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

☐ **Interim** X☐ **Final**

Date of Report May 3, 2019

Auditor Information

Name: K. E. Arnold	**Email:** kenarnold220@gmail.com
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:** October 8-9, 2018

Agency Information

Name of Agency CoreCivic (CC)		**Governing Authority or Parent Agency** *(If Applicable)*: NA	
Physical Address: 10 Burton Hills Blvd.		**City, State, Zip:** Nashville, TN 37125	
Mailing Address: Same as Above		**City, State, Zip:** Same as Above	
Telephone: 615-263-3000		**Is Agency accredited by any organization?** ☐ Yes X☐ No	
The Agency Is:	☐ Military	X☐ Private for Profit	☐ Private not for Profit
☐ Municipal	☐ County	☐ State	☐ Federal
Agency mission: See Body of Report			
Agency Website with PREA Information: http://www.corecivic.com/the-prison-rape-elimination-act-of-2003-prea			

Agency Chief Executive Officer

Name: Damon Hininger	**Title:** President and CEO
Email: Click or tap here to enter text.	**Telephone:** 615-263-3000

Agency-Wide PREA Coordinator

Name: Eric Pierson	**Title:** Senior Director PREA Compliance and Programs
Email: eric.Pierson@corecivic.com	**Telephone:** 615-263-6915
PREA Coordinator Reports to: Vice President, Operations and Administration	**Number of Compliance Managers who report to the PREA Coordinator** 60 plus

Facility Information

Name of Facility:	Arapahoe Community Treatment Center (ACTC)			
Physical Address:	3265 West Girard Ave. Englewood, CO 80110			
Mailing Address (if different than above):	Same as Above			
Telephone Number:	303-761-7685			
The Facility Is:	☐ Military	X☐ Private for Profit	☐ Private not for Profit	
☐ Municipal	☐ County	☐ State	☐ Federal	
Facility Type:	X☐ Community treatment center	☐ Halfway house	☐ Restitution center	
	☐ Mental health facility	☐ Alcohol or drug rehabilitation center		
	☐ Other community correctional facility			
Facility Mission:	See Body of Report			
Facility Website with PREA Information:	http://www.corecivic.com/the-prison-rape-elimination-act-of-2003-prea			
Have there been any internal or external audits of and/or accreditations by any other organization?	☐ Yes X☐ No			

Director

Name: Rory Gryniewicz	**Title:** Facility Director
Email: rory.gryniewicz@corecivic.com	**Telephone:** 303-761-7685 Ext 113

Facility PREA Compliance Manager

Name: Same as Above	**Title:** Same as Above
Email: Same as Above	**Telephone:** Same as Above

Facility Health Service Administrator			
Name: NA		**Title:** NA	
Email: NA		**Telephone:** NA	
Facility Characteristics			
Designated Facility Capacity: 135		**Current Population of Facility:** 117	
Number of residents admitted to facility during the past 12 months			192
Number of residents admitted to facility during the past 12 months who were transferred from a different community confinement facility:			5
Number of residents admitted to facility during the past 12 months whose length of stay in the facility was for 30 days or more:			192
Number of residents admitted to facility during the past 12 months whose length of stay in the facility was for 72 hours or more:			192
Number of residents on date of audit who were admitted to facility prior to August 20, 2012:			0
Age Range of Population:	X☐ Adults 18-70	☐ Juveniles Click or tap here to enter text.	☐ Youthful residents Click or tap here to enter text.
Average length of stay or time under supervision:			180 days
Facility Security Level:			Minimum
Resident Custody Levels:			Minimum
Number of staff currently employed by the facility who may have contact with residents:			22
Number of staff hired by the facility during the past 12 months who may have contact with residents:			12
Number of contracts in the past 12 months for services with contractors who may have contact with residents:			2
Physical Plant			
Number of Buildings: 1		**Number of Single Cell Housing Units:** 0	
Number of Multiple Occupancy Cell Housing Units:		15 Rooms	
Number of Open Bay/Dorm Housing Units:		0	
Description of any video or electronic monitoring technology (including any relevant information about where cameras are placed, where the control room is, retention of video, etc.): 38 Cameras, Central in Monitor Office			

Medical	
Type of Medical Facility:	NA
Forensic sexual assault medical exams are conducted at:	St. Anthony's Hospital

Other	
Number of volunteers and individual contractors, who may have contact with residents, currently authorized to enter the facility:	2 contractors
Number of investigators the agency currently employs to investigate allegations of sexual abuse:	1

Audit Findings

Audit Narrative

The Prison Rape Elimination Act (PREA) on-site audit of the Arapahoe Community Treatment Center (ACTC) was conducted October 8 and 9, 2018, 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 an encrypted thumb drive and mailed to the auditor's address via United States Postal Service. The same was securely packaged.

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, 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 ACTC Director/PREA Compliance Manager (ACTC 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 ACTC. The Director of Client Services asserts he/she cannot specifically cite a number associated with receipt of sexual abuse/harassment reports from residents housed at ACTC 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 and Assistant Director at 8:00AM on Monday, October 8, 2018. 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 8:30AM and 10:00AM, the auditor toured the entire facility with the Director and Assistant Director.

It is noted the rated capacity of ACTC is 135 residents and the institutional count on October 8, 2018 was 117 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) 20 residents for on-site interviews pursuant to the Resident Interview Questionnaire. Interviewees represented all floors and wings.

According to the Director, there were no resident(s), confined in the facility at the time of the on-site audit, who were Limited English Proficient (LEP), physically disabled (however, the interviewee presenting with mental health disabilities also reported physical disability), transgender or intersex, or residents who reported a sexual abuse.

It is noted the 20 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 random residents advised they had received training by ACTC staff, as well as, information gleaned pursuant to previous PREA training within State prisons, jails, other CC facilities, and transitional centers.

Thirteen random staff selected by the auditor from a staff roster provided by the Director, were interviewed. 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, the response protocols when a residents alleges abuse, and First Responder duties.

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

Agency Head
Director
ACTC 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 (2)
Security and Non-Security Staff Who Have Acted as First Responders (10 Security staff and 2 Non-Security staff)
Non-medical Staff Involved in Cross-Gender Strip or Visual Searches (1)
Contractors Who Have Contact With Residents (1)

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

It is noted CC is the umbrella company for ACTC.

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

Disabled (1 with mental disabilities)
Residents Who Reported a Sexual Abuse (0)
Transgender/Intersex(0)
Lesbian, Gay, Bisexual (2)

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

On October 8, 2018, the auditor was processed into the facility at the facility Front Entrance Desk. The auditor did note PREA third-party notification (telephonic reporting information) posted in the Front Entrance area which also houses the Visitation Area and upstairs Dayroom.

Similarly, PREA Hotline notification numbers were posted above the two resident telephones, in every resident room, and on various walls through the facility, inclusive of the upstairs Day Room where visitation is conducted. Ethics Liaison posters (staff private reporting mechanism) were posted in the Staff Break Room. PREA Audit Notices were prevalent throughout the facility, inclusive of the housing units, program areas, etc. It is also noted a reminder regarding opposite gender staff announcements is posted on resident doors in each housing unit.

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 circular in construction with two floors used for resident housing and staff office space. A Monitor's station is located on the top floor wherein cameras can be monitored. Sufficient Monitors, given the size of the facility, supervised the floors throughout periods of time the auditor was present at the facility, generally supervising two Dormitories each. It is noted that staff offices are located on the Upper Level.

The auditor noted camera surveillance (38 cameras) fairly well dispersed throughout the facility. The auditor notes there is a storage room in the lower level, complete with camera surveillance. However, there is no coverage of the adjacent staff restroom and elevator. This matter was addressed with both the Director and Assistant Director during the facility tour and they decided on two possible options. One option is re-positioning of the camera to capture the restroom and elevator or submission of need during the annual Staffing Plan review. The auditor recommends this issue be addressed to enhance supervision and monitoring in this critical area. Of note, resident rooms are located just past a door leading from the affected area to the Lower Level Day Room, resident rooms.

In addition to the above, the auditor notes there is an additional blind spot not covered by Recreation Yard video surveillance. There is a wrap around area leading, at least, partially around the facility. The separation gate from a monitored area was not locked, therefore allowing access to this area. Minimally, the auditor recommends this gate be secured.

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

In terms of camera locations noted throughout the facility tour, the auditor notes two cameras are located in the Dry Storage/Food Preparation area, one in the Laundry, one in the Boiler Room, three in the Lower Level Day Room (captures resident movement from each resident room surrounding the Day Room), and four cameras in the Upper Level Day Room (again providing good observation of movement in the area). Movement into the staff offices is captured pursuant to video monitoring. Other cameras, not addressed in this narrative, provide additional coverage to ensure resident sexual safety.

During the tour, the auditor noted transparent shower curtains were used in the Upper Level resident bathrooms. Subsequent to conversation with the Director, the same was expeditiously replaced with an opaque curtain more conducive with resident privacy.

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

An On-site Audit Closeout meeting was facilitated on October 9, 2018 with the Director. 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 his 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

ACTC provides residential treatment services to the Colorado Department of Corrections (CDOC) and Arapahoe County, housing Diversion cases. Daily security/programmatic and PREA operations are focused primarily on CC policies, procedures, and practices, also in consideration of CDOC policies. Residents, sentenced in State of Colorado Courts are generally housed at ACTC..

The facility is located at 3265 West Girard Avenue, Englewood, CO. Since January 1, 2017, the facility has been owned and operated by CC. The facility offers an alternative to jail or prison and provides work/residential re-entry services to residents. The designed capacity for ACTC is 135 male residents.

On-site programs and services include life skills, job readiness and development, as well as, case management. Most residents work within the community.

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

Number of Standards Exceeded: 115.231 and 115.288

115.231 Pursuant to the PAQ, the Director self reports 20 staff, who may have contact with residents, were trained or retrained in PREA requirements. This equates to 91% of the staff complement. Of note, the training year had not expired as of the dates of the on-site audit.

If there are any policy updates in regard to PREA matters, staff are trained on the policy. Employees who may have contact with residents receive PREA training on an annual basis.

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

As 115.231(c) requires the provision of semi-annual PREA Refresher Training, the auditor finds ACTC to exceed standard requirements given the provision of annual PREA Refresher Training.

115.288 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 residents at CC facilities.

In view of the above, the auditor finds ACTC to exceed compliance expectations with respect to 115.288. This procedure is representative of CC's commitment and zeal in terms of enhancement of resident sexual safety within facilities.

Number of Standards Met: 33

Number of Standards Not Met: 4

In regard to 115.217(a) and (b), it is noted the auditor's review of two HR files regarding staff promoted during the last 18 months reveals one staff completed the 14-2H CC while the other did not. The 14-2H CC contains the requisite three questions as required pursuant to 115.217(a)/the requisite question regarding sexual harassment as required pursuant to 115.217(b) and serves as compliance evidence with respect to promotions. Accordingly, the auditor, based on available evidence, finds this provision practice is not institutionalized. Accordingly, the auditor finds ACTC to be non-compliant with 115. 217(a) and (b).

In regard to 115.217(e), of the 11 random staff files reviewed by the auditor, one of three applicable files included a five-year criminal record background investigation, as of the date of the audit. Accordingly, the auditor finds ACTC to be non-compliant with 115.217(e). This standard provision requires the conduct and analysis of five-year criminal background record checks for all staff and contractors who have contact with residents.

In regard to 115.217(f), the auditor is aware the equivalent of the Form 14-2H CC is completed annually by all staff. It is the auditor's understanding this process is specifically intended to demonstrate compliance with 115.17(f). Specifically, annual employee certification regarding the three questions, as well as, sexual harassment provides reasonable assurance staff are appropriate for continued employment (freedom from sexual abuse and harassment).

Pursuant to the auditor's review of 11 random staff files, he has determined that seven random facility staff who have contact with residents did not complete 14-2H CC forms during calendar year 2017. Accordingly, these staff did not address the requisite questions and issues regarding sexual assault/harassment during the performance evaluation cycle for calendar year 2017. In view of the above, the auditor finds ACTC to be non-compliant with 115.217(f).

Standard 115.232(a) requires that all contractors and volunteers who have contact with residents are trained on their responsibilities under the agency's sexual abuse/harassment prevention, detection, and response policies and procedures.

It is noted during the course of the on-site audit, the auditor learned from the Director, that volunteers from a church group provide services at ACTC. They have not received the requisite training.

In view of the above, the auditor finds ACTC to be non-compliant with 115.232(a-c).

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.

Of note, the Director advises the one alleged sexual abuse victim (as referenced in the narrative for 115.271) was not afforded access to timely, unimpeded access to emergency medical treatment and crisis intervention services [115.282(a)], as well as, offered services as identified in 115.282(c). He reports the alleged sexual abuse incident was verbally passed along to CDOC staff however, there is no documentary evidence substantiating provision of the requisite examination, evaluation, testing, or treatment. In view of the above, the auditor finds ACTC to be non-compliant with 115.282(a) and (c).

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.

Of note, the Director advises the one alleged sexual abuse victim (as referenced in the narrative for 115.271) was not afforded access to testing for sexually transmitted infections. He further reports the alleged sexual abuse incident was verbally passed along to CDOC staff however, there is no documentary evidence substantiating provision of the requisite examination, evaluation, testing, or treatment. Accordingly, the auditor finds ACTC to be non-compliant with 115.283(f).

Summary of Corrective Action (if any)

In regard to the finding for 115.217(a) and (b), to ensure ACTC is compliant, the auditor imposes a 180-day corrective action period. While June 17, 2019 is the maximum corrective action completion date, the auditor may terminate the period earlier upon satisfaction practices are institutionalized.

Accomplishment of institutionalization will be demonstrated by submission of all 14-2H CC forms, related to promotions only, to the auditor for at least the next 90 days. The ACTC PCM will include HR document(s) reflecting the date of promotion for each affected employee and the position from which promoted, as well as, the position to which the employee was promoted. The target date for completion of this task is March 11, 2019.

To ensure this practice is completed henceforth, the ACTC PCM will provide refresher training to the Human Resources (HR) representative for ACTC to ensure understanding. This task may be accomplished pursuant to provision of a memorandum to the HR representative articulating policy and PREA provision requirements in this regard. The ACTC PCM will discuss the substance of the memorandum with the HR representative, securing his/her signature and date on the document. If this option is implemented, a copy of the signed and dated document will be forwarded to the auditor for inclusion in the audit file.

04/03/19 Update:

ACTC staff and HR staff report there has been no promotions at ACTC since the conclusion of the on-site audit.

It is noted the PCM trained the ACTC HR representative regarding the subject-matter of 115.217(a), (b), (e), and (f) in response to the cited corrective action. Training was accomplished in the form of a detailed memorandum addressing these provisions. The training is specific as to CC policy and practice to meet the letter and intent of these provisions. The HR representative and the PCM signed and dated the memorandum on March 28, 2019. Additionally, a separate cheat sheet of relevant standard provisions and their application to CC Community Corrections facilities has been provided to relevant stake holders.

In view of the above, the auditor finds ACTC substantially compliant with 115.217(a), (b), (e), and (f).

In regard to the finding for 115.217(e), to ensure ACTC is compliant, the auditor imposes a 180-day corrective action period. While June 17, 2019 is the maximum corrective action completion date, the auditor may terminate the period earlier upon satisfaction practices are institutionalized.

Accomplishment of institutionalization will be demonstrated by submission of all 5-year criminal back ground record checks (both staff and contractors) to the auditor for at least the next 90 days. The ACTC PCM will include HR document(s) reflecting the date of initial selection for each affected employee/contractor. The auditor will assess each such re-investigation for timeliness/compliance with 115.217(e) and if appropriate, he will close the finding.

The target date for completion of this task is March 11, 2019.

5/2/2019 Update:

The auditor's review of the three 5-year re-investigations due at this point, reveals timely completion of the same, in consideration of vendor processing. A spread sheet is used for tracking purposes to preclude gaps in completion of such re-investigations.

In view of the above, the auditor now finds ACTC substantially compliant with 115.217(e).

To ensure this practice is completed henceforth, the ACTC PCM will provide refresher training to the HR representative for ACTC to ensure understanding. This task may be accomplished pursuant to provision of a memorandum to the HR Manager articulating policy and PREA provision requirements in this regard. The ACTC PCM will discuss the substance of the memorandum with the HR representative, securing his/her signature and date on the document. If this option is implemented, a copy of the signed and dated document will be forwarded to the auditor for inclusion in the audit file.

In regard to the finding for 115.217(f), to ensure ACTC is compliant, the auditor imposes a 180-day corrective action period. While June 17, 2019 is the maximum corrective action completion date, the auditor may terminate the period earlier upon satisfaction practices are institutionalized.

Accomplishment of institutionalization will be demonstrated by submission of a roster of all staff to the auditor. He will randomly select names from the roster and submit the same to the ACTC PCM. The ACTC PCM will forward copies of 2018 14-2CC-H forms to the auditor. When satisfied with the examples, the auditor will close the finding.

The target date for completion of this task is March 11, 2019.

2/11/19 Update:

The Director has forwarded 21 completed 14-2H CC forms dated December, 2018 and relative to staff assigned to ACTC. The auditor has reviewed the same and authors of those documents responded in the negative to the three questions articulated in 115.217(a), as well as, the sexual harassment question articulated in 115.217(b). These documents represent 19 of the 22 staff assigned to ACTC.

In view of the above, the auditor finds ACTC has completed requisite corrective action for 115.217(f) and is now substantially compliant with the provision.

In regard to the finding for 115.232(a), to demonstrate compliance, the Director will ensure all volunteers who provide services at ACTC are properly trained. The Director will then provide the auditor with a roster of all volunteers who provide services at ACTC. The auditor will randomly select a representative sample of names and the Director will provide evidence substantiating requisite training compliance. Of note, the Policy and Training Acknowledgment Form will be used to document completion of

the requisite training, in accordance with the following CC policy. Additionally, the Director will provide a copy of any lesson plan used to properly train volunteers.

Once the auditor is satisfied the practice is institutionalized, he will close the finding as compliant.

It is noted the auditor has received evidence from the Director reflecting commencement of corrective action as described above. This evidence was received during the period of time between completion of the on-site audit and report writing.

03/05/19 Update:

The Director has provided the auditor with substantiating evidence regarding 115.232(a). Signed and dated Zero-tolerance Policy- Prohibited Sexual Behaviors Forms have been submitted regarding two contractors. The forms provide requisite information to signees. Forms are dated September 23, 2017 and August 6, 2018. Additionally, one of the contractors signed and dated a Core Civic PREA Policy Acknowledgment and /or Training Acknowledgment Form.

The volunteer (provides religious services) signed and dated his/her form on October 17, 2018. He/she likewise signed and dated the latter from mentioned in the preceding paragraph.

It is noted the "I understand" caveat is included on each form. Accordingly, signees indicate they understand the subject-matter presented.

The auditor finds ACTC substantially compliant with 115.232(a) and the provision is institutionalized.

In regard to the finding for 115.282(a) and (c), the auditor is imposing a 180-day corrective action period in which institutionalization of 115.282(a) and (c) is expected. While the target date for completion of the following corrective action is March 11, 2019, the 180-day date is June 17, 2019.

To substantiate institutionalization, the ACTC PCM will provide training to all ACTC staff regarding the specific facts of this scenario and the steps to take in future situations of this nature. For example, question the resident as to whether he is injured. Escort him to the appropriate hospital to ensure compliance with 115.282(a) and (c). If he refuses, properly document the refusal, including the resident's signature/date and the staff witness' signature and date. Ensure relevant documents are forwarded to the receiving institution. Communicate the incident and steps taken to the receiving institution, documenting the communication. The ACTC PCM will ensure this information is included in a lesson plan and forwarded to the auditor for inclusion in the audit file.

Upon conclusion of the training, the ACTC PCM will provide the auditor with a copy of the training sign-in sheet and the auditor will randomly select names from that document. The ACTC PCM will provide the auditor with a copy of the selected employees' Training Acknowledgment bearing his/her signature/date of receipt of the training and understanding of the subject-matter of the same.

During the corrective action period, the ACTC PCM will provide the auditor with all sexual abuse investigations (from this point forward until the end of the corrective action period, unless the auditor closes the finding earlier), inclusive of all related medical/mental health documentation. The auditor will assess each on a case-by-case basis with special emphasis on compliance with related provisions, and make a determination as to when compliance is institutionalized. When achieved, the auditor will close the finding.

In regard to the finding for 115.283(f), the auditor is imposing a 180-day corrective action period in which institutionalization of 115.283(f) is expected. While the target date for completion of the following corrective action is March 11, 2019, the 180-day date is June 17, 2019.

To substantiate institutionalization, the ACTC PCM will provide training to all ACTC staff regarding the specific facts of this scenario and the steps to take in future situations of this nature. For example, question the resident as to whether he is injured. Escort him for sexually transmitted infections testing as articulated in 115.283(f). If he refuses, properly document the refusal bearing his signature/date and the staff witness' signature and date. Ensure relevant documents are forwarded to the receiving institution. The ACTC PCM will ensure this information is included in a lesson plan and forwarded to the auditor for inclusion in the audit file.

Upon conclusion of the training, the ACTC PCM will provide the auditor with a copy of the training sign-in sheet and the auditor will randomly select names from that document. The ACTC PCM will provide the auditor with a copy of the selected employees' training certification bearing his/her signature and date for receipt of the training and understanding of the subject-matter of the same.

During the corrective action period, the ACTC PCM will provide the auditor with all sexual abuse investigations (from this point forward until the auditor closes the finding), inclusive of all related medical/mental health documentation. The auditor will assess each on a case-by-case basis, with special emphasis on compliance with related provisions, and make a determination as to when compliance is institutionalized. When achieved, the auditor will close the finding.

04/03/19 Update:

The auditor's review of a Training/Activity Attendance Roster reveals 19 staff participated in training regarding the subject-matter of 115.282(a)/(c) and 115.283(f). The Training/Activity Attendance Roster bears the caveat "I understand the training" and all 19 participants signed the document. The auditor's review of the lesson plan reveals substantial compliance with the subject-matter of 115.282(a)/(c) and 115.282(f).

The auditor's review of two sexual abuse/harassment investigations completed since the date of the on-site audit reveals neither allegation was based on sexual intercourse. Accordingly, there are no investigations wherein the fact pattern is similar to that articulated above.

In view of the above, the auditor is closing this finding, determining that ACTC is substantially compliant with 115.282(a)/(c) and 115.283(f).

In addition to the above, the auditor finds additional staff training is required for Standards 115.216(c) and 115.264(a). The basis for this training, as well as, the action to be taken is identified throughout the following paragraphs. The auditor has found the standards to be compliant however, this action must be taken.

In regard to 115.216(c), two of 13 random staff interviewees are 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 resident attempts to report sexual abuse. All 13 interviewees self report no such instances of using translators pursuant to the circumstances articulated above, have presented during the last 12 months.

While policy is clear and practice has not presented any deviation from either policy or standard provision, the auditor finds that re-training of staff regarding the specifics of 115.216(c) is necessary. Accordingly, the ACTC PCM will ensure re-training of all ACTC staff (accentuating the conditions under which use of such interpreters, translators, assistants is appropriate) on or before March 11, 2018.

As evidence of re-training, the ACTC PCM will provide the auditor a copy of the training plan used to facilitate re-training. Additionally, the PCM will ensure a copy of the training roster regarding the training, as well as, individual training documentation reflecting the employee's understanding of the subject-matter, is provided to the auditor.

04/03/19 Update:

The auditor's review of a Training/Activity Attendance Roster reveals 19 staff participated in training regarding the subject-matter of 115.216(c). The Training/Activity Attendance Roster bears the caveat "I understand the training" and all 19 participants signed the document. The auditor's review of the lesson plan reveals substantial compliance with the subject-matter of 115.216(c).

In regard to 115.264(a), four of the 10 security first responder and one of the two non-security first responder interviewees properly assert the following duties in terms of first responder duties:
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.

All of the above interviewees (12) assert the first step is to separate the victim and alleged perpetrator and ten interviewees assert the second step involves securing the crime scene. Six of the 12 interviewees assert the first responder ensures both victim and alleged perpetrator do not destroy physical evidence.

The auditor notes all interviewees, both security and non-security, were in possession of the laminated CC First Responder card at the time of the interview. The card accurately captures the verbiage reflected in 115.264(a).

While the auditor does not find sufficient basis to find ACTC non-compliant with 115.264 based on the aforementioned issue and evidence, there is cause to re-train staff regarding the same. As all staff receive the same First Responder training, refresher training appears to be an appropriate remedy.

In view of the above, the ACTC PCM will ensure all staff receive training regarding the four steps to be employed by First Responders, emphasis added regarding "**requesting**" the victim to refrain from destroying physical evidence and "**ensuring**" the perpetrator does not destroy physical evidence. Of note, First Responder refresher training must be completed on or before March 11, 2019.

The ACTC PCM will provide a roster of all staff to the auditor and he will randomly select staff names. The ACTC PCM will provide training certifications, substantiating provision of the relevant training for each selectee. Additionally, the ACTC PCM will provide a copy of the training syllabus to the auditor.

04/03/19 Update:

The auditor's review of a Training/Activity Attendance Roster reveals 19 staff participated in training regarding the subject-matter of 115.264(a). The Training/Activity Attendance Roster bears the caveat "I understand the training" and all 19 participants signed the document. The auditor's review of the lesson plan reveals substantial compliance with the subject-matter of 115.264(a).

PREVENTION PLANNING

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

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

115.211 (a)

- Does the agency have a written policy mandating zero tolerance toward all forms of sexual abuse and sexual harassment? 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 further 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 asserts 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. The policy also includes 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.

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 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 ACTC 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 OR the response to 115.212(a)-1 is "NO".) □ 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 ACTC do not contract with other facilities or companies to house residents designated for confinement at ACTC.

Accordingly, the auditor finds ACTC substantially compliant with 115.212.

Standard 115.213: Supervision and monitoring

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

115.213 (a)

- Does the agency develop for each facility a staffing plan that provides for adequate levels of staffing and, where applicable, video monitoring, to protect residents against sexual abuse? X□ Yes □ No
- Does the agency document for each facility a staffing plan that provides for adequate levels of staffing and, where applicable, video monitoring, to protect residents against sexual abuse? X□ Yes □ No
- Does the agency ensure that each facility's staffing plan takes into consideration the physical layout of each facility in calculating adequate staffing levels and determining the need for video monitoring? X□ Yes □ No
- Does the agency ensure that each facility's staffing plan takes into consideration the composition of the resident population in calculating adequate staffing levels and determining the need for video monitoring? X□ Yes □ No
- Does the agency ensure that each facility's staffing plan takes into consideration the prevalence of substantiated and unsubstantiated incidents of sexual abuse in calculating adequate staffing levels and determining the need for video monitoring? X□ Yes □ No
- Does the agency ensure that each facility's staffing plan takes into consideration any other relevant factors in calculating adequate staffing levels and determining the need for video monitoring? 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.) X□ Yes □ No □ NA

115.213 (c)

- In the past 12 months, has the facility assessed, determined, and documented whether adjustments are needed to the staffing plan established pursuant to paragraph (a) of this section? 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 114 and the average daily number of residents on which the staffing plan is predicated is 120.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 9, section D(1 and 2)(a-d) addresses 115.213(a).

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 assigned to each shift. The staffing plan is documented and maintained electronically (on Sharepoint) in the Director's Office and Assistant Director's Office. The daily schedule is available to all staff.

When assessing adequate staffing levels and the need for video monitoring, the facility plan considers the following:
a. Camera surveillance addresses blind spots. Camera surveillance is intended to address "cradle to grave" coverage. Specifically, there is a need to know where staff and residents are at all times. Who is in the building and who is out? Camera surveillance is intended to capture the hallway areas, staff offices, and obscure locations throughout the facility. Staffing is dictated by contract with Arapaho County.
b. High risk individuals are housed upstairs, in closer proximity to the Control Center. As ACTC is an all male facility, at least one male must be on shift at all times. Gang members are not necessarily a consideration at ACTC. The facility is a minimum security facility wherein minimum security residents are housed. Resident ethnicity is also not a significant consideration.

c. As the result of Sexual Abuse Response Team (SART) reviews, areas in which sexual abuse/sexual harassment incidents occurred, facility schedule, changes in supervisory patterns, and any new input from SART reviews dictates Staffing Plan considerations.

d. There are no other relevant factors under consideration at ACTC at this time.

In regard to daily checks for compliance with the staffing plan, daily camera checks are facilitated to ensure two staff are present on all shifts. The Operations Supervisor manages and audits staffing on a daily basis. The Director is part of the staff schedule review, the same being distributed on a monthly basis. Of note, the Director is also designated as the ACTC PCM.

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 12 months.

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

Pursuant to interview with the Director, 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.

The Director self reports there were no instances of deviation from the Staffing Plan during this audit period. Overtime is used, if necessary, to cover vacancies. The auditor's observation of staffing during the facility tour and non-regular business hours reveals substantial compliance with 115.13. Two monitors are assigned to the shift 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; or
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, page 9, section D(5)(a) and (b)(i-iii) and page 10, section D(5)(iv) address 115.213(b).

According to the ACTC PCM, the facility staffing plan is reviewed at least once each year. As both Director and PCM, he does review the same and is consulted regarding any necessary adjustments.

The auditor's review of the February, 2016 February, 2017, and February, 2018 Annual PREA Staffing Plan Assessments reveals substantial compliance with 115.213(c). The plans address the four requisite consideration factors and bear all requisite signatures.
In addition to the above, the auditor's review of the Colorado Community Corrections Standards reveals the requisite minimum two staff verbiage as previously articulated in the 115.213 narrative.

In view of the above, the auditor finds ACTC 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 less than 50 residents) X□ Yes □ No □ NA

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

115.215 (d)

- Does the facility implement policies and procedures that enable residents to shower, perform bodily functions, and change clothing without nonmedical staff of the opposite gender viewing their breasts, buttocks, or genitalia, except in exigent circumstances or when such viewing is incidental to routine cell checks? 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 ACTC. The Director further self reports 0 strip or cross-gender visual body cavity searches of residents were conducted at ACTC 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). 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 ACTC. Asked to provide an example of exigent circumstances, a sexual assault scenario might constitute urgent circumstances that might require cross-gender strip or visual body cavity searches. This would primarily involve an alleged perpetrator.

The auditor has found no evidence of cross-gender strip or visual searches conducted by non-medical staff, at ACTC 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. In the past 12 months, no female pat-down searches were conducted by male staff. As noted, the Director advises female residents are not housed at ACTC and the same was confirmed by the auditor.
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.

Given the fact female residents are not housed at ACTC, random staff were not questioned regarding the conduct of pat searches of female residents. Given the fact female residents are not housed at ACTC, interviews of female residents were not conducted.

Pursuant to the PAQ, the Director self reports facility policy requires that all cross-gender strip searches and cross-gender visual body cavity searches be documented. Additionally, policy requires all cross-gender pat searches of female residents, be documented. As previously mentioned, female residents are not housed at ACTC and accordingly, the same is not applicable. However, policy as reflected in the following sentence, would be applicable in such circumstances.

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.

Eighteen of 20 random resident interviewees self report female staff announce their presence by gender when entering their housing area. The two residents who responded otherwise self reported female staff sometimes announce their presence, with one resident self reporting the same occurs approximately 15% of the time. All 20 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 13 random staff interviewees self report they announce (female staff) their presence when entering housing areas at ACTC . Of the interviewees, male staff confirm this practice occurs. Similarly, all female interviewees self report residents are able to dress, shower, and toilet without being viewed by staff of the opposite gender. This practice was likewise confirmed by all male interviewees.

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. Additionally, with the exception of the somewhat transparent shower curtains previously mentioned, the auditor noted no instances wherein visibility of naked residents was prevalent. As previously stated, this condition was addressed during the audit.

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).

Twelve of 13 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 ACTC PCM reports no transgender or intersex residents were housed at ACTC during the on-site audit. Accordingly, the relevant interview(s) was/were not conducted.

Pursuant to the PAQ, the Director self asserts 82% of all security staff have received training on conducting cross-gender pat-down searches of transgender and intersex residents in a professional and respectful manner, consistent with security needs. This demographic applies to completions as of the time of the on-site audit.

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 training logs dated October 24, 2017 (16 staff) and June 26, 2018 (13 staff) reflects they received In-Service PREA training inclusive of cross-gender viewing and searches.
All of 13 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. Eleven of the 13 interviewees self report they received the requisite training either during Pre-Service or In-Service training.

In view of the above, the auditor finds ACTC 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 Director self reports 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, page 13, section I(5) 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 ACTC PCM, no limited English proficient residents were housed at ACTC at the time of the on-site audit. Accordingly, this interview could not be conducted. The one Disabled (Mental Health) interviewee self reports the facility provides information about sexual abuse/harassment that he is able to understand.

Pursuant to conversation with the ACTC Director, the auditor learned low functioning resident comprehension is aided by Mental Health Therapists. Additionally, when applicable, staff educate residents, during Intake, regarding PREA requirements and procedures, ensuring residents understand the material presented.

According to the Director, ACTC does not have any MOUs with a company(ies) for Braille services. Low functioning residents are handled through Mental Health Therapy or Treatment where they are referred to outpatient treatment. We do have staff review and educate the residents at Intake regarding PREA and they acknowledge their understanding.

Of note, pursuant to contact with resident interviewees and various residents during the facility tour and other nonscheduled tours, the auditor did not find any residents who appeared to present with low hearing, deafness, low vision, or blindness.

Pursuant to the PAQ, the Director self reports the agency has established procedures to provide residents 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.

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 wherein 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).

Two of 13 random staff interviewees are 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 resident attempts to report sexual abuse. All 13 interviewees self report no such instances of using translators pursuant to the circumstances articulated above, have presented during the last 12 months.

While policy is clear and practice has not presented any deviation from either policy or standard provision, the auditor finds that re-training of staff regarding the specifics of 115.216(c) is necessary. Accordingly, the ACTC PCM will ensure re-training of all ACTC staff (accentuating the conditions under which use of such interpreters, translators, assistants is appropriate) on or before March 11, 2018.

As evidence of re-training, the ACTC PCM will provide the auditor a copy of the training plan used to facilitate re-training. Additionally, the PCM will ensure a copy of the training roster regarding the training, as well as, individual training documentation reflecting the employee's understanding of the subject-matter, is provided to the auditor.

04/03/19 Update:

The auditor's review of a Training/Activity Attendance Roster reveals 19 staff participated in training regarding the subject-matter of 115.216(c). The Training/Activity Attendance Roster bears the caveat "I understand the training" and all 19 participants signed the document. The auditor's review of the lesson plan reveals substantial compliance with the subject-matter of 115.216(c).

In view of the above, the auditor finds ACTC 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, or 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 em-

ployers 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)

- Unless prohibited by law, does the agency provide information on substantiated allegations of sexual abuse or sexual harassment involving a former employee upon receiving a request from an institutional employer for whom such employee has applied to work? (N/A if providing information on substantiated allegations of sexual abuse or sexual harassment involving a former employee is prohibited by law.) 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 review of two HR files regarding staff promoted during the last 18 months reveals one staff completed the 14-2H CC while the other did not. The 14-2H CC contains the requisite three questions as reflected above and serves as the compliance evidence with respect to promotions. Accordingly, the auditor, based on available evidence, finds this provision practice is not institutionalized. Accordingly, the auditor finds ACTC to be non-compliant with 115. 217(a) and (b).

In addition to the above, although initial selection of the contractor, whose file the auditor reviewed, did not occur during this audit period, the auditor recommends he complete a 14-2H CC. This applies to all contractors similarly situated. The ACTC PCM will provide the auditor with a copy of the completed documents for retention in the audit file

To ensure ACTC is compliant with 115.217 (a) and (b), the auditor imposes a 180-day corrective action period. While June 17, 2019 is the maximum corrective action completion date, the auditor may terminate the period earlier upon satisfaction practices are institutionalized.

Accomplishment of institutionalization will be demonstrated by submission of all 14-2H CC forms, related to promotions only, to the auditor for at least the next 90 days. The ACTC PCM will include HR document(s) reflecting the date of promotion for each affected employee and the position from which promoted, as well as, the position to which the employee was promoted. The target date for completion of this task is March 11, 2019.

To ensure this practice is completed henceforth, the ACTC PCM will provide refresher training to the Human Resources (HR) representative for ACTC to ensure understanding. This task may be accomplished pursuant to provision of a memorandum to the HR representative articulating policy and PREA provision requirements in this regard. The ACTC PCM will discuss the substance of the memorandum with the HR representative, securing his/her signature and date on the document. If this option is implemented, a copy of the signed and dated document will be forwarded to the auditor for inclusion in the audit file.

04/03/19 Update:

ACTC staff and HR staff report there has been no staff promotions at ACTC since the conclusion of the on-site audit.

It is noted the PCM trained the ACTC HR representative regarding the subject-matter of 115.217(a), (b), (e), and (f) in response to the cited corrective action. Training was accomplished in the form of a detailed memorandum addressing these provisions. The training is specific as to CC policy and practice to meet the letter and intent of these provisions. The HR representative and the PCM signed and dated the memorandum on March 28, 2019. Additionally, a separate cheat sheet of relevant standard provisions and their application to CC Community Corrections facilities has been provided to relevant stake holders.

In view of the above, the auditor finds ACTC substantially compliant with 115.217(a), (b), (e), and (f).

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 issues. A criminal background record check is completed prior to the "start date" for all new employees thus, ensuring comprehensive knowledge of criminal background history.

Pursuant to conversation with the HR interviewee, the auditor finds CC acquired ACTC 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 11 random staff HR files reveals only one file wherein a criminal background record check is missing. Given the above explanation, it appears all other pre-hire criminal background record checks were/are timely.

Of note, the HR interviewee asserts criminal background record 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 provides simply 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 (asks the afore-mentioned three questions, as well as, whether the individual has been found to have perpetrated sexual harassment of residents) 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 record background checks do not address sexual harassment, the latter form is the only document available to validate the 14-2H CC.
In regard to the afore-mentioned random staff file reviews, eight of the 11employee files pertain to staff hired by CMI under the old contract. Of the 11 cases, the auditor's review of the application for the remaining three staff reveals there were prior institutional employer(s) in two instances and the afore-mentioned form was forwarded as required in those cases. There is no indication of any prior institutional employers in the last case. Clearly, CC HR staff have been cognizant of this requirement and diligent with follow-through.

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.

Pursuant to the PAQ, the Director self reports agency policy requires that 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 12 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 the facility performs criminal record background 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 record background checks regarding promotions.

This same procedure applies to contractors.

The auditor's random review of three staff HR files for staff hired during the last 12 months reveals criminal record background checks were completed prior to the entry on duty date. Additionally, prior Institution Employer checks were completed in two of the three cases with the explanation regarding the third case articulated above.

Pursuant to the PAQ, the Director self reports agency policy requires that a criminal background record check be 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.

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

The random contractor file reviewed by the auditor reveals a five-year reinvestigation was conducted during 2016. This contractor was clearly selected under the previous contract, therefore not applicable to this audit period.

Pursuant to the PAQ, the Director self reports agency policy requires that either criminal record background checks are conducted at least every five years for current employees and contractors who may have contact with residents or that 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 HR interviewee asserts CC tracks 5-year reinvestigation needs. Generally, the same is tracked via spread sheet. Re-investigations are requested by CC staff to the CDCJ representative.

Of the 11 random staff files reviewed by the auditor, one of three applicable files included a five-year criminal record background investigation, as of the date of the audit. Accordingly, the auditor finds ACTC to be non-compliant with 115.217(e).

To ensure ACTC is compliant with 115.217 (e), the auditor imposes a 180-day corrective action period. While June 17, 2019 is the maximum corrective action completion date, the auditor may terminate the period earlier upon satisfaction practices are institutionalized.

Accomplishment of institutionalization will be demonstrated by submission of all 5-year criminal back ground record checks (both staff and contractors) to the auditor for at least the next 90 days. The ACTC PCM will include HR document(s) reflecting the date of initial selection for each affected employee/contractor. The

auditor will assess each such re-investigation for timeliness/compliance with 115.217(e) and if appropriate, he will close the finding.

The target date for completion of this task is March 11, 2019.

5/2/2019 Update:

The auditor's review of the three 5-year re-investigations due at this point, reveals timely completion of the same, in consideration of vendor processing. A spread sheet is used for tracking purposes to preclude gaps in completion of such re-investigations.

In view of the above, the auditor now finds ACTC substantially compliant with 115.217(e).

To ensure this practice is completed henceforth, the ACTC PCM will provide refresher training to the HR representative for ACTC to ensure understanding. This task may be accomplished pursuant to provision of a memorandum to the HR Manager articulating policy and PREA provision requirements in this regard. The ACTC PCM will discuss the substance of the memorandum with the HR representative, securing his/her signature and date on the document. If this option is implemented, a copy of the signed and dated document will be forwarded to the auditor for inclusion in the audit file.

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. It is the auditor's understanding this process is specifically intended to demonstrate compliance with 115.17(f). Specifically, annual employee certification regarding the three questions, as well as, sexual harassment provides reasonable assurance staff are appropriate for continued employment (freedom from sexual abuse and harassment).

Pursuant to the auditor's review of 11 random staff files, he has determined that seven random facility staff who have contact with residents did not complete 14-2H CC forms during calendar year 2017. Accordingly, these staff did not address the requisite questions and issues regarding sexual assault/harassment during the performance evaluation cycle for calendar year 2017. In view of the above, the auditor finds ACTC to be non-compliant with 115.217(f).

To ensure compliance with 115.217(f), the auditor imposes a 180-day corrective action period. While June 17, 2019 is the maximum corrective action completion date, the auditor may terminate the period earlier upon satisfaction practices are institutionalized.

Accomplishment of institutionalization will be demonstrated by submission of a roster of all staff to the auditor. He will randomly select names from the roster and submit the same to the ACTC PCM. The ACTC PCM will forward copies of 2018 14-2CC-H forms to the auditor. When satisfied with the examples, the auditor will close the finding.

The target date for completion of this task is March 11, 2019.

2/11/19 Update:

The Director has forwarded 21 completed 14-2H CC forms dated December, 2018 and relative to staff assigned to ACTC. The auditor has reviewed the same and authors of those documents responded in the negative to the three questions articulated in 115.217(a), as well as, the sexual harassment question articulated in 115.217(b). These documents represent 19 of the 22 staff assigned to ACTC.

In view of the above, the auditor finds ACTC has completed requisite corrective action for 115.217(f) and is now substantially compliant with the provision.

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 auditor's review of the 14-2H CC reveals the affirmative duty to report caveat is reflected on the same.

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 regarding material omissions of 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, 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 or sexual harassment involving the former employee, unless prohibited by law.

In view of the above, the auditor finds ACTC 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.) 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 not acquired a new facility or made a substantial expansion or modification to existing facilities since the last PREA audit. Accordingly, the auditor finds 115.218(a) to be not applicable to ACTC.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, pages 32 and 33, section V(1) addresses 115.218(a).

Pursuant to the PAQ, the Director self reports the facility has installed or updated monitoring technology since the last PREA audit.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 33, section V(2) addresses 115.18(b).

According to the Agency Head interviewee, when designing, acquiring, or planning substantial modifications to facilities, CC commences the process through land purchase(s) and then subsequent construction. A design team facilitates most of the preparation and standards compliance work. Architects are well versed in PREA. Lines of sight are assessed to enhance resident sexual and personal safety and camera surveillance needs to address blind spots. The same protocol is utilized with regard to expansion and renovations. Requests for changes must be approved by the design team. The design team is part of the Real Estate Group.

The Direct self reports the Core Civic Real Estate Division assessed the Director's wish list for camera installation. Twenty-two new cameras were placed in previously non-existent areas.

The auditor's review of a document entitled Alterations to Physical Plant dated June 1, 2018 reveals 38 updated cameras were added to ACTC. The document clearly reflects the addition affects the security of the physical facility and its occupants.

In view of the above, the auditor finds ACTC substantially compliant with 115.218.

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? X□ Yes □ No

- 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 entity follow the requirements of paragraphs (a) through

(e) of this section? (N/A if the agency/facility is responsible for conducting criminal AND administrative sexual abuse investigations.) 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? (Check N/A if agency attempts to make a victim advocate from a rape crisis center available to victims per 115.221(d) above.) □ Yes □ No 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 is responsible for conducting administrative or criminal sexual abuse investigations (including resident-on-resident sexual abuse or staff sexual misconduct). The Director further self reports the Arapaho County Sheriff's Office (ACSO) facilitates criminal investigations.

All 13 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 usable evidence collection. Twelve of the 13 random staff interviewees assert ACSO 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/perpetrator. Responses regarding first responder duties are articulated in the narrative for 115.264.

Two of the 13 random staff interviewees assert the operations supervisor facilitates administrative investigations. In actuality, he/she is the only trained sexual abuse/harassment investigator at ACTC. One additional interviewee identifies the operations supervisor, Director, and Assistant Director as administrative investigators.

Pursuant to the PAQ, the Director self reports no youth are housed at ACTC and accordingly, that component of 115.221(b) is not applicable. The Director further self reports the protocol was adapted from or otherwise based on the most recent edition of the Department of Justice 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, pages 24 and 25, section 4(b) addresses 115.221(b).

The auditor reviewed a letter dated December 29, 2015 from a Lieutenant (ACSO) and finds such investigations to be conducted in accordance with Colorado Revised Statutes (CRS). SAFE/SANE examinations are also addressed in this letter.

The Director self reports the facility offers to all residents who experience sexual abuse access to forensic medical examinations. when medically or evidentiarily appropriate. 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 13 trained SANE nurses responsible for conducting all forensic medical examinations at St. Anthony Hospitals Forensic Nurse Examiner Team. Sane Nurses within this group complete a 64 hour on-line SANE training provided by the University of Colorado Memorial Hospital and she provides any follow-up training to team members. SANE Nurses are available twenty-four hours per day, seven days per week as staff are on-call to ensure coverage. It is noted that as part of the forensic examination, Sexually Transmitted Disease (STD) testing, education, and the first dose of medication are provided.

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.

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

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

According to the Director/ACTC PCM, victim advocacy services are available to ACTC residents pursuant to an MOU with Blue Bench. He asserts he will make contact with representatives from Blue Bench to establish any state certification/requirements regarding the provision of advocacy services. The auditor recommends this occur within the next 90 days.

The Director reports no residents who reported a sexual abuse were housed at ACTC during the on-site audit. Accordingly, such interview could not be conducted.

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 Director/ACTC PCM interviewee 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 ACTC PREA Investigator (Operations Supervisor) facilitates administrative investigations. Accordingly, the auditor finds 115.221(f) to be not-applicable to ACTC.

In view of the above, the auditor finds ACTC 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 such publication describe the responsibilities of both the agency and the investigating entity? [N/A if the agency/facility is responsible for conducting criminal investigations. See 115.221(a).] 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 and staff sexual misconduct). In the past 12 months, one allegation of sexual abuse was received. The allegation was investigated both administratively and criminally and both investigations have been completed.

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/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 specialty trained PREA 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 investigation referenced 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 page 24, section O(3)(a) and (b) addresses 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 single allegation referenced in the narrative for 115.221 was referred for criminal investigation and the same was completed by ACSO investigators. Furthermore, the referral is clearly documented in the record.

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

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

The auditor's review of the afore-mentioned letter from the ACSO reveals information regarding evidence protocol.

In view of the above, the auditor finds ACTC 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 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 Colorado Community Corrections PREA training slides reflects 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.

All 13 random staff interviewees self report they received training regarding the afore-mentioned 10 PREA topics either during Pre-Service or In-Service training. Of note, one interviewee asserts he/she had contact with residents prior to completion of this training. He/she asserts he/she may have worked under direct staff oversight (shadow) at the time. The Assistant Director confirmed this practice may have been used at the time however, staff were not given an independent floor assignment.

The auditor's review of the relevant file reveals the afore-mentioned employee received Pre-Service training on or about 34 days following the entry on duty date. With respect to one additional interviewee, he/she self reports In-Service training had not yet been received at ACTC however, Pre-Service training had been provided. The auditor's review of the relevant training file reveals the same to be accurate.

Taking into consideration the date of CC assumption of ACTC (January 1, 2017) and the fact all staff previously hired under the old contract were re-trained regarding PREA, the auditor's review of 8 randomly selected staff files, in addition to those referenced in the preceding paragraph, reveals substantial compliance with 115.231(a).

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 ACTC 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 20 staff, who may have contact with residents, were trained or retrained in PREA requirements. This equates to 91% of the staff complement. Of note, the training year had not expired as of the dates of the on-site audit.

If there are any policy updates in regard to PREA matters, staff are trained on the policy. Employees who may have contact with residents receive PREA training on an annual basis.

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

As 115.231(c) requires the provision of semi-annual PREA Refresher Training, the auditor finds ACTC to exceed standard requirements given the provision of annual PREA Refresher Training.

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 review of In-Service PREA Training/Activity Attendance Rosters date October 24, 2017 and June 26, 2018, reveal 16 staff completed In-Service PREA training on the former date while 13 completed the same training on the latter date. The auditor's review of 19 Core Civic PREA Policy Acknowledgment and/or Training Acknowledgment forms reveals completion of either Pre-Service PREA training (seven staff)

or In-Service PREA training (12 staff) and understanding of the same. These training sessions were facilitated during 2017 and 2018. Additionally, one Training Acknowledgment form reflects the same results.

The auditor's random review of staff training files also confirms compliance with 115.231(d).

In view of the above, the auditor finds ACTC to exceed standard expectations relative 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 have been trained on their responsibilities under the agency's policies and procedures regarding sexual abuse/harassment prevention, detection, and response. The Director further self reports two contractors, who have contact with residents, provide services at ACTC and both have been trained regarding the subject-matter referenced in the preceding sentence. There are no volunteers who provide services at ACTC. Accordingly, 100% of ACTC contractors have been properly trained.

It is noted during the course of the on-site audit, the auditor learned from the Director, that volunteers from a church group provide services at ACTC. They have not received the requisite training.

In view of the above, the auditor finds ACTC to be non-compliant with 115.232(a-c). Accordingly, the auditor is imposing a 180-day corrective action period to effectively train all volunteers at ACTC. While the target date for completion of the following corrective action is March 11, 2019, the 180-day date is June 17, 2019.

To demonstrate compliance with 115.232(a), the Director will ensure all volunteers who provide services at ACTC are properly trained. The Director will then provide the auditor with a roster of all volunteers who provide services at ACTC. The auditor will randomly select a representative sample of names and the Director will provide evidence substantiating requisite training compliance. Of note, the Policy and Training Acknowledgment Form will be used to document completion of the requisite training, in accordance with the following CC policy. Additionally, the Director will provide a copy of any lesson plan used to properly train volunteers.

Once the auditor is satisfied the practice is institutionalized, he will close the finding as compliant.

It is noted the auditor has received evidence from the Director reflecting commencement of corrective action as described above. This evidence was received during the period of time between completion of the on-site audit and report writing.

03/05/19 Update:

The Director has provided the auditor with substantiating evidence regarding 115.232(a). Signed and dated Zero-tolerance Policy- Prohibited Sexual Behaviors Forms have been submitted regarding two contractors. The forms provide requisite information to signees. Forms are dated September 23, 2017 and August 6, 2018. Additionally, one of the contractors signed and dated a Core Civic PREA Policy Acknowledgment and /or Training Acknowledgment Form.

The volunteer (provides religious services) signed and dated his/her form on October 17, 2018. He/she likewise signed and dated the latter from mentioned in the preceding paragraph.

It is noted the "I understand" caveat is included on each form. Accordingly, signees indicate they understand the subject-matter presented.

The auditor finds ACTC substantially compliant with 115.232(a), (b), and (c) and the provision is institutionalized at ACTC.

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

According to the contractor who may have 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.

The auditor's review of two Zero Tolerance Policy- Prohibited Sexual Behaviors documents related to two separate contractors reveals provision of requisite training as articulated in 115.232(a). Additionally, a PREA Certificate is included for one of these two contractors while a PREA Policy and Training Acknowledgment is included for the other individual. Both of the forms minimally reflect the contractor's printed name/signature/date and the "I understand" caveat.

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 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 contractor 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.

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 ACTC to be 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 221 residents were provided requisite information at Intake during the last 12 months. However, pursuant to follow-up with the Director, he self reports 192 resident have been admitted to ACTC since October, 2017. Compared against the PAQ information, this equates to 100% of the residents received at ACTC through Intake during the last 12 months.

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

Additionally, the auditor's review of the CoreCivic brochures entitled PREA Orientation Information and PREA Advisement reveal compliance with 115.233(a). Zero tolerance regarding sexual abuse/sexual harassment and reporting options are addressed in this document. The resident prints his name, signs, and dates the same. Staff witness the same, in writing.

A Colorado Community Corrections generated video entitled PREA Client Education is also included in the resident PREA education package.

In summary, all of these resources address the resident PREA educational materials required by 115.233.

The intake staff interviewee self reports he/she provides residents with information about the CC and ACTC zero-tolerance policy and how to report incidents or suspicions of sexual abuse or sexual harassment. Specifically, the Resident Handbook is provided for reading and these topics are addressed in the same. Pamphlets are likewise included in an Intake packet. The interviewee also provides verbal instruction during Intake. Both Intake and Orientation instruction are provided at Intake, as well as, residents view the PREA video.

All 20 random resident interviewees self report they received information about the facility's rules against sexual abuse/harassment, 17 of whom received the information during Intake. Similarly, all 20 random resident interviewees self report they were told about the following when they arrived at ACTC:

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.
c. Their right not to be punished for reporting sexual abuse or sexual harassment.
d. Fifteen of the 20 interviewees self report they received this information during Intake while five assert they received the information within one to seven days of Intake. Interviewees confirmed the materials provided to them were consistent with staff assertions as reflected above.

The auditor's review of 11 resident files reveals requisite information was provided at Intake in eight cases. Acknowledgment confirmations were missing in three files. Provision of requisite information is both timely and comprehensive.

The auditor notes the resident and a staff witness sign and date both PREA Advisement and PREA Orientation Forms as evidence of participation in PREA education activities. Additionally, staff complete a Monitor Packet: Diversion Client Checklist form, certifying provision of the requisite PREA information to each resident.
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 five residents were transferred to ACTC 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 ACTC.

One of the 20 random resident interviewees reported being transferred to ACTC from another community confinement center or Boot Camp facility. The auditor's review of his file reveals he received requisite PREA information during Intake at ACTC.

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, page 13, 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.
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 afore-mentioned narrative substantiate compliance with this provision. Executed documents, as discussed above, were applicable to one resident, as well as, present in the randomly selected resident files mentioned above.

According to the Director, all 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.

During the facility tour, the auditor noted numerous PREA posters in various areas. While examining numerous resident rooms, the auditor noted a sexual abuse/harassment reporting poster affixed to the wall in nearly all rooms. It is apparent there is an effort to continuously educated residents regarding PREA issues throughout their confinement at ACTC. Additionally, other posters depicting the zero tolerance policy regarding sexual abuse/harassment of residents are present throughout the facility.

In view of the above, the auditor finds ACTC 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 have received training in conducting such investigations in confinement settings? [N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.221(a).] 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 self reports 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 NIC course entitled Investigating Sexual Abuse in a Confinement Setting addresses the requirements of 115.234(b). Additionally, the staff training certificate relative to the afore-mentioned course substantiates completion of the same.

According to the investigative staff interviewee, he completed the 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, a little detail regarding evidence collection, 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 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. The Director self reports the agency maintains documentation showing that one investigator has completed the required training.

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

Completion documentation for the requisite course is addressed in the narrative for 115.234(a)
In view of the above, the auditor finds ACTC 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? □ Yes X□ No

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

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

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

115.235 (b)

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

115.235 (d)

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

- Do medical and mental health care practitioners contracted by and volunteering for the agency also receive training mandated for contractors and volunteers by §115.232? [N/A for circumstances in which a particular status (employee or contractor/volunteer) does not apply.] □ Yes □ No 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 ACTC. 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, as reflected above, and the auditor's observation and review of the ACTC Organizational Chart, medical and mental health staff are not employed at ACTC. Accordingly, such interviews could not be conducted.

Pursuant to the PAQ, the Director self reports facility medical staff do not conduct forensic examinations at ACTC.

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

As mentioned throughout the narrative for this standard, no Medical/Mental Health practitioners are employed at ACTC.

As there are no deviations from either standard or policy, the auditor finds ACTC to be 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).

One of the two staff who perform screening for risk of victimization and abusiveness interviewees self reports he/she does screen residents upon admission to ACTC or transfer from another facility for risk of sexual victimization or sexual abusiveness toward other residents. Additionally, he/she reports new commitments are screened within 24 hours of Intake. While residents are assigned a room prior to the conduct of such screening, they do not proceed to the same until this assessment is completed. Of note, the second interviewee reports he/she does not facilitate the initial assessment as he/she completes the reassessment.

Sixteen of 20 random resident interviewees self report when they first arrived at ACTC, 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 Lesbian, Gay, Bisexual, Transgender, or Intersex ((LGBTI), and whether they think they may be in danger of being sexually abused at ACTC. Fourteen interviewees self report they were asked these questions during Intake.

Of note, three interviewees were admitted to ACTC in excess of 12 months prior to the date of the on-site audit and accordingly, they were not asked the relevant questions. One interviewee self reported he was not asked the questions. Additionally, two interviewees self report they were asked the relevant questions within 1-7 days of Intake.

The auditor observed the day rooms wherein new commitments are maintained until completion of the initial screening assessment. Both are in clear view of staff and/or cameras.

Pursuant to the PAQ, the Director self reports this intake screening shall ordinarily take place within 72 hours of arrival at the facility. The Director self reports that during the last 12 months, 221 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. However, pursuant to follow-up with the Director, he self reports 192 resident have been admitted to ACTC since October, 2017. Compared against the PAQ information, this equates to 100% of the residents received at ACTC through Intake during the last 12 months.

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

The auditor's review of 11 random resident files [inclusive of those applicable to nearly all random resident interviewees who responded they had not been asked the relevant questions identified in the narrative for 115.241(a) or the screening was not conducted in a timely manner pursuant to 115.241(b)], reveals timely and complete screening in nine of 11 cases. In the two cases wherein untimely initial screenings were conducted, reviews were conducted within 48 hours of arrival, as opposed to, the policy required 24 hours of arrival.

Pursuant to the PAQ, the Director self asserts 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 an adult or child;
7) Whether the resident is or is perceived to be gay, lesbian, bisexual, transgender, intersex, or gender nonconforming;
8) Whether the resident has previously experienced sexual victimization; and
9) The resident's own perception of vulnerability.

The two staff who perform screening for risk of victimization and abusiveness interviewees self report 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, history of abuse against a child or adult, and any disciplinary actions regarding sexual abuse during confinement.

According to the interviewee who conducts initial 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 is reconciled to the degree possible. In terms of reassessments, the interviewee who conducts reassessments reports the file is reviewed to reconcile discrepancies between the resident's assertions and any factual issues.

The staff who conducts initial assessments interviewee reports all residents are interviewed individually behind closed doors in the Intake Room. The screening tool provides specific directions relative to the interview process and scoring of responses. According to the staff member who facilitates reassessments, the resident reports to his/her office wherein a face to face interview is conducted behind closed doors. Once completed, the paper instrument is scanned into the resident's electronic file. Of note, the auditor's review of the screening tool directions validates the statements of the staff who conduct assessments interviewees.

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. This is confirmed by screening staff interviewees as reflected in the narrative for 115.241(d).

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

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, 192 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 perform screening for risk of victimization and abusiveness interviewee (reassessments), the same are conducted within 30 days of arrival at ACTC. The target for completion of reassessments is two weeks to 30 days.

One of 20 random resident interviewees reports he was asked the questions reflected in the narrative for 115.241(a) above since arrival at ACTC. The questions were asked by his case manager within one week of arrival. As previously reflected in the narrative for 115.241, three residents arrived at ACTC in excess of 12 months prior to the on-site audit and accordingly, this question was not posed to them.

The auditor's review of one initial assessment and reassessment relative to the same resident reveals he arrived on May 29, 2018, received his initial screening on the same date, and was reassessed one day later. The auditor suggests the same is inconsistent with 115.241(f) as the reassessment is based on accrual of additional information. One day is not reasonable in terms of provision compliance.

The auditor's on-site review of 11 random resident files, many of which were those of random resident interviewees, reveals eight of the 30-day Reassessments were complete, thorough, and timely. One 30-day reassessment is not yet completed based on the recency of the resident's arrival at ACTC. Two reassessments were completed within four to seven days of the resident;s arrival at ACTC, thereby confirming the condition addressed in the preceding paragraph.

While the auditor finds ACTC to be substantially compliant with 115.241(f), he recommends greater emphasis be placed on reassessment within 14-30 days of arrival at ACTC. This will allow sufficient time for any research and reconciliation to occur, providing a better snapshot in time of the resident's sexual safety at ACTC.

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 12, 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 such a re-assessment.

According to the staff member who facilitates initial screening for risk of victimization and abusiveness interviewee, if there is no information available in the pre-screening packet, he/she does reassess after follow-up with relevant referring agencies. He/she further relates the case managers reassess within 30 days of arrival. The interviewee who facilitates reassessments reports he/she does reassess a resident's risk level 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. For example, if the operations supervisor, Assistant Director or Director referred a sexual abuse incident or information to him/her, he/she would reassess the resident.

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; and
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 both staff who perform screening for risk of victimization and abusiveness interviewees, 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 ACTC PCM interviewee, 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 ACTC Shared Drive. The Director advises he feels comfortable with this distribution (very small staff complement) and the ability to protect sensitive information from exploitation. Both staff who perform screening for risk of sexual victimization and abusiveness interviewees confirm the PCM's response.

In view of the above, the auditor finds ACTC 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? X□ Yes □ No

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

- Unless placement is in a dedicated facility, unit, or wing established in connection with a consent decree, legal settlement, or legal judgment for the purpose of protecting lesbian, gay, bisexual, transgender, or intersex residents, does the agency always refrain from placing: intersex residents in dedicated facilities, units, or wings solely on the basis of such identification or status? 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 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 ACTC 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 are separated from potential and known predators. Of note,, sexually violent predators are generally not housed at ACTC.

According to the staff who performs initial screening for risk of victimization and abusiveness interviewee, a four color chart is used to accomplish effective separation of potential and known victims from potential and known predators. Residents who are not highlighted by a color are unrestricted and can be housed with anyone. Sexual offenders are monitored unless a higher level of action precipitated by screening, is warranted. Individualized determinations are made about how to ensure the safety of each resident.

The auditor's review of a housing grid validates compliance with this provision.

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

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).

According to the ACTC PCM, transgender and intersex residents are not placed in specific units or rooms and each situation is assessed on a case-by-case basis. The screening tool is utilized and assignment is accomplished accordingly. 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.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 14, section J(1)(a) addresses 115.242(d).
The ACTC PCM asserts the agency the transgender or intersex resident's own views with respect to his own safety are given serious consideration in placement and programming assignments. Both staff who conduct screening for risk of victimization and abusiveness interviewees confirm the ACTC 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 ACTC PCM, transgender and intersex residents are given the opportunity to shower separately from other residents. Specifically, the would be able to use the upstairs showers. A camera is located in the hallway, capturing traffic in and out of the area. A staff member would be posted outside the shower area to ensure no other residents are in the shower. The staff who perform screening for risk of victimization and abusiveness interviewees confirm the ACTC PCM's identification of shower location however, they were unsure of the mechanics of the process. Accordingly, the auditor recommends the ACTC PCM train all staff regarding the supervision process.

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

The ACTC PCM asserts 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 ACTC PCM further asserts the initial screening identifies if the resident is or is perceived to be LGBTI. The staff member who facilitates room assignments addresses this matter, ensuring geographic isolation of LGBTI residents is not employed.

The two bi-sexual resident interviewees assert they have not been placed in a housing are only for LGBTI residents.

The auditor's review of the afore-mentioned housing status sheet validates compliance with 115.242(f).

In view of the above, the auditor finds ACTC 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 CCA Preventing Sexual Abuse & Misconduct and CoreCivic PREA- A Guide to the Prevention and Reporting of Sexual Misconduct brochures reveals multiple methods for private resident reporting of sexual abuse and sexual harassment incidents.

All 13 random staff interviewees are able to cite at least one method 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), Blue Bench, submission of emergency grievance, report to staff, and write a report.

All of the 20 random resident interviewees are able to cite at least one method available to them to cite the above. Options include talking to staff, dialing the Hotline (DOC TIPS), submit an Emergency Grievance,verbal report to police, report to family, advise therapist in community, and advise CDOC staff.

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 abuse or 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, page 15, section L(1)(a)(i and vii) addresses 115.251(b).

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

Fifteen of the 20 random resident interviewees assert they are allowed to make a report without having to give their name. Four interviewees assert they don't know whether they can make such a report and one interviewee asserts he can't make such a report.

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).

All 13 random staff interviewees assert when a resident alleges sexual abuse, he can do so verbally, in writing, anonymously, and from third parties. Eleven interviewees assert they immediately document any verbal reports of sexual abuse/harassment received from residents while two interviewees assert they document such allegations as soon as possible following receipt of the allegation.

Nineteen of 20 random resident interviewees assert reports of sexual abuse/harassment can be made both in person and in writing. Eleven interviewees assert a friend or relative can make the report for the resident without giving his name. Five interviewees were unsure if the latter could be accomplished and two said the latter report could not be made.

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 16, section 2(d) addresses 115.251(d).

All 13 random staff interviewees were able to cite at least one method 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 his cell phone during non-regular business hours (phone list is available on Sharepoint), CC Ethics Hotline, written report, report to Blue Bench, call 9-1-1, or write an e-mail.
Of note, an Ethics Hotline poster is placed in the Staff Break Room.

In view of the above, the auditor finds ACTC 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 □ NA

115.252 (b)

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

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

115.252 (c)

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

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

115.252 (d)

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

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

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

115.252 (e)

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

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

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

115.252 (f)

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

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

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

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

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

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

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

115.252 (g)

- If the agency disciplines a resident for filing a grievance related to alleged sexual abuse, does it do so ONLY where the agency demonstrates that the resident filed the grievance in bad faith? (N/A if agency is exempt from this standard.) 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 has an administrative procedure for dealing with resident grievances regarding sexual abuse.

CMI Policy Number 1.140 entitled Grievances, section 11 (a-e) addresses 115.252(a).

Pursuant to the PAQ, the Director self reports agency policy or procedure allows a resident to submit a grievance regarding an allegation of sexual abuse at any time, regardless of when the incident is alleged to have occurred. The Director further self reports agency policy does not require a resident to use an informal grievance process, or otherwise attempt to resolve with staff an alleged incident of sexual abuse.

CMI Policy Number 1.140 entitled Grievances, section 11 (a-c) addresses 115.252(b).

The requirements of 115.252(b) are specifically articulated in section 45 of the ACTC CC Resident Handbook.

Pursuant to the PAQ, the Director self reports agency policy and procedure allow a resident to submit a grievance alleging sexual abuse without submitting it to the staff member who is the subject of the complaint. Agency policy and procedure requires that a resident grievance alleging sexual abuse not be referred to the staff member who is the subject of the complaint.

CMI Policy Number 1.140 entitled Grievances, section 11 (d)(1 and 2) addresses 115.252(c).

The requirements of 115.252(c) are specifically articulated in section 45 of the ACTC CC Resident Handbook.

Pursuant to the PAQ, the Director self reports agency policy and procedure requires that a decision on the merits of any grievance or portion of a grievance alleging sexual abuse be made within 90 days of filing the grievance. In the past 12 months, 0 grievances have been filed wherein sexual abuse was alleged. The Director further self reports the agency always notifies the resident, in writing, when the agency files for an extension, including notice of the date by which a decision will be made.

CMI Policy Number 1.140 entitled Grievances, section 11 (e)(1-3) addresses 115.252(d).

Pursuant to the PAQ, the Director self reports agency policy and procedure permits third parties, including fellow residents, staff members, family members, attorneys, and outside advocates, to assist residents in

filing requests for administrative remedies relating to allegations of sexual abuse and to file such requests on behalf of residents. The Director further self reports agency policy and procedure requires that if the resident declines to have third-party assistance in filing a grievance alleging sexual abuse, the agency documents the resident's decision to decline. The Director self reports 0 grievances alleging sexual abuse have been filed by residents in the past 12 months wherein the resident declined third-party assistance, containing documentation of the resident's decision to decline.

CMI Policy Number 1.140 entitled Grievances, section 11 (e)(4-6) addresses 115.252(e).

Pursuant to the PAQ, the Director self reports the agency has a policy and established procedures for filing an emergency grievance alleging that a resident is subject to a substantial risk of imminent sexual abuse. Agency policy and procedure for emergency grievances alleging substantial risk of imminent sexual abuse requires an initial response within 48 hours. The Director self reports 0 emergency grievances alleging substantial risk of imminent sexual abuse were filed in the last 12 months. Agency policy and procedure for emergency grievances alleging substantial risk of imminent sexual abuse requires a final agency decision be issued within five days.

CMI Policy Number 1.140 entitled Grievances, section 11 (e)(7) addresses 115.252(f).

Pursuant to the PAQ, the Director self reports the agency has a written policy that limits its ability to discipline a resident for filing a grievance alleging sexual abuse to occasions where the agency demonstrates that the resident filed the grievance in bad faith. The Director further self reports in the last 12 months, 0 resident grievances alleging sexual abuse resulted in disciplinary action by the agency against the resident for having filed the grievance in bad faith.

CMI Policy Number 1.140 entitled Grievances, section 11 (e)(8) addresses 115.252(g).

In view of the above, the auditor finds ACTC substantially compliant with 115.252.

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;
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 brochures identified in the narratives for 115.221 and 115.251 establish compliance with 115.253. Additionally, the auditor's review of a photograph included in the PAQ packet reveals requisite information [as required by 115.253(a)] is included on an ACTC PREA Resource Board. "Blue Bench" information is clearly identified on this bulletin board.

Sixteen of the 20 random resident interviewees assert there are services available outside the facility for dealing with sexual abuse, if the resident needed it. Three interviewees assert there are no such services while one interviewee did not know if such services are available. Of note, some of the interviewees alluded the information is available in some of the pamphlets received during Intake.

Eight of the interviewees assert they are aware of available services and eight of 20 could not identify any services. Some of the service options cited by interviewees are as follows; hospital, Blue Bench, counseling, community therapy groups, crisis services, Human Services, mental health, and therapeutic.

Eight of the interviewees assert the facility provides mailing addresses and telephone numbers for these outside services while nine interviewees assert such information is not provided. Eight interviewees did not know what community services are available to sexual abuse victims. Eight interviewees assert the numbers are free to call.

Of note, some interviewees assert relevant information is provided in flyers and/or posted on bulletin boards.

According to the ACTC PCM, no residents who reported a sexual abuse were housed at ACTC at the time of the on-site audit and accordingly, this interview could not be conducted.
Following each random resident interview, the auditor educated those who were not aware of requisite information as to where the information can be found.

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 rules governing privacy, confidentiality, and/or privilege that apply to disclosure 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 Core Civic PREA- A Guide to the Prevention and Reporting of Sexual Misconduct brochure reveals compliance with 115.253(b).

Eighteen of the 20 random resident interviewees assert that what is said to people from the outside services remains private. Eight interviewees assert that such conversations could be told to or listened to by someone else while nine assert such conversations could not be monitored as such. Reasons cited for such sharing of information or monitoring of calls by the designated community provider(s) are as follows; sexual abuse at ACTC, if someone is in danger (law enforcement concern), threatened or actual suicide, a Mandatory Reporting issue, 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 that residents clearly have sufficient information and resources available to them with respect to community resources for assistance with sexual abuse follow-up, if needed. Additionally, while resident interview responses did not overwhelmingly substantiate their knowledge regarding the subject-matter of 115.253, there is reason to believe requisite information has been provided to them for their consumption.

The auditor finds ACTC to be 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-party reporting options. According to the Director, PREA posters are posted throughout the facility for the 1-877-DOC-TIPS line and resident Concern posters are up posted throughout the facility. The telephone number on the visitor log with the 1-877-DOC-TIPS line requires updating.

The auditor notes all visitors/contractors/volunteers sign the visitor's log and accordingly, the information is readily available to them. Additionally, reporting information is readily available on posters that are visible in the Main Entrance to the facility.
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 ACTC to be 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? □ Yes X□ 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; 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 13 random staff interviewees assert the agency requires all staff to report any knowledge, suspicion, or information regarding any incident of sexual abuse/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. Twelve of the 13 interviewees assert policy requires immediate reporting to a supervisor, Director, Assistant Director, Operations Supervisor, or On-Call. The remaining interviewee asserts the report must be made as soon as possible following receipt of the allegation and accompanying information.

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, investigative, and other security and management decisions.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 16, 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 ACTC and accordingly, interviews were not conducted.

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

According to the Director/ACTC PCM, no residents under the age of 18 are housed at ACTC. 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 ACSO, if warranted. Contact would be made with the appropriate social services agency.

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/harassment, including those from third-party and anonymous sources, are reported directly to the designated facility investigator. As both Director and ACTC PCM, he is in the first line of reporting and he personally disseminates such information to the investigator (Operations Supervisor).

The auditor's review of an Incident Investigation Report and Incident Report dated June 25, 2018 reveals a resident reported an alleged sexual abuse on June 22, 2018. The alleged sexual abuse allegedly occurred months prior to the report. These documents clearly reveal timely reporting to the Director/ACTC PCM and Investigator. Direction provided by the Director/ACTC PCM is also articulated in the documents.

In view of the above, the auditor finds ACtC 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 (e.g., 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, Policy section and page 16, 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 immediately removed from the danger zone and placed under staff supervision. If necessary, the resident may be moved to another facility.

All 13 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 ACTC 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 to provide 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 it has provided such notification within 72 hours of receiving the allegation.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 20, section 5(b)(i) and (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 were 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 ACSO to initiate a criminal investigation.

According to the Director, when he receives an allegation from another facility or agency that an incident of sexual abuse/harassment previously occurred at ACTC, he immediately initiates an investigation pursuant to standard procedure. If the matter is criminal, in nature, contact is made with ACSO.

In view of the above, the auditor finds ACTC 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 one alleged incident of sexual abuse occurred at ACTC during the last 12 months. Pursuant to the fact pattern, the alleged incident occurred several months prior to reporting and the alleged perpetrator was no longer employed at the facility. Accordingly, the steps identified in 15.264(a) were not applicable.

In this case, contact was made with ACSO. Given the circumstances of the allegation, the timeline, and fact pattern, the crime scene location was unknown and therefore, could not be preserved and protected. In view of the above, this step was not applicable to the alleged scenario.

CC Policy 14-2 entitled Sexual Abuse Prevention and Response, PCN 14-2(01) reflects the proper verbiage relative to this standard provision.

The auditor's review of a PREA First Responder Duties at ACTC document reveals substantial compliance with 115.264(a). Verbiage in that document reflects both victim and perpetrator are instructed not to destroy physical evidence.

Four of the 10 security first responder and one of the two non-security first responder interviewees properly assert the following duties in terms of first responder duties:
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.

All of the above interviewees (12) assert the first step is to separate the victim and alleged perpetrator and ten interviewees assert the second step involves securing the crime scene. Six of the 12 interviewees assert the first responder ensures both victim and alleged perpetrator do not destroy physical evidence.

The auditor notes all interviewees, both security and non-security, were in possession of the laminated CC First Responder card at the time of the interview. The card accurately captures the verbiage reflected in 115.264(a).

While the auditor does not find sufficient basis to find ACTC non-compliant with 115.264 based on the aforementioned issue and evidence, there is cause to re-train staff regarding the same. As all staff receive the same First Responder training, refresher training appears to be an appropriate remedy.

In view of the above, the ACTC PCM will ensure all staff receive training regarding the four steps to be employed by First Responders, emphasis added regarding "**requesting**" the victim to refrain from destroying physical evidence and "**ensuring**" the perpetrator does not destroy physical evidence. Of note, First Responder refresher training must be completed on or before March 11, 2019.

The ACTC PCM will provide a roster of all staff to the auditor and he will randomly select staff names. The ACTC PCM will provide training certifications, substantiating provision of the relevant training for each selectee. Additionally, the ACTC PCM will provide a copy of the training syllabus to the auditor.

04/03/19 Update:

The auditor's review of a Training/Activity Attendance Roster reveals 19 staff participated in training regarding the subject-matter of 115.264(a). The Training/Activity Attendance Roster bears the caveat "I understand the training" and all 19 participants signed the document. The auditor's review of the lesson plan reveals substantial compliance with the subject-matter of 115.264(a).

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

1) Request that 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 remaining random staff interviewee parallels the security and non-security staff interviewees in terms of his/her response to the first responder duties. Specifically, he/she asserts first responders must ensure both victim and alleged perpetrator do not destroy physical evidence.

In view of the above, the auditor finds ACTC 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 in Pre-Service and 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. A Sexual Abuse Response Team has been developed and checklists are used to certify completion of action steps. Generally speaking, the shift supervisor(s) (Monitor II) initiate action and work the action steps. The pan is articulated in CC policy and all staff are trained regarding the plan during both Pre-Service and annual In-Service training.

In view of the above, the auditor finds ACTC 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.

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 resident pending an investigation or a determination of whether and to what extent discipline is warranted.

In view of the above, the auditor finds ACTC substantially compliant with 115.266.

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

☐ **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 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, he is the designated Retaliation Monitor at ACTC.

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

The Director asserts retaliation monitoring was not initiated in regard to the one sexual abuse allegation occurring in the last 12 months as the reporter lodged the allegation as he was being removed from the program. Removal from the program on the date of reporting precluded retaliation monitoring. Furthermore, the alleged perpetrator no longer worked at the facility as of three months prior to the report. Additionally, the allegation was determined to be Unfounded by ACSO investigators.

The Director asserts he monitors both staff and resident victims.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 11 and 13, sections 3(a)(vii through ix) and 3(b)(i) addresses 115.267(b).

According to the Agency Head interviewee, staff and residents who report sexual abuse/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, 30/60/90 Retaliation Monitoring Forms are used to document meetings. In terms of measures taken to ensure protection of residents from retaliation, changing resident rooms, transferring the perpetrator (if necessary, the victim) to other institutions, offering emotional support services (Blue Bench), if the alleged perpetrator is a staff member- change his/her shift or duty assignment/transfer to another facility, are a few strategies to address retaliation. 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, are a few strategies that can be implemented.

As previously mentioned, the Director is also designated as the Retaliation Monitor. In addition to the information provided by the Director as reflected in the preceding paragraph, the Director immediately initiates contact with residents who have reported sexual abuse. Minimally, he facilitates 30/60/90 day reviews of each victim.

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. 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 Director asserts he monitors unwarranted staff write-ups of residents, increased visibility in area of victim's housing, talking more with specific residents, and any noticeable increase in confrontation between the staff member and resident(s) as indicators of staff retaliation towards residents. Staff isolation from other staff and residents, excessive call-offs, changes in hygiene patterns, withdrawal, and notably poor performance may be indicators of staff retaliation victimization. In regard to resident victims of retaliation, increased physical altercations, increase in submitted grievances, aggressive/changes in behavior, changes in hygiene patterns, isolation, and increase in work "no shows" are potential key indicators.

As previously indicated, monitoring, minimally, is comprised of 30/60/90 day intervals. Bi-weekly check-ins with the victim of retaliation are facilitated. There is space on the monitoring form for comments.

There is no maximum amount of time for the monitoring process. Monitoring can be extended beyond the minimal 90-day time frame, if deemed necessary.

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.

Status checks or check-ins are addressed in the narrative for 115.267(c) above.

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 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.

In view of the above, the auditor finds ACTC substantially compliant with 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 and 24, section O(1-3) address 115.271(a).

According to the investigative staff interviewee, an investigation is initiated as soon as possible following receipt of an allegation of sexual abuse. If he is on-site, either the Director or Monitor Supervisor contacts him and advises of the situation. If the allegation is reported during his off-duty hours, he would normally report to the facility, dependent upon the nature of the allegation and the circumstances. Minimally, if for some reason he cannot report to the facility, on-duty supervisory staff would be directed to contact ACSO to investigate.

In regard to anonymous or third-party reports of sexual abuse/harassment, they are handled the same as any sexual abuse/harassment investigation.

The previously referenced investigation report reveals the matter was referred to ACSO upon notification.

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

The investigative staff interview regarding investigative staff specialized training is articulated in the narrative for 115.234(a).

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:

Ensure victim and perpetrator are separated (5 minutes);
Ensure crime scene is secured (5 minutes);
Ensure victim and perpetrator are monitored by staff (5 minutes however, this would be simultaneous with the above steps);
Interview alleged victim to establish the allegation (15-20 minutes);
Review any staff and/or resident written statements (10-15 minutes);
Interview staff and resident witnesses, assessing consistency (15-20 minutes); and
Review camera and resident files (30-60 minutes).

The investigation process mirrors the above with the addition of report writing (inclusive of the conduct of direct and circumstantial evidence analysis and credibility assessments of all involved in the incident). In regard to direct and circumstantial evidence the interviewee is responsible for collecting camera footage, telephone monitoring data, any grievances filed by the victim or against the alleged perpetrator, and file materials, all physical evidence is collected by ACSO investigators.

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 24, 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

and ACSO.

The investigative staff interviewee asserts compelled interviews are not conducted by ACTC staff. The same would be facilitated by ACSO 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)(e) 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 he assesses motives/potential motives, history of past allegations, consistency of statements amongst all principles, the existence of mental health issues and potential drug/alcohol usage. He further relates he 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) 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 he assesses policy compliance and whether staff acted in accordance with the scope of their employment. This assessment and review considers the entire scope of investigative findings.

The interviewee asserts administrative investigations are documented in written reports. Such reports include victim/perpetrator/witness credibility assessments, observations regarding camera surveillance, assessment of circumstantial evidence, and a summary of findings, inclusive of whether the allegation(s) is/are substantiated, unsubstantiated, or unfounded. The investigative report is actually completed as an Incident Report. Any handwritten reports are scanned into the electronic system for safe retention.

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).

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. It is noted the auditor reviewed the single sexual abuse allegation received during the last 12 months and notes documentation validating referral for criminal investigation. However, there is no evidence the same was referred for prosecution.

The investigative staff interviewee asserts cases are referred for criminal investigation whenever the evidence points to the existence of a criminal violation. Non-consensual sexual contact or abuse allegation(s) equal automatic referral. The interviewee asserts he triages the case to determine sufficiency of evidence and the extent of criminal behavior.

ACSO investigators are responsible for referral of cases for prosecution.

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).

The policy citation noted in the narrative for 115.271(d) is likewise applicable to 115.271(j).

The investigative staff interviewee asserts he continues the investigation, regardless of whether a staff member alleged to have committed a sexual abuse 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/ACTC PCM asserts the operations supervisor maintains contact with ACSO investigators via e-mail, checking on the status of criminal investigations. Generally, he asserts this is accomplished on a weekly basis.

According to the investigative staff interviewee, he acts as a liaison (addresses any evidentiary, interview coordination/scheduling needs) whenever ACSO investigators investigate sexual abuse incident(s). He remains in touch with such investigators, tracking investigation progress. Minimally, he maintains monthly contact.

In view of the above, the auditor finds ACTC 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 25, section O(5) addresses 115.272(a).

The investigative staff interviewee asserts he relies on a preponderance of evidence or less to substantiate allegations of sexual abuse/harassment. Of course, the investigator facilitates administrative investigations.

The auditor's review of the one sexual abuse investigation conducted during the last 12 months reveals substantial compliance with 115.272(a). The referenced investigation was administrative, in nature, and a precursor to the ACSO criminal investigation. Of note, the criminal investigation was deemed to be “Unfounded".

In view of the above, the auditor finds ACTC 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 an agency facility, does the agency request the relevant information from the investigative agency in order to inform the resident? (N/A if the agency/facility is responsible for conducting administrative and criminal investigations.) 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? X□ 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 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 on-going criminal investigation of sexual assault was conducted at ACTC during the last 12 months. As the same has not yet been concluded, notification has not been facilitated.
Since conclusion of the on-site audit, the auditor has learned the criminal investigation in this matter has concluded and the same is Unfounded. The auditor notes the reporting resident was being removed from the facility, on an unrelated charge, at the time he made the report. He was removed from the facility that same day and accordingly, provision of such notification is unwarranted pursuant to 115.273(f).

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

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. He asserts he makes all such notifications. The investigative staff interviewee substantiates the Director's statement in totality.

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 one ongoing criminal criminal investigation is being facilitated by ACSO. This is the only allegation and investigation of sexual abuse during the last 12 months. Specifics regarding the notification status of this case are identified in the narrative of 115.273(a), above.

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 administrative investigation reveals ACTC staff did follow-up with the Arapaho County Sheriff's Office regarding the status of the criminal investigation as reflected in e-mails dated June 22, 2018 and July 13, 2018. The e-mails, from the Operations Supervisor to the Assistant Director, specifically address the criminal referral of the matter and the name of the investigator.

According to the investigative staff interviewee, he generally maintains, minimally, monthly contact with ACSO regarding the status of criminal investigations.

Pursuant to the PAQ, the Director self reports that following a resident's allegation a staff member has committed sexual abuse against the resident, the facility subsequently informs the resident (unless the agency has determined that 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 that the staff member has been indicted on a charge related to sexual abuse within the facility; or
The agency learns that the staff member has been convicted on a charge related to sexual abuse within the facility.
As previously referenced throughout this report, the criminal investigation of the one sexual abuse allegation received during the last 12 months is deemed to be Unfounded. Accordingly, given the same, the fact the alleged perpetrator resigned employment three months prior to the report, and the fact the resident was removed from the facility, on an unrelated matter on the same day of the report, such notification was not provided nor warranted.

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

Pursuant to the PAQ, following a resident's allegation he has been sexually abused by another resident at ACTC, 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 26, section Q(3)(a and b) addresses 115.273(d).

The auditor has not located any resident-on-resident allegations of sexual abuse that have been investigated during the last 12 months.

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 lack of notifications, in accordance with 115.273(e), are discussed above.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, pages 26 and 27, section Q(4) addresses 115.273(e).

In view of the above, the auditor finds ACTC 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).

The Director advises no staff have been subject to disciplinary sanctions up to and including termination for violating agency sexual abuse/harassment policies during the last 12 months.

Pursuant to the PAQ, the Director self reports in the past 12 months, one facility staff member is alleged to have violated agency sexual abuse or sexual harassment policies. The Director further self reports this individual has not resigned or been terminated from employment. The alleged perpetrator resigned from the facility three months prior to the date the allegation was reported.
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/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).

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, one facility staff member has 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).

As previously indicated in the narrative for 115.272, one sexual abuse allegation was referred to ACSO for criminal investigation.

In view of the above, the auditor finds ACTC 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, no 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 28, section R(3) addresses 115.277(a).

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 28, section R(3) addresses 115.277(b).

The Director asserts he would remove contractors and volunteers who violated agency sexual abuse/harassment policies, from the facility.

In view of the above, the auditor finds ACTC 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)

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

Auditor Overall Compliance Determination

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

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 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).

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 are normally 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.

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 offers therapy, counseling, or other interventions designed to address and correct the underlying reasons or motivations for abuse. In view of the above, facility staff consider whether to require the offending resident to participate in such interventions as a condition of access to programming or other benefits.

As previously noted in this report, no medical/mental health staff are employed at ACTC. Counseling such as this would be facilitated in the community. Accordingly, the subject-matter of this provision falls under the purview of the Director and Assistant Director to direct such referrals, if deemed appropriate.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 27 and 28, section R(1)(c) addresses 115.278(d).

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, 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, page 27, section R(1)(b)(i) addresses 115.278(f).

With respect to the one sexual abuse allegation investigated during the last 12 months, the auditor finds the resident was not disciplined for the sexual abuse allegation and accompanying findings rather, he was disciplined relative to a separate matter. 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 ACTC 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 Director self reports that as medical and mental health care is not provided at ACTC, such secondary materials are available at the appropriate hospital.

Of note, the Director advises the one alleged sexual abuse victim (as referenced in the narrative for 115.271) was not afforded access to timely, unimpeded access to emergency medical treatment and crisis intervention services, as well as, offered services as identified in 115.282(c). He reports the alleged sexual abuse incident was verbally passed along to CDOC staff however, there is no documentary evidence substantiating provision of the requisite examination, evaluation, testing, or treatment. In view of the above, the auditor finds ACTC to be non-compliant with 115.282(a) and (c).

Accordingly, the auditor is imposing a 180-day corrective action period in which institutionalization of 115.282(a) and (c) is expected. While the target date for completion of the following corrective action is March 11, 2019, the 180-day date is June 17, 2019.

To substantiate institutionalization, the ACTC PCM will provide training to all ACTC staff regarding the specific facts of this scenario and the steps to take in future situations of this nature. For example,

question the resident as to whether he is injured. Escort him to the appropriate hospital to ensure compliance with 115.282(a) and (c). If he refuses, properly document the refusal, including the resident's signature/date and the staff witness' signature and date. Ensure relevant documents are forwarded to the receiving institution. Communicate the incident and steps taken to the receiving institution, documenting the communication. The ACTC PCM will ensure this information is included in a lesson plan and forwarded to the auditor for inclusion in the audit file.

Upon conclusion of the training, the ACTC PCM will provide the auditor with a copy of the training sign-in sheet and the auditor will randomly select names from that document. The ACTC PCM will provide the auditor with a copy of the selected employees' Training Acknowledgment bearing his/her signature/date of receipt of the training and understanding of the subject-matter of the same.

During the corrective action period, the ACTC PCM will provide the auditor with all sexual abuse investigations (from this point forward until the end of the corrective action period, unless the auditor closes the finding earlier), inclusive of all related medical/mental health documentation. The auditor will assess each on a case-by-case basis with special emphasis on compliance with related provisions, and make a determination as to when compliance is institutionalized. When achieved, the auditor will close the finding.

04/03/19 Update:

The auditor's review of a Training/Activity Attendance Roster reveals 19 staff participated in training regarding the subject-matter of 115.282(a)/(c) and 115.283(f). The Training/Activity Attendance Roster bears the caveat "I understand the training" and all 19 participants signed the document. The auditor's review of the lesson plan reveals substantial compliance with the subject-matter of 115.282(a)/(c) and 115.282(f).

The auditor's review of two sexual abuse/harassment investigations completed since the date of the on-site audit reveals neither allegation was based on sexual intercourse. Accordingly, there are no investigations wherein the fact pattern is similar to that articulated above.

In view of the above, the auditor is closing this finding, determining that ACTC is substantially compliant with 115.282(a)/(c) and 115.283(f).

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).

The interview narratives for security and non-security first responders, as reflected in 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.

Other than the matter referenced above, the auditor has found no other 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.

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).

The finding regarding non-compliance with 115.282(c) is articulated above.

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 ACTC 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.) □ 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.) □ 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.

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.

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.

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

ACTC is an all-male facility and therefore, the auditor finds 115.283(e) is 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).

Of note, the Director advises the one alleged sexual abuse victim (as referenced in the narrative for 115.271) was not afforded access to testing for sexually transmitted infections. He further reports the alleged sexual abuse incident was verbally passed along to CDOC staff however, there is no documentary evidence substantiating provision of the requisite examination, evaluation, testing, or treatment. Accordingly, the auditor finds ACTC to be non-compliant with 115.283(f).

Accordingly, the auditor is imposing a 180-day corrective action period in which institutionalization of 115.283(f) is expected. While the target date for completion of the following corrective action is March 11, 2019, the 180-day date is June 17, 2019.

To substantiate institutionalization, the ACTC PCM will provide training to all ACTC staff regarding the specific facts of this scenario and the steps to take in future situations of this nature. For example, question the resident as to whether he is injured. Escort him for sexually transmitted infections testing as articulated in 115.283(f). If he refuses, properly document the refusal bearing his signature/date and the staff witness' signature and date. Ensure relevant documents are forwarded to the receiving institution. The ACTC PCM will ensure this information is included in a lesson plan and forwarded to the auditor for inclusion in the audit file.

Upon conclusion of the training, the ACTC PCM will provide the auditor with a copy of the training sign-in sheet and the auditor will randomly select names from that document. The ACTC PCM will provide the auditor with a copy of the selected employees' training certification bearing his/her signature and date for receipt of the training and understanding of the subject-matter of the same.

During the corrective action period, the ACTC PCM will provide the auditor with all sexual abuse investigations (from this point forward until the auditor closes the finding), inclusive of all related medical/mental health documentation. The auditor will assess each on a case-by-case basis, with special emphasis on compliance with related provisions, and make a determination as to when compliance is institutionalized. When achieved, the auditor will close the finding.

04/03/19 Update:

The auditor's review of a Training/Activity Attendance Roster reveals 19 staff participated in training regarding the subject-matter of 115.282(a)/(c) and 115.283(f). The Training/Activity Attendance Roster bears the caveat "I understand the training" and all 19 participants signed the document. The auditor's review of the lesson plan reveals substantial compliance with the subject-matter of 115.282(a)/(c) and 115.282(f).

The auditor's review of two sexual abuse/harassment investigations completed since the date of the on-site audit reveals neither allegation was based on sexual intercourse. Accordingly, there are no investigations wherein the fact pattern is similar to that articulated above.

In view of the above, the auditor is closing this finding, determining that ACTC is substantially compliant with 115.282(a)/(c) and 115.283(f).

Pursuant to the PAQ, the Director self reports treatment services are provided to the victim without financial cost, 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).

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 ACTC. 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 ACTC during the last 18 months. As previously indicated, CC acquired ACTC on or about January 1, 2017.

As reflected in the narrative for 115.271, the single sexual abuse allegation reported during the last 12 months was determined to be Unfounded, from a criminal perspective. The auditor's review of the CC Incident Report dated June 25, 2018 reveals the alleged victim incurred no reported injuries and was not admitted to a hospital.

In view of the above, the auditor finds ACTC 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

☐ **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 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 ACTC. Upon further review, the auditor finds one criminal investigation is complete.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, pages 22 and 23, section N(1) addresses 115.286(a).

As previously reflected throughout this report, the one sexual abuse investigation involved a resident who reported the alleged incident as he was being removed from the facility. Pursuant to an email from ACSO, the criminal investigation is determined to be UNFOUNDED. Accordingly, there is no basis for the conduct of a sexual abuse incident review team (SART) review.

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, 0 criminal or administrative sexual abuse investigations were facilitated at ACTC. This issue is addressed in the narrative for 115.286(a).

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

Of note and as previously referenced in the narrative for 115.286(a), the ACSO found the single allegation to be UNFOUNDED. Accordingly, a SART review is not warranted in this situation.

Pursuant to the PAQ, the Director self reports the SART team 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 ACTC.

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

In a memorandum to the file, the Director notes he, the Assistant Director, and Operations Supervisor, minimally, comprise the SART team at ACTC.

The Director asserts the facility does have a SART team. The team is comprised of the Director, Assistant Director, and Operations Supervisor, allowing for input from line supervisors, investigators, and medical/ mental health practitioners.

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).

According to the Director, the team works to determine whether the alleged incident was the result of a policy, technological, or performance failure. Is there an issue with physical plant? What was done right/what was wrong/ and what can be done differently? Have training needs been exposed as the result of the incident?

The SART team considers:

1. Was the incident motivated by race, ethnicity, gender identity, LGBTI identification 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.

The ACTC PCM reports there was no SART review in the one case occurring within the last 12 months, as the reporter was being arrested when he reported the incident. Additionally, the incident was under investigation by the ACSO. The auditor has confirmed the criminal investigation has been concluded.

According to the ACTC PCM, SART reports are forwarded to him for review. Actually, the ACTC PCM chairs most of the SART reviews. He reviews the substance of the report and assesses needed changes. If recommendation(s) are made, he 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).

In view of the above, the auditor finds ACTC substantially compliant with 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).

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).

ACTC does not contract with any other facility(ies) for confinement of its residents. Accordingly, the auditor finds 115.287(e) to be not applicable to ACTC.

According to the Director, CoreCivic provided sexual abuse/sexual harassment data to the U.S. Department of Justice during 2017. It is noted CoreCivic assumed ACTC during 2017.

In view of the above, the auditor finds ACTC 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 2017 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 residents at CC facilities.

In view of the above, the auditor finds ACTC to exceed compliance expectations with respect to 115.288. This procedure is representative of CC's commitment and zeal in terms of enhancement of resident 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 however, some hard copy files are located in a desk drawer in the locked Investigator's Office. The auditor recommends the purchase and use of a locked filing cabinet maintained in the Operations Supervisor's Office. 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 ACTC PCM advises PREA investigations are electronically forwarded to the CCPC and Corporate maintains the paper trail. Corporate maintains relevant statistics and makes effectiveness assessments. Additionally, the CC annual report is promulgated at Corporate.

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. The same does include a synopsis of local corrective actions, where warranted, and a Corporate-wide global synopsis of agency progress in addressing sexual abuse.

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 annual 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 2017 Annual Report is maintained on the same and is approved by the CC Executive Vice President and Chief Corrections Officer.

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/ACTC PCM, personal/confidential information is typically redacted from the annual report. The report is generated by the CCPC.

In view of the above, the auditor finds ACTC exceeds standard expectations for 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 maintained.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 29, section T(1)(a)(iv) addresses 115.289(a).

The ACTC PCM advises PREA investigations are electronically forwarded to the CCPC and Corporate maintains the paper trail. Corporate maintains relevant statistics and makes effectiveness assessments. Hard copies of some staff and resident reports are maintained in the desk of the operations supervisor behind a locked door. As previously indicated, the auditor recommends a locking cabinet be purchased for retention of these documents in the office of the operations supervisor.

Pursuant to the PAQ, the Director self reports agency policy requires that aggregated sexual abuse data from facilities under its direct control 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 29, 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 29, 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 ACTC 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.) X□ Yes □ No □ NA

- If this is the third year of the current audit cycle, did the agency ensure that at least two-thirds of each facility type operated by the agency, or by a private organization on behalf of the agency, were audited during the first two years of the current audit cycle? (N/A if this is **not** the *third* year of the current audit cycle.) □ Yes □ No X□ 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 was provided acceptable accommodations for the conduct of both staff and resident interviews. The Director/ACTC PCM was very facilitative and responsive in terms of provision of additional documentation and/or clarification during the pre-audit phase.

Standard 115.403: Audit contents and findings

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

115.403 (f)

- The agency has published on its agency website, if it has one, or has otherwise made publicly available, all Final Audit Reports within 90 days of issuance by auditor. The review period is for prior audits completed during the past three years PRECEDING THIS AGENCY AUDIT. In the case of single facility agencies, the auditor shall ensure that the facility's last audit report was published. The pendency of any agency 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*)

Pursuant to the auditor's review of the CC website, the auditor did find the last Final PREA audit report. The auditor did review the Final Report prior to the on-site audit.

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 **May 3, 2019**

Auditor Signature **Date**

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

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