ No

Auditor Overall Compliance Determination

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

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

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

Pursuant to the PAQ, the Director self reports the agency has a policy requiring that, upon receiving an allegation that a resident was sexually abused while confined at another facility, the head of the facility must notify the head of the facility or appropriate office of the agency or facility where sexual abuse is alleged to have occurred. The Director further self reports in the past 12 months, the facility received 0 allegations that a resident was sexually abused while confined at another facility.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 20, section 5(a) addresses 115.263(a).

Pursuant to the PAQ, the Director self reports agency policy requires the facility head provides such notification as soon as possible, but no later than 72 hours after receiving the allegation.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 20, section 5(a) addresses 115.263(b).

Pursuant to the PAQ, the Director self reports the facility documents that it has provided such notification within 72 hours of receiving the allegation.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 21, section 5(b)(c) addresses 115.263(c).

Pursuant to the PAQ, the Director self reports facility policy requires allegations received from other facilities/ agencies are investigated in accordance with PREA standards. The Director further self reports in the past 12 months, there was 0 allegations of sexual abuse received by the facility from other facilities.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 21, section 5(d) addresses 115.263(d).

The Agency Head interviewee advises if another agency or facility within another agency refers allegations of sexual abuse or sexual harassment that occurred within a CC facility, the Director is generally the administrator who receives the call. Subsequent to receipt of such a call, the Director would advise the facility investigator to open an investigation. Dependent upon the circumstances, the investigator would initiate an administrative investigation or contact DPD to initiate a criminal investigation.

According to the Director, when an allegation is received from another facility regarding an incident that allegedly occurred at a DF, an investigation would be initiated pursuant to standard procedure. There are no examples of another facility or agency reporting such allegations.

In view of the above, the auditor finds DF substantially compliant with 115.263.

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?
  X□ 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? X□ 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? X□ 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? X□ 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? X□ Yes □ No

Auditor Overall Compliance Determination

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

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

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

Pursuant to the PAQ, the Director self reports the agency has a first responder policy for allegations of sexual abuse. Specifically, upon learning of an allegation that a resident was sexually abused, the first security staff member to respond to the report shall be required to:

1) Separate the alleged victim and abuser;
2) Preserve and protect any crime scene until appropriate steps can be taken to collect any evidence;
3) If the abuse occurred within a time period that still allows for the collection of physical evidence, request that the alleged victim not take any actions that could destroy physical evidence including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating; and
4) If the abuse occurred within a time period that still allows for the collection of physical evidence, ensure the alleged abuser does not take any actions that could destroy physical evidence such as those described in paragraph 3 above.
The Director self reports zero alleged incidents of sexual abuse occurred at DF during the last 12 months.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, pages 17 and 18, sections M(1)(a-f) and (2)(a) address 115.264(a).

The auditor's review of a Priority: PREA laminated staff card reveals substantial compliance with 115.264(a).

Neither the security first responder nor the non-security first responder interviewees were able to identify all steps involved in the first response duty expectations. Specifically, both interviewees assert the first responder does not allow the victim and perpetrator to destroy physical evidence.

In view of the above and the interview results articulated in the narrative for 115.221(a), the auditor finds DF non-compliant with 115.264(a). Accordingly, the corrective action period and corrective action steps articulated in the narrative for 115.221(a) are likewise applicable to 115.264(a) and (b).

January 27, 2020 Update:

Pursuant to the auditor's review of the training plan regarding first responder duties, the same is clearly commensurate with 115.264(a). The Training/Activity Attendance Roster relative to this training reflects the printed/signed names of participants/title, as well as, the "I understand the training I received" caveat, of 21 DF staff. Accordingly, the auditor finds corrective action is complete.

In view of the above, the auditor finds DF substantially compliant with 115.264.

Pursuant to the PAQ, the Director self reports agency policy requires if the first responder is not a security staff member, that responder shall be required to:

1) Request the alleged victim not take any actions that could destroy physical evidence; and
2) Notify security staff.

The Director further self reports that of the allegations of sexual abuse within the past 12 months, there were 0 times a First Responder was a non-security staff member.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 18, section M(1)(e) addresses 115.264(b).

Of note, all staff receive the same First Responder training as all staff receive the same PREA training, both Pre-Service and In-Service.

The random staff interviewee responses to first responder responsibilities are clearly synopsized in the narrative for 115.221(a), along with corrective action to bring this provision and standard into compliance.

In view of the above, the auditor finds DF substantially compliant with 115.264.

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? X□ Yes □ No

Auditor Overall Compliance Determination

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

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

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

Pursuant to the PAQ, the Director self reports the facility has developed a written institutional plan to coordinate actions taken in response to an incident of sexual abuse among staff first responders, medical and mental health practitioners, investigators, and facility leadership.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, pages 10-12, section G(1-3) and pages 17-26, section M-O address 115.265(a). Specific duties and responsibilities are articulated for various individuals and departments as a response to an incident of sexual abuse.

The auditor's review of this plan reveals a comprehensive and substantive plan to enable proper staff response to an incident of sexual abuse.

The Director asserts staff are trained regarding the coordinated response plan during In-Service training.

According to the Director, the facility does have a plan to coordinate actions among staff first responders, medical and mental health practitioners, investigators, and facility leadership in response to an incident of sexual abuse. The plan is clearly articulated in CC Policy 14-2 CC. Checklists are used to certify completion of action steps. DF staff are trained regarding the nuances of the plan on an annual basis.

In view of the above, the auditor finds DF substantially compliant with 115.265.

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? X□ Yes □ No

115.266 (b)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

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

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

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

Pursuant to the PAQ, the Director self reports the facility is not involved in any collective bargaining process, either currently or since the last PREA audit.

During the on-site audit, the auditor confirmed this assertion.

The Agency Head interviewee advises there are five or fewer facilities under the CC umbrella that are unionized. Collective Bargaining Agreements permit the agency to remove alleged staff sexual abusers from contact with any inmate pending an investigation or a determination of whether and to what extent discipline is warranted.

Since the auditor finds no DF deviation from standard, compliance with 115.266 is established.

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? X□ Yes □ No

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

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

115.267 (d)

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

115.267 (f)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

X☐ **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*)

Pursuant to the PAQ, the Director self reports the agency has 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. According to the Director, she, the Assistant Facility Director and two case managers are the designated retaliation monitors at DF.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 11, section 3(a)(iv-vi) addresses 115.267(a).
CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, pages 11 and 12, sections 3(a)(iv through ix) and 3(b)(i and ii) address 115.267(b).

According to the Agency Head interviewee, staff and residents who report sexual abuse/sexual harassment allegations are protected from retaliation pursuant to frequent retaliation monitoring check-ins (residents/staff), in addition to a 30/60/90 day formal review schedule. Staff charged with retaliation monitoring responsibilities follow disciplinary action(s), housing unit changes, removal of perpetrator(s) from area of victim housing, transfer of alleged abuser(s), and change in programming. In regard to alleged staff perpetrators, monitoring and follow-up regarding staff conduct is a primary consideration to the resident safety equation.

According to the Director, she follows up and checks-in with the case managers to ensure monitoring forms are completed. Questioning determines what is going on with the resident and how they are doing emotionally. The Assistant Facility Director addresses quality control with respect to retaliation monitoring forms. The Director and the Assistant Facility Administrator facilitates staff retaliation monitoring. I

In terms of measures taken to ensure protection of residents from retaliation, termination of the perpetrator from the program and transfer of the victim (if necessary for safety reasons) to another institution, are options. Resident victims can be placed in different rooms more conducive with effective surveillance and monitoring. If the alleged perpetrator is a staff member, his/her shift may be changed, he/she may be removed from the facility. It is important to ensure the victim feels comfortable from a sexual safety perspective.

In regard to staff victims of retaliation, removal of the retaliating staff member or resident from the facility and placement of the alleged staff perpetrator on Administrative Leave, can be implemented. If investigation reveals sufficient evidence, employment termination proceedings are may be implemented. Additionally, EAP may be recommended in terms of the staff victim.

The designated staff member charged with monitoring retaliation interviewee corroborates the statement of the Director reflected above. Additionally, she asserts she initiates contact with residents who reported sexual abuse. Minimally, 30/60/90 day reviews are conducted with periodic check-ins. Check-ins are documented in electronic progress notes.

Pursuant to the PAQ, the Director self reports the facility monitors the conduct or treatment of residents or staff who reported sexual abuse and of residents who were reported to have suffered sexual abuse to see if there are any changes that may suggest possible retaliation by residents or staff. The Director reports retaliation monitoring is continued for at least 90 days or more, if necessary through duration of placement. The facility does act promptly to remedy such retaliation.

The facility continues such monitoring beyond 90 days if the initial monitoring indicates a continuing need. The Director self reports retaliation has not occurred within the last 12 months.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 11, section 3(a)(iv and v) addresses 115.267(c). Documented monitoring occurs at 30/60/90 day intervals.

The auditor's review of one sexual harassment investigation reveals Retaliation Monitoring was facilitated for the requisite 90 days for both the victim and a resident who provided information during the conduct of the investigation. Accordingly, DF exceeded standard expectations as 115.267(c) requires such monitoring in cases of residents who reported to have suffered sexual abuse and of residents who were reported to have suffered sexual abuse.

With respect to the sexual abuse allegation, the alleged victim was housed at another facility and accordingly, retaliation monitoring could not be effected by DF staff or at DF. Additionally, the investigation was determined to be Unfounded and accordingly, DF staff's responsibility to facilitate retaliation monitoring terminated in accordance with 115.278(f).

The Director and designated staff member charged with retaliation monitoring interviewee assert they monitor changes in resident behavior(s), hygiene changes, isolation, withdrawal, and decreased job performance. Observations by the treatment provider are also considered.

In regard to staff, the same issues are assessed. Increased call-offs and decreased job performance are also key indicators.

As previously indicated, monitoring, minimally, is comprised of 30/60/90 day intervals. Check-ins with the victim of retaliation are also facilitated.

There is no maximum length of time for the monitoring process. If additional monitoring times is needed, the same can be extended beyond the minimal 90-day time frame, if deemed necessary. Monitoring could be extended indefinitely based on monitor's judgment.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 11, section 3(a)(iv) addresses 115.267(d). The auditor recommends that a prescribed status check period and documentation of the same be added to policy.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 11, section 3(a)(vi) addresses 115.267(e).

When a resident who cooperates with an investigation expresses a fear of retaliation, the Agency Head interviewee asserts he receives the same benefits and treatment as articulated in the narrative for 115.267(b) above.

115.267(e) retaliation monitoring is also discussed in the narrative for 115.267(c) above.

In view of the above, the auditor finds DF exceeds standard expectations with respect to 115.267.

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).) X□ 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).)
  X□ 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? X□ 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? X□ Yes □ No

- Do investigators interview alleged victims, suspected perpetrators, and witnesses?
  X□ Yes □ No

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

115.271 (f)

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

115.271 (h)

- Are all substantiated allegations of conduct that appears to be criminal referred for prosecution? X□ 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? X□ 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? X□ 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).) X□ Yes □ No □ NA

Auditor Overall Compliance Determination

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

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

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

Pursuant to the PAQ, the Director self reports the facility has a policy related to criminal and administrative agency investigations.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 1, section entitled Policy, and pages 23 through 25, section O(1-3) address 115.271(a).

According to the investigative staff interviewee, an investigation is initiated immediately following receipt of an allegation of sexual abuse. If she is on-site, either the Director or she immediately commences the

investigation. .If the allegation is reported during her off-duty hours, she would immediately report to the facility..

In regard to anonymous or third-party reports of sexual abuse/harassment, they are handled the same as any sexual abuse/harassment investigation. Of note, such reports can be challenging to investigate, absent some specifics.

The auditor's review of the investigations referenced above reveals substantial compliance with 115.271. The Director and Assistant Facility Director maintain close contact with DPD, even with respect to sexual harassment allegations and investigations. Investigations are completed in a timely, comprehensive, and methodical manner.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 7, section b(i) and page 19, section 3(f), and page 25, section 3(b) address 115.271(b).

Trained sexual abuse/harassment investigators are addressed in the narrative for 115.234.

According to the investigative staff interviewee, in 2015, she completed the on-line NIC Course entitled "Investigating Sexual Abuse in a Confinement Setting". This on-line course included topics such as interviewing techniques relative to victims and perpetrators in a confinement setting, execution of Miranda and Garrity warnings, evidence collection in sexual abuse cases, and the evidence standard necessary to substantiate a case for administrative action or prosecution referral.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 19, section 3(g), and pages 24 and 25, sections O(1-3) address 115.271(c).

The investigative staff interviewee asserts the initial steps in initiating an investigation and time frames for implementation of each step are as follows:

Check crime scene relative to first responder effectiveness and ensure no evidence tampering (30 minutes);
Review documents generated by staff (30 minutes);
Threshold questioning of victim (30 minutes to one hour);
Notify DPD (10 minutes);
Review video and files (two to five hours);
Follow-up with DPD (10 minutes);
Interview witness(es) (30minutes-one hour);
Interview perpetrator (one minute-two hours);
Re-interview victim (30 minutes to one hour);
Report writing (one to two hours); and
Contact CC, partner (30 minutes).

The criminal investigation process mirrors the above with the exception of evidence collection.

In regard to direct and circumstantial evidence the interviewee is responsible for collecting, all physical evidence is collected by DPD investigators. The interviewee would collect only camera footage, telephone monitoring data (if applicable), relevant file materials, and any resident/staff/witness written statements.

The auditor's review of the 1-15-CC Form reveals retention time lines regarding investigative materials. CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 25, section O(3)(b) addresses 115.271(d). This provision stipulates as follows:

At this facility, additional contracting agency requirements pertaining to the investigation of rape, sexual assault, or employee on resident sexual misconduct are:

contact the Denver Police Department- Sex Crimes Unit.

The investigative staff interviewee asserts compelled interviews are not conducted by DF staff. The same would be facilitated by DPD investigator(s) and they would likewise maintain contact with prosecutors.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, pages 24, section O(1)(d) addresses 115.271(e). Additionally, the narrative referenced in 115.271(d) is applicable.

In regard to credibility assessments relative to staff and resident witnesses, the investigative staff interviewee asserts these individuals are credible until proven otherwise. She further relates she would not, under any circumstances, require a resident who alleges sexual abuse to submit to a polygraph examination or truth-telling device as a condition for proceeding with an investigation.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 24, section O(1)(f) addresses 115.271(f).

With respect to determining whether staff actions or failure to act contributed to the incident of sexual abuse, the investigative staff interviewee asserts she assesses facts against performance/policy deviations/Code of Ethics. She makes determinations based on results of assessment.

The interviewee asserts administrative investigations are documented in written reports. The reports generally address the following format:

Executive Digest [general synopsis of the allegation(s) and some findings];
Evidence analysis (if known, direct evidence but definitely, circumstantial and indirect;
Victim/witness/perpetrator credibility analysis;
Timeline;
Conclusion; and
Findings.

As previously indicated, the Denver Police Department Sex Crimes Unit was involved in the investigation of both a sexual abuse and sexual harassment matter investigated during the last 12 months. The investigation reports did reflect an assessment of whether staff actions or failures to act contributed to the sexual harassment, if applicable.

The investigative staff interviewee asserts criminal investigations are documented. In actuality, the reports are similar to the administrative reports completed by the interviewee and as described above in the narrative for 115.271(f).

While the auditor did not review any criminal investigation reports, several e-mails reflect the logic regarding prosecution referrals, etc. The same are commensurate with the requirements of 115.271.

Pursuant to the PAQ, the Director self reports substantiated allegations of conduct that appear to be criminal are referred for prosecution. The Director further self reports there were no substantiated allegations of conduct that appeared to be criminal that were referred for prosecution since the last PREA audit.

The investigative staff interviewee asserts cases are referred for criminal investigation whenever the evidence points to the existence of a criminal violation. Referrals for prosecution are generally facilitated by DPD when it appears the evidentiary standard has been met. The interviewee asserts sexual abuse investigations are generally criminal matters based on the nature of the offense.

The auditor's comment regarding e-mails from the criminal investigative agency is addressed in the narrative for 115.271(g).

Pursuant to the PAQ, the Director self reports the agency retains all written reports referenced in the above paragraphs of this section for as long as the alleged abuser is incarcerated or employed by the agency, plus five years.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 29, section T(1) addresses 115.271(i). Additional policy citations with respect to 115.271(i) are noted in the narrative for 115.287(d). The afore-mentioned retention schedule clearly substantiates compliance with 115.271(i).
The auditor's review of the CCA Record Retention Schedule reveals compliance with 115.271(i).

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 25, section O(3)(a) addresses 115.271(j).

The investigative staff interviewee asserts she continues the investigation regardless of whether a staff member alleged to have committed a sexual abuse act terminates employment prior to a completed investigation into his/her conduct and/or when a victim who alleges sexual abuse/harassment or an alleged abuser leaves the facility prior to a completed investigation into the incident.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 24, section O(2)(a)(i), (b) and (c) addresses 115.271(l).

The Director/PCM asserts she maintains consistent e-mail contact with DPD investigators, checking on the status of criminal investigations. Generally, this occurs on a weekly basis.

As previously referenced above, the numerous e-mail threads regarding the two investigations facilitated during the last year, substantiates attempts to be informed regarding the status of investigations.

According to the investigative staff interviewee, she acts as a liaison (e.g. addresses any evidentiary needs, interview coordination/scheduling, etc.) whenever DPD investigators investigate sexual abuse incident(s).

In view of the above, the auditor finds DF substantially compliant with 115.271.

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? X□ Yes □ No

Auditor Overall Compliance Determination

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

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

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

Pursuant to the PAQ, the Director self reports the agency imposes a standard of a preponderance of the evidence or a lower standard of proof when determining whether allegations of sexual abuse or sexual harassment are substantiated.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 26, section O(5) addresses 115.272(a).

The investigative staff interviewee asserts she relies on a preponderance of evidence to substantiate allegations of sexual abuse/harassment. She asserts this equates to, "it is more believable the incident occurred, than not". Preponderance generally equates to 51% or more of available evidence.

The auditor's review of the one sexual abuse and one sexual harassment investigations conducted during the last 12 months reveals substantial compliance with 115.272(a). The referenced investigations were administrative, in nature, and similarly assessed by the DPD.

In view of the above, the auditor finds DF substantially compliant with 115.272.

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? X□ 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.) X□ 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? X□ 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? X□ 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? X□ 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? X□ 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? X□ 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? X□ 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*)

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

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

Pursuant to the PAQ, the Director self reports the agency has a policy requiring that any resident who makes an allegation he or she suffered sexual abuse in an agency facility is informed, verbally or in writing, as to whether the allegation has been determined to be substantiated, unsubstantiated, or unfounded following an investigation by the agency. The Director self reports one administrative sexual harassment and one sexual abuse investigation were completed during the last 12 months.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 26, section Q(1) addresses 115.273(a). This policy stipulates provision of the notification upon completion of a sexual abuse investigation.

The auditor's review of one Inmate/Resident PREA Allegation Status Notification issued to the alleged victim of sexual harassment, advising the status of the investigation was unsubstantiated, exceeds standard expectations as 115.273(a) requires such notifications in sexual abuse matters only. The notification was provided subsequent to completion of the investigation and both the subject of the

investigation and staff properly signed and dated the same. Additionally, with respect to the sexual abuse allegation, the alleged victim was housed at another facility however, DF staff mailed a copy of the requisite notification to him at the current facility. The notification reflects the investigation was unfounded.

According to the Director, the facility does notify a resident who makes an allegation of sexual abuse when the allegation has been determined to be substantiated, unsubstantiated, or unfounded following an investigation. She asserts all such notifications are effected on a Resident Notification Form. The investigative staff interviewee substantiates the Director's statement.
In view of the above, provision of notifications pursuant to 115.273(a) and (b) are applicable at DF.

Pursuant to the PAQ, if an outside entity conducts such investigations, the agency requests the relevant information from the investigative entity in order to inform the resident of the outcome of the investigation. The Director further self reports DPD was involved in both the sexual abuse and harassment investigations in both a consultancy role and investigative role relative to the sexual abuse case. As previously indicated, communication regarding these matters was abundant. As reflected above, both alleged victims were notified of the results of the investigations.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 26, section Q(1) addresses 115.273(b).

The auditor's review of the afore-referenced investigations reveals DF staff did follow-up with DPD regarding the status of the criminal investigation as reflected in e-mails.

Pursuant to the PAQ, the Director self reports following a resident's allegation that a staff member has committed sexual abuse against the resident, the facility subsequently informs the resident (unless the agency has determined the allegation is unfounded) whenever:

The staff member is no longer posted within the resident's unit;
The staff member is no longer employed at the facility;
The agency learns the staff member has been indicted on a charge related to sexual abuse within the facility; or
The agency learns the staff member has been convicted on a charge related to sexual abuse within the facility.
As previously referenced in the narrative for 115.273(a), this provision is not applicable to DF as the investigation was determined to be unfounded.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, pages 26 and 27, section Q(2)(a-d) addresses 115.273(c).

Pursuant to the PAQ, following a resident's allegation he or she has been sexually abused by another resident at DF, the agency subsequently informs the alleged victim whenever:

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

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 27, section Q(3)(a and b) addresses 115.273(d).

The auditor finds there are no investigations regarding sexual abuse by another resident during the audit period.

Pursuant to the PAQ, the Director self reports the agency has a policy that all notifications to residents described under this standard are documented. The written notifications in accordance with 115.273(e) are discussed above.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 27, section Q(4) addresses 115.273(e).

In view of the above, the auditor finds DF substantially compliant with 115.273.

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? X□ Yes □ No

115.276 (b)

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

Auditor Overall Compliance Determination

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

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

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

Pursuant to the PAQ, the Director self reports staff is subject to disciplinary sanctions up to and including termination for violating agency sexual abuse or sexual harassment policies.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 28, section 2(a) addresses 115.276(a).

Pursuant to the PAQ, the Director self reports in the past 12 months, zero facility staff members are alleged to have violated agency sexual abuse or harassment policies. The Director further self reports zero staff have resigned or been terminated from employment for offenses related to such conduct.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 28, section 2(a) addresses 115.276(b).

Pursuant to the PAQ, the Director self reports disciplinary sanctions for violations of agency policies relating to sexual abuse or sexual harassment (other than actually engaging in sexual abuse) are 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. The Director further self reports that in the past 12 months, 0 staff from the facility have been disciplined, short of termination, for violation of agency sexual abuse or sexual harassment policies.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 28, section 2(b) addresses 115.276(c).

The auditor has found no evidence of disciplinary sanctions taken against staff for violations of agency sexual abuse/harassment policies during the last 12 months.

Pursuant to the PAQ, the Director self reports 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, are reported to law enforcement agencies, unless the activity was clearly not criminal, and to any relevant licensing bodies. The Director further self reports during the last 12 months, zero facility staff have been reported to law enforcement or licensing boards following termination (or resignation prior to termination) for violating agency sexual abuse or sexual harassment policies.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 28, section 2(c) addresses 115.276(d).

In view of the above, the auditor finds DF substantially compliant with 115.276.

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? X□ Yes □ No
- Is any contractor or volunteer who engages in sexual abuse reported to: Law enforcement agencies unless the activity was clearly not criminal? X□ Yes □ No
- Is any contractor or volunteer who engages in sexual abuse reported to: Relevant licensing bodies? X□ 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? X□ Yes □ No

Auditor Overall Compliance Determination

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

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

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

Pursuant to the PAQ, the Director self reports agency policy requires that any contractor or volunteer who engages in sexual abuse be reported to law enforcement agencies, unless the activity was clearly not criminal, and to relevant licensing bodies. Additionally, the Director self reports agency policy requires that any contractor or volunteer who engages in sexual abuse be prohibited from contact with residents. According to the Director, in the past 12 months, zero contractors or volunteers have been reported to law enforcement agencies and relevant licensing bodies.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 29, section R(3) addresses 115.277(a).

In addition to the above, the CoreCivic Zero-Tolerance Policy-Prohibited Sexual Behavior document, signed and dated by each contractor/volunteer, reflects the requirements of 115.277 in the section entitled Corrective Action for Contractors and Volunteers that Engage in Prohibited Sexual Behavior.

Pursuant to staff and resident interviews and documentation reviews, the auditor has not found any incidents wherein the requirements of 115.277 were invoked or would require the same.

Pursuant to the PAQ, the Director self reports the facility takes appropriate remedial measures and considers 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.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 29, section R(3) addresses 115.277(b).

The Director asserts she revokes contractor/volunteer privileges and eliminates contact with residents, pending the results of an investigation, should a contractor/volunteer be involved in a sexual abuse/ harassment incident with a resident.

In view of the above, the auditor finds DF substantially compliant with 115.277.

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? X□ 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? X□ 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? X□ 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? X□ 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? X□ 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? X□ 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.) X□ Yes □ No □ NA

Auditor Overall Compliance Determination

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

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

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

Pursuant to the PAQ, the Director self reports residents are subject to disciplinary sanctions only pursuant to a formal disciplinary process following an administrative finding that the resident engaged in

resident-on-resident sexual abuse. The Director also self reports residents are subject to disciplinary sanctions only pursuant to a formal disciplinary process following a criminal finding of guilt for resident-on-resident sexual abuse. In the past 12 months, there were 0 administrative and/or criminal findings of resident-on-resident sexual abuse that occurred at the facility.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 27, section R(1)(a)(i) addresses 115.278(a).

The auditor's review of the CoreCivic Client Handbook reveals substantial compliance with 115.278 in terms of administrative charges and sanctions.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 27, section R(1)(a)(iii) addresses 115.278(b).

According to the Director, residents who facilitate a resident-on-resident sexual abuse incident may normally be recommended, during an administrative disciplinary process, for termination from the program following a substantiated administrative or criminal investigation. However, the formal removal process is facilitated by CDOC (separate administrative action) following a hearing for remand to CDOC custody. Such sanctions are commensurate with the nature and circumstances of the abuse committed.

The Director generates an informational report to CDOC officials and they issue the misconduct report. CDOC staff conduct the hearing and they consider any mental health issues.

Of note, the Director asserts residents with histories of prison or community sexual abuse are generally not accepted into the program.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 27, section R(1)(a)(iv) addresses 115.278(c).

Pursuant to the PAQ, the Director self reports the facility does not offer therapy, counseling, or other interventions designed to address and correct the underlying reasons or motivations for abuse. In view of the above, facility staff do not consider whether to require the offending resident to participate in such interventions as a condition of access to programming or other benefits.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 28, section R(1)(c) addresses 115.278(d).

In view of the fact medical and mental health staff are not on board at DF, therapy, counseling, or other interventions are not offered to address and correct the underlying reasons or motivations for abuse.

Pursuant to the PAQ, the Director self reports the agency disciplines residents for sexual conduct with staff only upon finding that the staff member did not consent to such contact.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 27, section R(1)(a)(v) addresses 115.278(e).

The auditor finds no allegations or investigations relative to resident sexual contact with staff, conducted during the last 12 months, addressing the subject-matter of 115.278(e).

Pursuant to the PAQ, the Director self reports the agency prohibits disciplinary action for a report of sexual abuse made in good faith based upon a reasonable belief that the alleged conduct occurred, even if an investigation does not establish evidence sufficient to substantiate the allegation.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, pages 27 and 28, section R(1)(b)(i) addresses 115.278(f).

Of note, this matter is addressed in the PREA: A Guide to the Prevention and Reporting of Sexual Misconduct pamphlet provided to each resident upon intake.

The auditor has found no evidence of deviation from the requirements of 115.278(f).

Pursuant to the PAQ, the Director self reports the agency prohibits all sexual activity between residents. The Director further self reports the agency deems such activity to constitute sexual abuse only if it determines that the activity is coerced.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 27, section R(1)(a)(vi) addresses 115.278(g).

In view of the above, the auditor finds DF substantially compliant with 115.278.

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?
  X□ 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? X□ Yes □ No

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

Auditor Overall Compliance Determination

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

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

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

Pursuant to the PAQ, the Director self reports resident victims of sexual abuse receive timely, unimpeded access to emergency medical treatment and crisis intervention services. The Director further self reports the nature and scope of such services are determined by medical and mental health practitioners according to their professional judgment. The same occurs at the respective hospital. The Director self reports that as medical and mental health care is not provided at DF, such secondary materials are maintained at the hospital.

During the facility tour, the auditor validated no medical/mental health staff are employed at DF.

Page 2, section entitled Access to Emergency Medical Health Services, paragraph 1 of the MOU between CMI and St. Anthony North Neighborhood Health Center addresses 115.282(a). Additionally, forensic examinations provided by SAFE/SANE Nurses are addressed in the CoreCivic PREA: A guide to the Prevention and Reporting of Sexual Misconduct pamphlet, sections entitled Reporting and Confidentiality and Treatment and Counseling.

The interview narratives for security and non-security first responders, as reflected in 115.221, 115.262, and 115.264, address preliminary steps taken by first responders to protect the victim. Specific responsibilities in terms of medical evaluation and the conduct of a forensic examination are articulated in the narrative and relevant policy cited for 115.265.

The auditor has found no incidents wherein medical care and follow-up were warranted.

Pursuant to the PAQ, the Director self reports resident victims of sexual abuse while incarcerated 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. The Director self reports that as medical and mental health care is not provided at DF, such secondary materials are maintained at the hospital.

Page 2, section entitled Access to Emergency Medical Health Services, paragraph 2 of the MOU between CMI and St. Anthony North Neighborhood Health Center addresses 115.282(c).

Pursuant to the PAQ, the Director self reports treatment services are provided to every victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 25, section 4(c) addresses 115.282(d).

Page 2, section entitled Access to Emergency Medical Health Services, paragraph 3 of the MOU between CMI and St. Anthony North Neighborhood Health Center addresses 115.282(d).

In view of the above, the auditor finds DF substantially compliant with 115.282.

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? X□ 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? X□ Yes □ No

115.283 (c)

- Does the facility provide such victims with medical and mental health services consistent with the community level of care? X□ 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 X□ 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 X□ NA

115.283 (f)

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

Auditor Overall Compliance Determination

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

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

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

Pursuant to the PAQ, the Director self reports the facility offers 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.

CC Policy Change Notice (PCN) 14-2(01) CC entitled Sexual Abuse Prevention and Response, page 1, section W(2)(a) addresses 115.283(a) in entirety.

As previously mentioned, medical/mental health providers are not employed at DF. All medical/mental health care is provided in the surrounding community. As the auditor understands, such care is provided to residents pursuant to Medicare, their private insurance provider, or some other form of payment.

When questioned as to the method employed at DF to initiate 115.283(a) and (b) referrals, the Director asserts the respective case manager, assistant facility director, or Director makes the appropriate medical or mental health referral for residents who have reported previous institutional abuse. Pursuant to the auditor's interview of one resident, who reported prior sexual victimization during screening, he was offered a meeting with medical/mental health practitioners however, he declined the meeting.

CC Policy Change Notice (PCN) 14-2(01) CC entitled Sexual Abuse Prevention and Response, page 1, section W(2)(b) addresses 115.283(b) in entirety.

As mentioned throughout this report, the auditor has been advised no residents who reported a sexual abuse are on-site and accordingly, such interview was not conducted.

CC Policy Change Notice (PCN) 14-2(01) CC entitled Sexual Abuse Prevention and Response, page 1, section W(2)(c) addresses 115.283(c) in entirety. Additionally, provision of medical/mental health care consistent with the community level of care is addressed in the CoreCivic PREA: A guide to the Prevention and Reporting of Sexual Misconduct pamphlet, section entitled Reporting and Confidentiality.

DF is an all-male facility and therefore, the auditor finds 115.283(d) not applicable to the facility.

DF is an all-male facility and therefore, the auditor finds 115.283(e) not applicable to the facility.

Pursuant to the PAQ, the Director self reports resident victims of sexual abuse while incarcerated are offered tests for sexually transmitted infections as medically appropriate.

CC Policy Change Notice (PCN) 14-2(01) CC entitled Sexual Abuse Prevention and Response, page 2, section W(2)(e) addresses 115.283(f) in entirety.

Page 2, section entitled Access to Emergency Medical Health Services, paragraph 2 of the MOU between CMI and St. Anthony North Neighborhood Health Center addresses 115.283(f).

Pursuant to the PAQ, the Director self reports 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.

CC Policy Change Notice (PCN) 14-2(01) CC entitled Sexual Abuse Prevention and Response, page 2, section W(2)(f) addresses 115.283(g) in entirety.

Page 2, section entitled Access to Emergency Medical Health Services, paragraph 3 of the MOU between CMI and St. Anthony North Neighborhood Health Center addresses 115.283(g). Additionally, forensic examinations provided by SAFE/SANE Nurses are addressed in the CoreCivic PREA: A guide to the Prevention and Reporting of Sexual Misconduct pamphlet, section entitled Reporting and Confidentiality.

Pursuant to the PAQ, the Director self reports the facility attempts to conduct a mental health evaluation of all known resident-on-resident abusers within 60 days of learning of such abuse history, and offers treatment when deemed appropriate by mental health practitioners.

CC Policy Change Notice (PCN) 14-2(01) CC entitled Sexual Abuse Prevention and Response, page 2, section W(2)(g) addresses 115.283(h) in entirety.

Of note, there are no medical and mental health practitioners at DF. All care is provided in community hospital(s).

In a separate conversation, the Director advised that no resident-on-resident sexual abusers have been housed at DF during the last 18 months. As previously indicated, CC acquired DF on or about January 1, 2017.

The auditor notes the alleged victim of the Unfounded sexual assault investigation was housed at another facility.

In view of the above, the auditor finds DF substantially compliant with 115.283.

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? X□ Yes □ No

115.286 (b)

- Does such review ordinarily occur within 30 days of the conclusion of the investigation? X□ 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? X□ 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? X□ 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? X□ 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? X□ Yes □ No
- Does the review team: Assess the adequacy of staffing levels in that area during different shifts? X□ Yes □ No
- Does the review team: Assess whether monitoring technology should be deployed or augmented to supplement supervision by staff? X□ 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? X□ Yes □ No

115.286 (e)

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

Auditor Overall Compliance Determination

X☐ **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*)

Pursuant to the PAQ, the Director self reports the facility conducts a sexual abuse incident review at the conclusion of every criminal or administrative sexual abuse investigation, unless the allegation has been determined to be unfounded. The Director further self reports in the past 12 months, 0 criminal or administrative sexual abuse investigations were facilitated at DF. However, one administrative and criminal investigation has been conducted relative to a sexual harassment allegation.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 23, section N(1) addresses 115.286(a).

Given the fact the previously referenced investigation centered on a sexual harassment allegation, a SART review is not required pursuant to standard or policy.

As a SART review was conducted with respect to the sexual harassment allegation, the auditor finds DF exceeds standard expectations.

Pursuant to the PAQ, the Director self reports the facility ordinarily conducts a sexual abuse incident review within 30 days of the conclusion of the criminal or administrative sexual abuse investigation. The Director further self reports in the past 12 months, zero criminal or administrative sexual abuse investigations were facilitated at DF. As mentioned in the narrative for 115.286(a), one allegation of sexual harassment was investigated.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 23, section N(1)(b) addresses 115.286(b).

It appears the SART review was completed in accordance with 115.286 however, the auditor notes the PCM appears to have documented the date the alleged incidents were reported in the "Report Date" section of the report, as opposed to, the date the physical SART review was completed. Going forward, this must be corrected for purposes of ensuring the proper audit trail.

Pursuant to the PAQ, the Director self reports the sexual abuse incident review team (SART) includes upper-level management officials and allows for input from line supervisors, investigators, and medical or mental health practitioners. The auditor notes no medical or mental health staff are employed at DF.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 23, section N(1)(a) addresses 115.286(c).

The auditor finds the composition of the SART, in question, to be commensurate with standard expectations.

The Director asserts the facility does have a SART team. The team is comprised of the Director and Senior Director (Division 7), allowing for input from line supervisors, investigators, and medical/mental health practitioners. Case managers may also be included on the team.

Pursuant to the PAQ, the Director self reports the facility prepares a report of its findings from sexual abuse incident reviews, including but not necessarily limited to, determinations made pursuant to paragraphs (d)(1)-(d)(5) of this provision and any recommendations for improvement, and submits such report to the facility head and PREA Coordinator.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 23, section N(2)(a-e) and N(3) address 115.286(d).

The auditor's review of the CC Sexual Abuse or Assault Incident Review Form reveals substantial compliance with 115.286(d).

According to the Director, the team works to determine whether the alleged incident was the result of a policy, technology, inadequate staffing, or performance failure. Additionally, any potential trends, with respect to sexual abuse of residents, are tracked with recommendations for correction articulated in the report. The SART process is designed to enhance the PREA program and resident sexual safety at DF.

The SART team considers:

1. Was the incident motivated by race, ethnicity, gender identity, LGBTI identification status or perceived status or perceived status, or gang affiliation, or was it motivated or otherwise caused by other group dynamics at the facility;
2. Physical examination of the area, in the facility, where the incident allegedly occurred to assess whether physical barriers in the area may enable abuse;
3. Assessment of the adequacy of staffing levels in the area during different shifts;
4. Assessment of whether monitoring technology should be deployed or augmented to supplement staff supervision.

According to the Director/PCM, SART reports are generated by her. If recommendation(s) are made, she looks to implement the same unless there is a written basis for non-compliance with the recommendation.

The Assistant Director, a member of the SART team, corroborated the statement of the Director in terms of the four SART team considerations.

Pursuant to the PAQ, the Director self reports the facility implements the recommendations for improvement or documents its reasons for not doing so.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 23, section N(4)addresses 115.286(e).

The auditor notes 0 recommendations were made with respect to the incident referenced throughout the narrative for 115.286.

In view of the above, the auditor finds DF exceeds expectations with respect to 115.286.

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? X□ Yes □ No

115.287 (b)

- Does the agency aggregate the incident-based sexual abuse data at least annually? X□ 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? X□ 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? X□ 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 X□ 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.) X□ Yes □ No □ NA

Auditor Overall Compliance Determination

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

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

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

Pursuant to the PAQ, the Director self reports the agency collects accurate, uniform data for every allegation of sexual abuse at facilities under its direct control using a standardized instrument and set of definitions. The Director further self reports the standardized instrument includes, 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.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 29, section T(1)(a)(i) addresses 115.287(a/c).

The auditor's review of the CC IRD (Incident Reporting Definitions) and CC 5-1E forms reveals substantial compliance with 115.287(a/c).

Pursuant to the PAQ, the Director self reports the agency aggregates the incident-based sexual abuse data at least annually.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 29, section T(1)(a)(ii) addresses 115.287(b).

The auditor's review of the CC website reveals substantial compliance with 115.287(b) as aggregated data is available for audit years.

Pursuant to the PAQ, the Director self reports the agency maintains, reviews, and collects data as needed from all available incident-based documents, including reports, investigation files, and sexual abuse incident reviews.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 29, section T(1) addresses 115.287(d).

Based on the PAQ review and on-site review of documents, the auditor finds UF substantially compliant with 115.287(d).

DF does not contract with any other facility(ies) for confinement of its residents. Accordingly, the auditor finds 115.287(e) not applicable to DF.

Pursuant to the PAQ, the Director self reports CoreCivic provided sexual abuse/sexual harassment data to the U.S. Department of Justice during 2018. It is noted CoreCivic assumed DF during calendar year 2017.

In view of the above, the auditor finds DF substantially compliant with 115.287.

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? X□ 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?
X□ 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? X□ 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 X□ 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? X□ 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? X□ Yes □ No

Auditor Overall Compliance Determination

X□ **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*)

Pursuant to the PAQ, the Director self reports the agency reviews 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 and training including:

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

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 30, section 3(a)(i-iii) addresses 115.288(a).

The auditor's review of the 2018 CC Annual Report reveals substantial compliance with 115.288(a), (b), and (c). The report is published on the CC website.

The Agency Head interviewee advises CC accesses information from several sources, using incident-based sexual abuse data to assess and improve sexual abuse prevention, detection, and response policies, practices, and training. Specifically, he advises that a 5-1 Incident Reporting System is implemented wherein incidents and reports are, minimally, reviewed by Corporate and designated facility staff within a 24-hour period. Monthly, a report of PREA related incidents details frequency and location(s) of incidents within the facility, amongst other criteria. Pursuant to this procedure, Corporate and facility staff collaborate to diagnose any PREA-related issues, concerns, etc. These proactive steps, in addition to SART review

findings and continual monitoring of data, are utilized to attain optimal efficiency in terms of sexual safety of inmates/residents at CC facilities.

In view of the above, the auditor finds DF to exceed compliance expectations with respect to 115.288. This procedure is representative of CC's commitment and zeal in terms of enhancement of inmate sexual safety within facilities.

While the CCPC interviewee was not interviewed during this audit, his statement with respect to previous CC audits is noteworthy. He asserts the agency does review data collected and aggregated in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies and training. Such data is securely retained in password protected programs at both the facility and CCPC's office. Access to this information is limited.

Auditor's Note: PREA investigation reports and ancillary documentation are electronically generated. The auditor observed this process throughout the on-site audit.

The CCPC further advises the agency takes corrective action on an ongoing basis based on this data. For example, anything identified pursuant to a mock audit or SART review is considered for implementation.

The PCM asserts the agency reviews data collected and aggregated pursuant to 115.287 in order to assess and improve effectiveness of its sexual abuse prevention, detection, and response policies, and training. Data is maintained electronically by the Director/PCM, Assistant Facility Administrator, and CCPC. The data is maintained in a password protected system with access by the Director/PCM and Assistant Facility Administrator only. If corrective action is warranted, the same is taken.

The Director/PCM also asserts the agency prepares an annual report of findings from its data review and any corrective actions for each facility, as well as, the agency as a whole. The CCPC actually compiles the report.

Pursuant to the PAQ, the Director self reports the annual report includes a comparison of the current year's data and corrective actions with those from prior years. The Director further self reports the annual report provides an assessment of the agency's progress in addressing sexual abuse.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 30, section 3(b) addresses 115.288(b).

The auditor finds substantial compliance with 115.288(b) pursuant to review of the Annual CC PREA Report.

Pursuant to the PAQ, the Director self reports the agency makes its annual report readily available to the public at least annually through its website and the reports are approved by the agency head.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 30, section 3(c) addresses 115.288(c).

The auditor's review of the CC website reveals the 2018 Annual Report is maintained on the same.

According to the Agency Head interviewee, he reviews all PREA Annual Reports as he is the direct supervisor of the CCPC. He copiously reviews each report for comprehensiveness and content, forwarding the same to the CC Chief Corrections Officer for final review and signature.

Pursuant to the PAQ, the Director self reports when the agency redacts material from an annual report for publication, the redactions are limited to specific materials where publication would present a clear and

specific threat to the safety and security of the facility. Furthermore, the agency indicates the nature of the material redacted.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 30, section 3(d) addresses 115.288(d).

According to the Director/PCM, personal names and identifiers are typically redacted from the annual report and the agency indicates the nature of the redacted material. The report is generated by the CCPC.

The auditor has found no evidence of such redactions with respect to the 2018 CC Annual Report.

In view of the above, the auditor finds DF exceeds standard expectation(s) with respect to 115.288.

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? X□ 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? X□ Yes □ No

115.289 (c)

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

Auditor Overall Compliance Determination

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

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

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

Pursuant to the PAQ, the Director self reports the agency ensures incident-based and aggregate data are securely retained.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 29, section T(1)(a)(iv) addresses 115.289(a).

The PCM asserts the agency reviews data collected and aggregated pursuant to 115.287 in order to assess and improve effectiveness of its sexual abuse prevention, detection, and response policies, and training. Data is maintained electronically by the Director/PCM, Assistant Facility Administrator, and CCPC. The data is maintained in a password protected system with access by the Director/PCM and Assistant Facility Administrator only. If corrective action is warranted, the same is taken.

Pursuant to the PAQ, the Director self reports agency policy requires that aggregated sexual abuse data from facilities under its direct control and private facilities with which it contracts be made readily available to the public, at least annually through its website.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 30, section (c)(i) addresses 115.289(b).

The auditor's review of the CC website reveals aggregated sexual abuse data is available on an annual basis.

Pursuant to the PAQ, the Director self reports before making aggregated sexual abuse data publicly available, the agency removes all personal identifiers.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 30, section (c)(ii) addresses 115.289(c).

The auditor's review of aggregated sexual abuse data on the website reveals all personal identifiers have been removed.

Pursuant to the PAQ, the Director self reports the agency maintains sexual abuse data collected pursuant to 115.287 for at least 10 years after the date of initial collection, unless federal, state, or local law requires otherwise.

The auditor's review of the CC Records Retention Schedule reveals compliance with 115.289(d).

In view of the above, the auditor finds DF substantially compliant with 115.289.

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.*) X□ 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 X□ 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 X□ 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.) X□ Yes □ No □ NA

115.401 (h)

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

115.401 (i)

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

115.401 (m)

- Was the auditor permitted to conduct private interviews with residents? X□ 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? X□ Yes □ No

Auditor Overall Compliance Determination

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

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

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

The auditor found all accommodations and provision of documents, interviewees to be exceptional. Staff and resident responsiveness to interviews and questions is noteworthy. Special thanks to the Director/PCM for expediting the on-site audit.

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.) X□ Yes □ No □ NA

Auditor Overall Compliance Determination

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

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

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

None.

AUDITOR CERTIFICATION

I certify that:

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

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

X□ 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.

K. E. Arnold **January 27, 2020**

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.