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

☐ **Interim** X☐ **Final**

Date of Interim Audit Report: May 25, 2021

Date of Final Audit Report: September 23, 2021

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:** April 19-20, 2021

Agency Information

Name of Agency: CoreCivic			
Governing Authority or Parent Agency *(If Applicable)*: NA			
Physical Address: 5501 Virginia Way Suite 110		**City, State, Zip:** Brentwood, Tennessee 37027	
Mailing Address: SAA		**City, State, Zip:** SAA	
The Agency Is:	☐ Military	X☐ Private for Profit	☐ Private not for Profit
☐ Municipal	☐ County	☐ State	☐ Federal
Agency Website with PREA Information: https://www.corecivic.com/the-prison-rape-elimination-act-of-2003-prea			

Agency Chief Executive Officer

Name: Damon Hininger, President and Chief Executive Officer	
Email: damon.Hininger@corecivic.com	**Telephone:** 615-263-3000

Agency-Wide PREA Coordinator

Name: Eric S. Pierson, Senior Director, PREA Compliance and Programs	
Email: eric.pierson@corecivic.com	**Telephone:** 615-263-6915

PREA Coordinator Reports to: Steven Conry, Vice President, Core Services	**Number of Compliance Managers who report to the PREA Coordinator:** 65 (indirect)

Facility Information

Name of Facility: Longmont Community Treatment Center			
Physical Address: 236 Main St.		**City, State, Zip:** Longmont, Co 80501	
Mailing Address (if different from above): SAA		**City, State, Zip:** SAA	
The Facility Is:	☐ Military	X☐ Private for Profit	☐ Private not for Profit
☐ Municipal	☐ County	☐ State	☐ Federal

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

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

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

☐ ACA
☐ NCCHC
☐ CALEA
☐ Other (please name or describe: X☐ N/A

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

Facility Director

Name: Krystal Patrick	
Email: krystal.Patrick@corecivic.com	**Telephone:** 303-651-7071 x 223

Facility PREA Compliance Manager

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

Facility Health Service Administrator X☐ N/A

Name:	
Email:	**Telephone:**

Facility Characteristics

Designated Facility Capacity:	69
Current Population of Facility:	40
Average daily population for the past 12 months:	54
Has the facility been over capacity at any point in the past 12 months?	☐ Yes X☐ No
Which population(s) does the facility hold?	☐ Females ☐ Males X☐ Both Females and Males
Age range of population:	18-69
Average length of stay or time under supervision	80 days
Facility security levels/resident custody levels	Minimum

Number of residents admitted to facility during the past 12 months	150
Number of residents admitted to facility during the past 12 months whose length of stay in the facility was for *72 hours or more*:	148
Number of residents admitted to facility during the past 12 months whose length of stay in the facility was for *30 days or more:*	120
Does the audited facility hold residents for one or more other agencies (e.g. a State correctional agency, U.S. Marshals Service, Bureau of Prisons, U.S. Immigration and Customs Enforcement)?	X☐ Yes ☐ No
Select all other agencies for which the audited facility holds residents: Select all that apply (N/A if the audited facility does not hold residents for any other agency or agencies):	☐ Federal Bureau of Prisons ☐ U.S. Marshals Service ☐ U.S. Immigration and Customs Enforcement ☐ Bureau of Indian Affairs ☐ U.S. Military branch ☐ State or Territorial correctional agency X☐ County correctional or detention agency X☐ Judicial district correctional or detention facility ☐ City or municipal correctional or detention facility (e.g. police lockup or city jail) ☐ Private corrections or detention provider ☐ Other - please name or describe: ☐ **N/A**
Number of staff currently employed by the facility who may have contact with residents:	11
Number of staff hired by the facility during the past 12 months who may have contact with residents:	4
Number of contracts in the past 12 months for services with contractors who may have contact with residents:	0
Number of individual contractors who have contact with residents, currently authorized to enter the facility:	0
Number of volunteers who have contact with residents, currently authorized to enter the facility:	7

Physical Plant	
Number of buildings: **Auditors should count all buildings that are part of the facility, whether residents are formally allowed to enter them or not. In situations where temporary structures have been erected (e.g., tents) the auditor should use their discretion to determine whether to include the structure in the overall count of buildings. As a general rule, if a temporary structure is regularly or routinely used to hold or house residents, or if the temporary structure is used to house or support operational functions for more than a short period of time (e.g., an emergency situation), it should be included in the overall count of buildings.**	1
Number of resident housing units: **Enter 0 if the facility does not have discrete housing units. DOJ PREA Working Group FAQ on the definition of a housing unit: How is a "housing unit" defined for the purposes of the PREA Standards? The question has been raised in particular as it relates to facilities that have adjacent or interconnected units. The most common concept of a housing unit is architectural. The generally agreed-upon definition is a space that is enclosed by physical barriers accessed through one or more doors of various types, including commercial-grade swing doors, steel sliding doors, interlocking sally port doors, etc. In addition to the primary entrance and exit, additional doors are often included to meet life safety codes. The unit contains sleeping space, sanitary facilities (including toilets, lavatories, and showers), and a dayroom or leisure space in differing configurations. Many facilities are designed with modules or pods clustered around a control room. This multiple-pod design provides the facility with certain staff efficiencies and economies of scale. At the same time, the design affords the flexibility to separately house residents of differing security levels, or who are grouped by some other operational or service scheme. Generally, the control room is enclosed by security glass, and in some cases, this allows residents to see into neighboring pods. However, observation from one unit to another is usually limited by angled site lines. In some cases, the facility has prevented this entirely by installing one-way glass. Both the architectural design and functional use of these multiple pods indicate that they are managed as distinct housing units.**	20 rooms with 2 to 12 beds
Number of single resident cells, rooms, or other enclosures:	0
Number of multiple occupancy cells, rooms, or other enclosures:	20
Number of open bay/dorm housing units:	0
Does the facility have a video monitoring system, electronic surveillance system, or other monitoring technology (e.g. cameras, etc.)?	X☐ Yes ☐ No
Has the facility installed or updated a video monitoring system, electronic surveillance system, or other monitoring technology in the past 12 months?	X☐ Yes ☐ No

Medical and Mental Health Services and Forensic Medical Exams	
Are medical services provided on-site?	☐ Yes X☐ No
Are mental health services provided on-site?	☐ Yes X☐ No

Where are sexual assault forensic medical exams provided? Select all that apply.	☐ On-site X☐ Local hospital/clinic ☐ Rape Crisis Center ☐ Other (please name or describe:

Investigations

Criminal Investigations	
Number of investigators employed by the agency and/or facility who are responsible for conducting CRIMINAL investigations into allegations of sexual abuse or sexual harassment:	0
When the facility received allegations of sexual abuse or sexual harassment (whether staff-on-resident or resident-on-resident), CRIMINAL INVESTIGATIONS are conducted by: Select all that apply.	☐ Facility investigators ☐ Agency investigators X☐ An external investigative entity
Select all external entities responsible for CRIMINAL INVESTIGATIONS: Select all that apply (N/A if no external entities are responsible for criminal investigations)	X☐ Local police department ☐ Local sheriff's department ☐ State police ☐ A U.S. Department of Justice component ☐ Other (please name or describe: ☐ N/A

Administrative Investigations	
Number of investigators employed by the agency and/or facility who are responsible for conducting ADMINISTRATIVE investigations into allegations of sexual abuse or sexual harassment?	3
When the facility receives allegations of sexual abuse or sexual harassment (whether staff-on-resident or resident-on-resident), ADMINISTRATIVE INVESTIGATIONS are conducted by: Select all that apply	X☐ Facility investigators ☐ Agency investigators ☐ An external investigative entity
Select all external entities responsible for ADMINISTRATIVE INVESTIGATIONS: Select all that apply (N/A if no external entities are responsible for administrative investigations)	☐ Local police department ☐ Local sheriff's department ☐ State police ☐ A U.S. Department of Justice component ☐ Other (please name or describe: X☐ N/A

Audit Findings

Audit Narrative (including Audit Methodology)

The Prison Rape Elimination Act (PREA) on-site audit of the Longmont Community Treatment Center (LCTC) in Longmont, CO was conducted April 19 and 20, 2021, 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 uploaded to a secure electronic program.

The documentation review included, but was not limited to, agency and facility policies, staff training slides, completed forms regarding both staff and resident training, Memorandums Of Understanding (MOUs), organizational chart(s), Core Civic (CC) PREA brochure (tri-fold), photographs of PREA related materials (e.g. posters, etc.), executed Human Resource (HR) documents associated with relevant PREA standard(s), staff training certifications, and Victimization/Aggressor screenings. This review prompted several questions and informational needs that were addressed with the LCTC Director/ PREA Compliance Manager (PCM). The majority of informational needs were addressed pursuant to this process.

Following the audit process, the auditor contacted the Director of Client Services at The Blue Bench (provides victim advocacy services to victims of sexual abuse at LCTC) regarding the frequency of interaction with residents, third-party reporters, and staff at the facility. The interviewee advises that victim advocacy interaction at LCTC, as described above, is minimal to none.

The auditor met with the Director/PCM at 7:45AM on Monday, April 19, 2021. The auditor provided an overview of the audit process and advised the Director/PCM the same would be facilitated in the least disruptive manner possible. Additionally, the auditor advised the Director/PCM of the tentative schedule(s) for the conduct of the audit. Between 8:15AM and 9:15AM, the auditor toured the entire facility with the Director/PCM.

It is noted the rated capacity of LCTC is 69 residents and the institutional count on April 19, 2021 was 49 residents.

During the on-site audit, the auditor was staged in a conference room on the 1st floor of the facility for document reviews and facilitation of confidential interviews with staff/residents. The auditor randomly selected (from a resident roster provided by the Director/PCM) and interviewed seven residents on-site pursuant to the Random Resident Interview Questionnaire. At least one resident (representative of the total sample of resident interviewees) was interviewed from each living area throughout the facility. The auditor notes zero letters were received from either residents or staff prior to the conduct of the on-site audit.

None of the seven random resident interviewees were also interviewed pursuant to specialty interviewee questionnaires. Accordingly, all seven interviewees are counted as random resident interviewees only.

The PCM self reports zero residents who are physically disabled, zero residents with low vision/blindness, or deafness were confined at LCTC during the on-site audit. Likewise, the Director/PCM self reports zero residents who reported sexual abuse during previous confinement were confined at LCTC during the on-site audit and accordingly, those specialty interviews could not be conducted. Of note, pursuant to staff/resident interviews and on-site observations, the auditor found no contradictory evidence with respect to potential specialty questionnaire interviewees.

It is noted the seven 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 interviewees presented reasonable knowledge of PREA policies and practices. Of note, the auditor inquired as to the basis for their knowledge and several interviewees assert they had received training by LCTC staff, as well as, staff at other facilities.

Of note, all 14 random and specialty interviewees assert they feel sexually safe at LCTC.

The auditor notes there are 13 staff currently on board at LCTC. One of the 13 staff was unavailable for interview as the result of days off and accordingly, 12 total staff were available for interviews. Ten random staff selected by the auditor from a staff roster provided by the PCM, were interviewed. In view of the above, the Random Sample of Staff Interview Questionnaire was administered to this sample group of interviewees, as well as, some specialty interviews. 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 resident alleges sexual abuse, and First Responder duties.

The following specialty staff questionnaires were utilized during this review:

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

The auditor notes the Director/PCM was interviewed pursuant to the Director, PREA Coordinator, Incident Review Team, and Retaliation Monitor questionnaires.

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

In addition to the above, the Director/PCM asserts telephone numbers for volunteers are unavailable as the same are not requested in any application documents. Accordingly, the requisite volunteer interviews cannot be facilitated by the auditor. ***The auditor does recommend that telephone numbers be included in any volunteer applicant documentation for access by facility staff, as well as, auditors.

Finally, the auditor contacted the Longmont Police Department on two separate occasions, speaking with investigative staff who referred the requested interview to other investigators. The auditor did not receive any return calls from the proposed interviewees. Accordingly, the auditor is submitting this report absent the criminal investigator interview.

It is noted CC is the umbrella company for LCTC.

The auditor reviewed 10 Staff Training records, 10 resident files, 10 staff HR files, nine PREA investigative files, and other records reflected throughout the following narrative prior to the audit, during the au-

dit, and subsequent to completion of the same. The auditor randomly selected all file reviews, with the exception of investigative files.

On April 19, 2021 the auditor was processed into the facility at the facility Front Entrance/Security Office. Standard security processing was employed. As mentioned in various area(s) of this report, a zero tolerance policy for sexual abuse/harassment and reporting obligations/options, as well as, an “I understand” caveat is included at the top of the Visitation Log page.

During the facility tour, the auditor noted an Ethics Liaison poster (staff private reporting mechanism) was posted in Staff Assembly Area. PREA Audit Notices were prevalent throughout the facility, inclusive of the housing units, pods, program areas, etc.

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/toilet areas), placement of PREA posters and informational resources, security monitoring, and resident programming.

Throughout the tour, the auditor observed numerous PREA posters and informational documents hung on housing unit bulletin boards, in program areas, and in staff offices/gathering places, and in resident rooms. Clearly, residents have access to continual education regarding PREA processes.

The auditor noted ample camera surveillance (24 cameras) in strategic areas, inclusive of programs and operations areas. Residents and staff appear to be easily tracked throughout the facility. It is also noted cameras are positioned in key areas outside buildings and recreation areas.

The auditor observed camera monitoring and mirrors, particularly focusing on camera placements and the degree of resident exposure in their cells and shower areas. Monitors provided the auditor several different views of housing unit/program/operational area cameras and he found no evidence of resident exposure in violation of PREA standards and expectations. There are no cameras in rooms or the loft area and toilet/shower areas. Physical staff supervision is addressed in the narrative for 115.13.

The auditor notes female residents are housed in the front of the facility, near the Security Office. Housing also includes an area known as the loft.

During the tour, the auditor did note properly shielded (shower curtains) shower areas and toilets. In the male bathroom, urinals are exposed however, the auditor notes the same cannot be observed from the entry way. Reportedly, female staff remain in the hallway, as opposed to, entering the bathroom.

Staff offices do not have windows in the door. While the doors are not always open when residents are inside, camera views capture resident and staff traffic in the area.

The LCTC building has two floors. The main floor contains all the resident sleeping rooms, resident laundry area, security office and the Director’s office. The basement floor houses all case management offices, two conference rooms, a large “day room” type area, kitchen, pantry, and walk in cooler.

During the facility tour, the auditor noted a sign on every resident room door reading, "Opposite Gender Must Announce Upon Entry".

Facility Characteristics

The LCTC operates under a contract with Boulder County. LCTC does not hold a direct contract with the Colorado Department of Corrections. The Department of Corrections sends residents back to the county to provide local jurisdictional oversight.

LCTC is a previously converted roller skating rink located in the city of Longmont, CO. The same is located on one of the main streets in the town of Longmont.

The CC Mission Statement reads as follows.

We help government better the public good through:

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

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

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

Summary of Audit Findings

Standards Exceeded

Number of Standards Exceeded: 2
List of Standards Exceeded: 115.231, 115.288

Standards Met

Number of Standards Met: 39

Standards Not Met

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

PREVENTION PLANNING

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

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

115.211 (a)

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

115.211 (b)

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

Auditor Overall Compliance Determination

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

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

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

Pursuant to the PAQ, 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 facility has a written policy which includes definitions of prohibited behaviors regarding sexual abuse and sexual harassment and the policy includes sanctions for those found to have participated in prohibited behaviors. Additionally, the policy includes a description of agency strategies and responses to reduce and prevent sexual abuse and sexual harassment of residents.

CC 14-2 CC entitled Sexual Abuse Prevention and Response, pages 1-30 addresses 115.211(a).

Pursuant to the PAQ, the Director self reports the agency employs or designates an upper-level, agency-wide CoreCivic PREA Coordinator (CCPC) 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 CCPC is in the agency's organizational structure and the auditor verified the same pursuant to review of the CC Organizational Chart.

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

The CCPC reports to the CC Vice President of Core Services. In turn, the Vice President of Core Services reports to the CC Executive Vice President and Chief Corrections Officer. The PCM reports to the Senior Director, Division VII.

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 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 PAQ for sufficiency and comprehensiveness prior to forwarding the same to PREA auditors. The CC Quality Assurance Department (QAD) currently facilitates mock audits of each facility. The CCPC reviews each mock audit report and coordinates corrective action with Wardens and facility PCMs. He posts common audit deficiencies on a shared website so stakeholders can implement 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 LCTC substantially compliant with 115.211.

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

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

115.212 (a)

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

115.212 (b)

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

115.212 (c)

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

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

Auditor Overall Compliance Determination

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

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

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

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

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

Standard 115.213: Supervision and monitoring

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

115.213 (a)

- Does the facility have a documented staffing plan that provides for adequate levels of staffing and, where applicable, video monitoring, to protect residents against sexual abuse?
- X□ Yes □ No In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: The physical layout of each facility? X□ Yes □ No

- In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: The composition of the resident population? X□ Yes □ No

- In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: The prevalence of substantiated and unsubstantiated incidents of sexual abuse? X□ Yes □ No

- In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: Any other relevant factors? X□ Yes □ No

115.213 (b)

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

115.213 (c)

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

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

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

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

Auditor Overall Compliance Determination

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

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

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

Pursuant to the PAQ, the Director self reports the agency develops and documents a staffing plan that provides for adequate levels of staffing, and where applicable, video monitoring to protect residents against sexual abuse. The Director self reports the average daily number of residents since the last PREA audit is 57 and the average daily number of residents on which the staffing plan is predicated is 69.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 7, section D(1)(a-d) addresses 115.213(a). Page 32 of the Colorado Community Corrections Standards, section OMA-020 also addresses the minimum staffing guidelines for community confinement facilities. A minimum of two staff, whose primary duties entail client supervision, must be on shift within the facility at all times.

The Director/PCM asserts the facility does have a staffing plan. Adequate staffing levels and video monitoring to protect residents against sexual abuse are considered in the plan. At least two monitors are assigned per shift with one monitor assigned to the security office at all times. The staffing plan is documented and maintained in the Director's Office as she possesses the only hard copy of the same.

As previously indicated, the staffing plan follows the Colorado Community Corrections Standards, generally coinciding with the daily roster.

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

a. The staffing plan assessment focuses on blind spots and line of sight. Other variables include the size of the facility, physical layout and its impact on effective supervision, and size of the resident population.
b. The transgender/intersex population, gangs (more affiliates than validated members), and ethnic balance trigger no management concerns. There are no staffing plan concerns associated with the resident population.
c. Substantiated and unsubstantiated cases are closely monitored for trends. If trends are identified, we first assess if there are any local measures we can implement to offset the same. For example, re-positioning of cameras or changes in program schedules/staff security rounds may be viable options. If absolutely necessary, staffing or video surveillance increases may be requested through Corporate.
d. There are no other relevant factors under consideration at LCTC at this time.

In regard to daily checks for compliance with the staffing plan, the operations supervisor (os) schedules staffing for all shifts and oversees the daily roster, in conjunction with the Director.

An established protocol is used to fill vacancies. During non-regular business hours, the on-call administrator effects staffing decisions to ensure no vacant security posts, even if he/she personally fills the vacancy. Non-security staff can be detailed to the vacant security post for the shift and overtime may be an option,

generally the last resort however. The operations supervisor is also in the loop to ensure security posts are filled on a daily basis.

LCTC is always compliant with the contract and staffing plan.

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. The Director further self reports there were no instances of deviation from the staffing plan during the last year.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 8, section D(5 and 6) addresses 115.213(b).

The Director asserts all instances of non-compliance with the PREA Staffing Plan would be documented. Specifically, the deviation would be documented in a 5-1 packet as a reportable incident and forwarded to the CCPC and Senior Director, Division 7. The Senior Director for Division 7 is also alerted immediately. The Director self reports there were no instances of deviation from the staffing plan during the last 18 months.

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 7, section D(2)(a-c) addresses 115.213(c). Additionally, Colorado Community Corrections Standards, section OMA-020, addresses 115.213 as referenced in the narrative for 115.213(a).

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

The auditor's review of the April 30, 2019 and June 22, 2020 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 per shift, as previously articulated in the narrative for 115.213(a), are present.

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

Standard 115.215: Limits to cross-gender viewing and searches

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

115.215 (a)

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

115.215 (b)

- Does the facility always refrain from conducting cross-gender pat-down searches of female residents, except in exigent circumstances? (N/A if the facility does not have female residents.) 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 the facility does not have female 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? (N/A if the facility does not have female residents). X□ Yes □ No □ NA

115.215 (d)

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

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

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

115.215 (e)

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

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

115.215 (f)

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

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

Auditor Overall Compliance Determination

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

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

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

Pursuant to the PAQ, the Director self reports cross-gender strip searches or cross-gender visual body cavity searches of the anal or genital opening are not conducted at LCTC. However, as reflected in the policy narrative cited below, the same can be conducted in exigent circumstances. The Director further self reports zero strip or cross-gender visual body cavity searches of residents were conducted at LCTC during the last 12 months.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response in Community Corrections, page 12, section J(3) addresses 115.215(a). Such searches can be completed in exigent circumstances. Exigent circumstances are defined in this policy provision, as well as, the specifics of provision requirements.

The non-medical staff (who may be involved in cross-gender strip or visual searches) interviewee asserts such searches are not facilitated at LCTC. However, in the event a credible source substantiated by other evidence, suggests a resident is known to have secreted drugs in his/her rectum, etc., such searches could be facilitated. The same could be construed as exigent circumstances.

The auditor has found no evidence of cross-gender strip or visual body cavity searches conducted by non-medical staff at LCTC 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 residents' access to regularly available programming or other outside opportunities in order to comply with this provision. In the last 12 months, no female pat-down searches were conducted by male staff.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response in Community Corrections, page 12, section J(1) addresses 115.215(b). Exigent circumstances are defined in this policy provision, as well as, the specifics of provision requirements.

Nine of 10 random staff interviewees assert female residents' access to outside programs or outside opportunities are not restricted if there is insufficient female staff on shift to conduct pat searches. All three female random resident interviewees assert participation in outside activities or programs has not been restricted due to female staff being unavailable to conduct pat-down searches.

The auditor has found no evidence of cross-gender pat searches of female residents conducted by male staff at LCTC during the last 12 months.

Pursuant to the PAQ, the Director self reports facility policy requires all cross-gender strip searches and cross-gender visual body cavity searches are documented. Likewise, facility policy requires that all cross-gender pat-down searches of female residents are documented.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response in Community Corrections, page 13, section J(5) addresses 115.215(c).

The auditor has found no evidence of the conduct of either cross-gender pat searches of female residents or cross-gender strip searches or visual body cavity searches of LCTC residents during the audit period.

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 in Community Corrections, page 13, section J(6)(7)(a-e), (8) and (9) addresses 115.215(d).

All seven random resident (male and female) interviewees self report opposite gender staff announce their presence, by gender, when entering their housing area. All seven interviewees also 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 10 random staff interviewees self report opposite gender staff announce their presence, by gender, when entering housing and shower/toilet areas at LCTC. Similarly, all interviewees self report residents are able to dress, shower, and toilet without being viewed by staff of the opposite gender.

During the facility tour, the auditor observed a notice on every solid 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 on-site audit, wherein opposite gender staff failed to announce their presence (by gender) whenever they entered a housing area or bathroom.

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 13 and 14, section J(10)(a-c) and (h) addresses 115.215(e).

All 10 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 transgender resident interviewee asserts she does not have any reason to believe that she was strip-searched for the sole purpose of determining her genital status.

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

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 14, section J(10)(g)(i-v) and page 6, section C(4) address 115.215(f).

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

In addition to the above, the auditor's review of PREA Training Acknowledgments dated February 7, 2019, January 25, 2019, September 6, 2019, June 28, 2019, November 14, 2019, and August 29, 2019 reveals nine staff completed the aforementioned In-Service PREA Overview class during which the requisite training was provided. The auditor's review of another Orientation form bearing the same date reveals requisite training was provided to one employee completing Orientation training. PREA Training Acknowledgments dated April 29, 2019, May 6, 2019, June 10, 2019, and June 24, 2019 reveal five LCTC staff completed the same class during Orientation. PREA Training Acknowledgments dated January 6, 2020 and May 2, 2020 reveal two staff completed requisite training while one staff completed the same class during Orientation on June 22, 2020.

The auditor's on-site review of 10 random staff training files reveals requisite training was provided in six cases (Pre-Service) and all applicable cases (nine annual In-Service). With respect to four Pre-Service cases, those staff were hired during the previous audit cycle. With respect to the singular staff member who did not complete In-Service training, he/she has not yet completed her first year of employment at LCTC.

The auditor notes the above narrative encompasses staff representative of all disciplines.

All 10 random staff interviewees assert the agency does train staff how to conduct cross-gender pat down searches of female residents and professional and respectful searches of transgender/intersex residents. Nine of 10 interviewees also self report they received the requisite training either during Pre-Service, In-Service training, or both. The auditor notes that file reviews reveal requisite training was provided to staff, inclusive of the one employee who asserts he/she did not receive the same.

In view of the above, the auditor finds LCTC 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/harassment.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 11, section H(6)(a) and (b) addresses 115.216(a).

According to the Agency Head interviewee, the agency has established procedures to provide residents with disabilities and residents who are Limited English Proficient (LEP) equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment. Specifically, LanguageLine is used, when necessary, to communicate with LEP residents. Gen-

erally speaking, staff translators can also be used. TTTY units are available in every facility and Braille is available in some facilities.

The disabled (one cognitively impaired and one mentally challenged), plus one low hearing interviewees self report the facility provides information about sexual abuse/harassment that they are able to understand.

The auditor notes posters are positioned at reasonable heights for physically disabled resident review. Similarly, the Blue Bench pamphlet is posted at a reasonable height wherein the same can be easily reviewed by residents and facility/resident visitors. Additionally, printed materials appear to be written at a reading level appropriate to the resident population.

The Director asserts Google Translator can be accessed for hearing impaired residents. When needed, staff read and explain materials to blind residents and deaf or hard of hearing residents read materials themselves. Staff also read aloud PREA information to mentally incompetent residents.

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

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 11, section H(7) addresses 115.216(b).

The auditor's review of the LanguageLine Solutions contract and instructions reveals substantial compliance with 115.216(b). Additionally, the auditor's review of the PREA: Prevent, Detect, Respond tri-fold brochure is presented in both English and Spanish.

The Limited English Proficient (LEP) interviewee self reports the facility provides information about sexual abuse/harassment that he is able to understand. The auditor notes this interview was facilitated with the assistance of a staff translator.

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 11, section H(8) addresses 115.216(c).

Eight of 10 random staff interviewees were aware of at least one condition under which a resident translator, interpreter, reader, or other resident assistant can be used to assist with translation in the event a disabled or Limited English Proficient (LEP) resident attempts to report sexual abuse. The auditor notes that several interviewees quickly identified the condition(s) following dissection of a scenario. All 10 interviewees self report no such instances of using resident translators pursuant to the circumstances articulated in 115.216(c) have presented during the last 12 months.

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

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

Standard 115.217: Hiring and promotion decisions

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

115.217 (a)

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

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

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

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

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

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

115.217 (b)

- Does the agency consider any incidents of sexual harassment in determining whether to hire or promote anyone who may have contact with residents? X□ Yes □ No

- Does the agency consider any incidents of sexual harassment in determining whether to enlist the services of any contractor, who may have contact with residents? X□ Yes □ No

115.217 (c)

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

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

115.217 (d)

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

115.217 (e)

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

115.217 (f)

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

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

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

115.217 (g)

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

115.217 (h)

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

Auditor Overall Compliance Determination

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

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

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

Pursuant to the PAQ, the Director self reports agency policy prohibits hiring or promoting anyone who may have contact with residents and prohibits enlisting the services of any contractor who may have contact with residents who:

Has engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility, or other institution;
Has been convicted of engaging or attempting to engage in sexual activity in the community facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse; or
Has been civilly or administratively adjudicated to have engaged in the activity described in the above paragraph.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 4, section B(1)(a-c) addresses 115.217(a).

The auditor's review of a new employee application hired on or about January 25, 2021 reveals the requisite 115.217(a) and (b) questions were both asked and answered. The applicant completed a 14-2 CC-H form (Self Declaration of Sexual Abuse/Sexual Harassment), indicating the lack of positive responses to 115.217(a) and (b) questions, on January 18, 2021 and January 25, 2021. Additionally, two documents entitled Colorado Department of Public Safety reveal review and confirmation of employment acceptability following successful completion of a DCJ criminal background record check and a CBI/FBI Employment Fingerprint Card check. CDOC staff effected the determination of employability following successful results as aforementioned.

In addition to the above, the auditor's review of a promotion application regarding an employee who was promoted on October 13, 2019, his/her 14-2 CC-H completed on October 8, 2019, his approval documents for employability as certified by CDOC, and a copy of a 3-20-2B form entitled PREA Questionnaire for Prior Institutional Employers reveals compliance with 115.217(a), (b), (c), and (f). Of note, the 3-20-2B was not addressed by the prior institutional employer as the facility had been closed.

The Director advises there are no contractors on board at LCTC who have contact with residents. LCTC contractors are only used on an "as needed" basis and are never alone with residents. The consistent contractors are laundry machine repair and servicing, vending machines, food delivery for the kitchen, pay phone, and pest control operators. None are ever alone with residents.

It is noted the auditor's on-site random review of one Human Resources (HR) file regarding staff promoted during the last 18 months reveals he/she completed the 14-2H CC in a timely manner and prior to the promotion date. Additionally, criminal background record checks reveal non-existence of 115.217(a) and (b) issues with respect to the promotions.

The auditor's on-site random review of three HR files for staff hired at LCTC during the last 18 months reveals the requisite 14-2H CC form [captures the three115.217(a) questions plus the 115.217(b) question] were completed by the applicants either prior to the date of hire or on the date of hire. Three of five additional random staff file reviews pertained to employees who were hired outside the last 18 month time frame and they completed requisite documents prior to the date of hire. It is noted however, requisite 115.217(a) and (b) questions were asked on the applications for each of the five applicants.

Finally, the auditor's review of two additional random staff HR files relative to staff who were hired either during the last audit period or prior to the same reveals the 14-2H CC has been completed for at least two years. Accordingly, the same is consistent with CC policy.

The auditor notes timely criminal record background record checks also substantiate the lack of 115.217(a) issues in the staff member's history. Additionally, inquiry with prior institutional employers in the only applicable case was met with non-response. Steps to secure requisite information are clearly documented on the form.

The auditor finds compliance with 115.217(a) and (b) is demonstrated.

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 4, section B(2)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 has 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. Pursuant to the applicable PREA provision standard, [115.217(h)], there is an expectation of response regarding PREA issues.

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

The auditor's review of one Form 3-20-2B reveals LCTC is substantially compliant with 115.217(b) as an attempt to secure requisite information was made by Human Resources (HR) staff. As previously mentioned, the auditor notes there was a non-response from the prior institutional employer.

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 also 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 (a) 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 four applicants were hired during the last 12 months who may have contact with residents and all have had criminal background record checks.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 5, sections B(7) and (8) address 115.217(c).

Pursuant to on-site review, the auditor's review of eight random staff HR files (all applicable to new hires during this audit period) reveals that timely criminal background record checks were completed in all cases (completed prior to the date of hire).

The specifics regarding the one prior institutional employer questionnaire are clearly articulated in the narrative for 115.217(a). The auditor finds LCTC substantially compliant with 115.217(c) based on performance.

The HR interviewee asserts the facility performs criminal background record checks and considers pertinent civil or administrative adjudications for all newly hired employees who may have contact with residents. The practice, as described by the HR interviewee, is clearly articulated in the narrative for 115.217(a).

This narrative also addresses procedural processing of criminal background record checks regarding promotions and contractors.

Pursuant to the PAQ, the Director self reports agency policy requires a criminal background record check is completed before enlisting the services of any contractor who may have contact with residents. The Director further self reports there were zero contracts for services wherein a criminal background record check was conducted during the last 12 months. As previously indicated in the narrative for 115.217(a), there are no contractors within the context of 115.217 or 115.232 at LCTC.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 5, section B(7)addresses 115.217(d).

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

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 5, section B(7) addresses 115.217(e).

The auditor's review of a spreadsheet utilized by Human Resources (HR) staff reveals that the same captures the five-year re-investigation update.

The HR interviewee asserts CC tracks 5-year reinvestigation needs. Generally, the same is tracked via spread sheet and an alert signifies the need for re-investigation. Re-investigations are requested by CC staff to the CDCJ representative.

The auditor's on-site review of two random staff five-year re-investigations reveals substantial compliance with 115.217(e).

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, pages 4 and 5, sections B(3-5) addresses 115.217(f).

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

The auditor also notes the three 115.217(a) and one 115.217(b) questions are reflected in both the new employee and promotion applications.

Pursuant to on-site review of 10 random staff files, the auditor notes that in six applicable cases (those wherein the staff member was hired prior to 2019), the 14-2H CC was completed for at least two years.

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) as an applicant (asked separate from the application), at the interview, and following hire. Additionally, staff are asked the same questions on an annual basis and during the promotion phase. The 14-2H CC is completed annually as of calendar year 2018, to encompass the performance evaluation process and affirmative duty to report. Of note, the affirmative duty to report caveat is also reflected on the 14-2H CC.

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

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 5, section B(6) addresses 115.217(g) in totality.

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

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 5, section B(9) addresses 115.217(h) in totality.

According to the Director, during the last 12 months, zero requests for information were received from an institutional employer, to whom a CC or ex-CC employee has applied to work, relative to substantiated allegations of sexual abuse or sexual harassment.

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

In view of the above, the auditor finds LCTC 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 date of the last PREA audit.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, pages 8, section E(1) and (2) addresses 115.218(a).

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 inmate 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.

Pursuant to the PAQ, the Director self reports the facility has installed three cameras since the last PREA audit.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 8, section E(3) addresses 115.218(b).

According to the Director, the Form 7-1B is not available regarding the installation of the three additional cameras at LCTC. The Director asserts the camera needs were identified as part of a Capex project and the request was subsequently approved. The auditor's review of two purchasing documents, as well as, a facility diagram reflective of the locations of the three cameras reveals substantial compliance with 115.218(b).

In view of the above, the auditor finds LCTC 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)? □ Yes □ No

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

115.221 (d)

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

- If a rape crisis center is not available to provide victim advocate services, does the agency make available to provide these services a qualified staff member from a community-based organization, or a qualified agency staff member? (N/A if agency *always* makes a victim advocate from a rape crisis center available to victims.) X□ Yes □ No □ NA

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

115.221 (e)

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

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

115.221 (f)

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

115.221 (g)

- Auditor is not required to audit this provision.

115.221 (h)

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

Auditor Overall Compliance Determination

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

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

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

Pursuant to the PAQ, the Director self reports the facility is responsible for conducting administrative sexual abuse investigations (including resident-on-resident sexual abuse or staff sexual misconduct). The Director further self reports the Longmont Police Department (LPD) facilitates criminal investigations relative to LCTC residents. When conducting a sexual abuse investigation, the agency investigators follow a uniform evidence protocol. This caveat is articulated in the MOU between LPD and CC.

The Director asserts she has been working with LPD to update the existing MOU regarding the conduct of criminal sexual abuse investigations. The auditor's review of the outdated and updated MOUs reveals substantial compliance with 115.221(a). By virtue of emails dated May 12, 2020, January 26, 2021, and April 9, 2021, it is clear the Director has attempted to resolve this matter. At this point, there is no signature by both parties.

All 10 random staff interviewees assert they know and understand the agency's protocol for obtaining usable physical evidence if a resident alleges sexual abuse. The responses regarding first responder duties essentially encompass evidence preservation. LPD investigators conduct criminal investigations

and they are responsible for physical evidence collection while all staff are responsible to secure the crime scene and guard against destruction of physical evidence by the victim and perpetrator.

Six of 10 random staff interviewees were able to correctly identify all four tasks as cited at 115.264(a). The majority of misinformation centers on telling or ensuring both the victim and perpetrator do not destroy physical evidence, as opposed to, requesting that the victim and ensuring the perpetrator doesn't destroy physical evidence.

Nine of 10 random staff interviewees assert the Director facilitates administrative sexual abuse/harassment investigations and all 10 interviewees assert LPD investigators facilitate criminal investigations.

Pursuant to the PAQ, the Director self reports no youth are housed at LCTC and accordingly, that component of 115.221(b) is not applicable to the facility. The Director further self reports the protocol was adapted from or is otherwise based on the most recent edition of the DOJ's Office on Violence Against Women publication, "A National Protocol for Sexual Assault Medical Forensic Examinations, Adults/ Adolescents, " or similarly comprehensive and authoritative protocols developed after 2011.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 24, section O(b) addresses 115.221(b).

Pursuant to the PAQ, the Director self reports the facility offers to all residents who experience sexual abuse access to forensic medical examinations. Forensic medical examinations are offered without financial cost to the victim.

Where possible, examinations are conducted by SAFE/SANE Nurse Examiners. When SAFE/SANE Nurses are unavailable, a qualified medical practitioner performs forensic medical examinations.

Although an MOU is a work in progress with U. C. Health, if the situation arose, efforts to provide SANEs would be documented. 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 19, section M(11) addresses 115.221(c).

The Director asserts she has been working with UC Health to update the existing MOU regarding the conduct of SANE examinations. The auditor's review of the updated MOU reveals substantial compliance with 115.221(a) and 115.283. By virtue of emails dated May 12, 2020, January 26, 2021, and April 9, 2021, it is clear the Director has attempted to resolve this matter. At this point, there is no signature by both parties.

The SANE Nurse interviewee asserts she is one of a team of 12-15 SANE nurses responsible for conducting all forensic medical examinations at U.C. Health. Forensic examinations for LCTC residents are conducted at U.C. Health facilities.

Three in-house SANEs cover relevant facilities daily and 12 on-call SANEs augment services. The interviewee advises a 64 hour didactic training is provided to SANEs, inclusive of on-line work and the conduct of supervised (by the departmental manager) in-person examinations. This program is extracted from a State curriculum.

SANEs are available twenty-four hours per day, either in-house or on-call. In the event of non-availability, the manager provides back-up.

SANE examinations include a urine pregnancy scan for females who have been vaginally abused; provision of informational materials regarding pregnancy care and treatment options, if requested; tests for sexually transmitted infections; and provision of prophylaxis, if warranted pursuant to the findings.

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 CC and the Blue Bench (BB) dated October 7, 2019.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 19, section M(12) addresses 115.221(d).

The auditor's review of another sexual abuse investigation surrounding an incident that occurred on June 11, 2019 reveals the victim declined victim advocacy. The same is denoted on an investigative document entitled Checklist for Sexual Abuse/Penetration Cases.

The auditor's review of an investigation regarding an incident of sexual abuse occurring on February 3, 2021 reveals substantial compliance with 115.221(d). Specifically, the victim requested victim advocate (VA) services in conjunction with the substantiated abuse and the Blue Bench provided the same.

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

According to the Director/PCM, victim advocacy services are available to LCTC residents pursuant to an MOU with the BB. BB information is posted within the facility.

The auditor verified victim advocate (VA) credentials pursuant to review of the Blue Bench website. It is recommended that the Director/PCM discuss VA credentialing with executives from the Blue Bench.

One resident who reported a sexual abuse interviewee asserts the Director advised him of VA availability however, he never followed up with the Blue Bench. The second interviewee reports she was advised regarding VA availability and she followed up with a Blue Bench VA. The interviewee reports she was provided with an application and resources. The victim did not request counseling as she already has a counselor.

Pursuant to the PAQ, the Director self reports if requested by the victim, a VA 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 19, section M(13) addresses 115.221(e).

The Director/PCM asserts, if requested by the victim, a victim advocate is accessed through BB to accompany the victim and provide emotional support, crisis intervention, information, and referrals during the forensic medical examination process and investigatory interviews. This is addressed in the BB MOU.

As reflected throughout this narrative, the LCTC Investigator facilitates administrative sexual abuse/harassment investigations. Accordingly, the auditor finds 115.221(f) not-applicable to LCTC.

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

Standard 115.222: Policies to ensure referrals of allegations for investigations

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

115.222 (a)

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

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

115.222 (b)

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

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

- Does the agency document all such referrals? X□ Yes □ No

115.222 (c)

- If a separate entity is responsible for conducting criminal investigations, does the policy describe the responsibilities of both the agency and the investigating entity? (N/A if the agency/facility is responsible for conducting criminal investigations. See 115.221(a).) X□ Yes □ No □ NA

115.222 (d)

- Auditor is not required to audit this provision.

115.222 (e)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

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

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

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

Pursuant to the PAQ, the Director self reports the agency ensures an administrative or criminal investigation is completed for all allegations of sexual abuse and sexual harassment (including resident-on-resident sexual abuse and staff sexual misconduct). In the last 12 months, two allegations of sexual abuse/harassment were received and both were investigated administratively and criminally. Both investigations were completed.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 22, section N(1) addresses 115.222(a).

According to the Agency Head interviewee, an administrative or criminal investigation is completed for all allegations of sexual abuse or sexual harassment. Administrative investigations are completed by a

PREA trained investigator and whenever the Inspector General (IG) arm of the partner is tasked with facilitation of criminal investigations, they are generally PREA trained pursuant to the contract.

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

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

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

The auditor's review of the two administrative investigations alluded to above, reveals substantial compliance with 115.222(a). The investigation takes the form of an electronically generated CC Incident Report, accompanied by an electronic investigative 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 18, section M(9) and page 23, section O(1) address 115.222(b).

The investigative staff interviewee asserts agency policy requires allegations of sexual abuse/harassment be referred for investigation to an agency with the legal authority to conduct criminal investigations, unless the allegation does not involve potentially criminal behavior. LPD sexual abuse investigators conduct criminal investigations at LCTC.

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

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 23, section O(2) and (3) addresses 115.222(c). 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.

In view of the above, the auditor finds LCTC 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 right to be free from sexual abuse and sexual harassment;
4) The right of residents and employees to be free from retaliation for reporting sexual abuse and sexual harassment;
5) The dynamics of sexual abuse and sexual harassment in confinement;
6) The common reactions of sexual abuse and sexual harassment victims;
7) How to detect and respond to signs of threatened and actual sexual abuse;
8) How to avoid inappropriate relationships with residents;
9) How to communicate effectively and professionally with residents, including lesbian, gay, bisexual, transgender, 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 5 and 6, section C(2)(a-j) addresses 115.231(a).

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

The auditor's review of PAQ Pre-Service and In-Service CORECIVIC PREA POLICY ACKNOWLEDGMENT AND/OR TRAINING ACKNOWLEDGMENT forms reveals one staff member was provided In-Service PREA Overview training during 2019. This document includes the "I understand the subject-matter presented" caveat and is signed/dated by the employee participant.

In addition to the above, a Training Activity Enrollment/Attendance Roster reflects 36 staff completed Gender Responsive and Trauma Informed Care In-Service training classes conducted on August 12, 13, 18, and 19, 2020.

Training Activity Enrollment/Attendance Rosters dated 1/14/19, 6/10/19, and 6/24/19 reveal four staff completed Orientation PREA training on the respective dates. Additionally, CORECIVIC PREA POLICY AC-

KNOWLEDGMENT AND/OR TRAINING ACKNOWLEDGMENT forms validate these four staff understand the PREA Orientation subject-matter. Six CORECIVIC PREA POLICY ACKNOWLEDGMENT AND/OR TRAINING ACKNOWLEDGMENT forms further reveal six staff completions of PREA In-Service training during 2019.

The same types of documents validate two staff completed PREA Orientation during 2020. Eleven staff completed PREA In-Service training during 2020.

In addition to the above, the same types of documents validate one staff member completed PREA Orientation during 2021. Three staff completed PREA In-Service training during 2021.

The auditor's review of 10 random staff training files reveals two staff hires within the last 12 months received pre-service PREA training on their entry-on-duty date or during the first week following their entry-on-duty date. Seven files reflect affected staff members received at least two consecutive PREA Annual Refresher Training (ART- In-Service) trainings.

All 10 random staff interviewees self report they received training regarding the aforementioned 10 PREA topics either during Pre-Service and/or PREA ART training.

Pursuant to the PAQ, the Director self reports training is tailored to the male and female genders of the residents housed at the facility. Employees who are reassigned from facilities housing the opposite gender are given additional training.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 5, section C(1) addresses 115.231(b).

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

The auditor's review of one each of the documents mentioned in the narrative for 115.231(a) reveals the transferring employee completed requisite 115.231(b) training on April 13, 2021.

Pursuant to the PAQ, the Director self reports 11 staff, who may have contact with residents, were trained or retrained in PREA requirements. This equates to 100% of the staff complement. If there are any policy updates in regard to PREA matters, staff are trained on the policy during staff meetings.

Employees who may have contact with residents receive PREA training on an annual basis. Given the fact 115.231(c) requires refresher training every two years to ensure all employees know the agency's current sexual abuse/harassment policies and procedures and the fact LCTC facilitates annual PREA ART, the auditor finds LCTC exceeds standard requirements with respect to this provision.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, pages 5 and 6, section C(2) addresses 115.231(c).

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

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 6, section C(3) addresses 115.231(d).

The auditor's on-site review of staff training files, as reflected in the narrative for 115.231(a), reveals staff signed and dated the requisite Core Civic PREA Policy Acknowledgment and/or Training Acknowledgment forms acknowledging their understanding of the subject-matter presented for 2018, 2019, and/or 2020. Additionally, training participants sign CC training rosters. Accordingly, the auditor finds LCTC substantially compliant with 115.231(d).

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

Standard 115.232: Volunteer and contractor training

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

115.232 (a)

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

115.232 (b)

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

115.232 (c)

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

Auditor Overall Compliance Determination

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

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

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

Pursuant to the PAQ, the Director self reports all volunteers and contractors who have contact with residents are trained on their responsibilities under the agency's policies and procedures regarding sexual abuse/harassment prevention, detection, and response. The Director further self reports nine trained volunteer(s) are recognized for provision of services at LCTC. As previously noted in the narrative for 115.17, zero unescorted contractors provide services at LCTC.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 6, section C(8) addresses 115.232(a).

The auditor's review of the CC Volunteer Orientation video reveals substantial compliance with 115.232. The same provides sufficient information and background enabling all contractors/volunteers to fulfill their PREA responsibilities.

The auditor notes volunteers and contractors have not been granted access to the facility during the last 12 months in view of COVID-19 restrictions. According to the Director/PCM, telephone numbers for volunteers are unavailable as the same are not requested in any application documents. Accordingly, the requisite volunteer interviews cannot be facilitated by the auditor. ***The auditor does recommend that telephone numbers be included in any volunteer applicant documentation.

The auditor's review of two completed CORECIVIC Zero Tolerance Policy- Prohibited Sexual Behaviors documents reveals two volunteers signed and dated the same, acknowledging review of the comprehensive document and understanding of the same. The document addresses all facets of 115.232.

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

Pursuant to the PAQ, the Director self reports the level and type of training provided to volunteers and contractors is based on the services they provide and level of contact they have with residents. The Director further self reports volunteers, 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 7, section C(8)(b)(1) and (2) addresses 115.232(b).

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

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 7, section C(8)(d) addresses 115.232(c).

In view of the above, the auditor finds LCTC 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 the 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 further self reports 150 residents were provided requisite information at intake during the last 12 months, equating to 100% of residents admitted during the last 12 months who were provided this information at intake.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 10 and 11, section H(1)(a-e) addresses 115.233(a).

The intake staff interviewee self reports he/she provides residents with information about the CC and LCTC zero-tolerance policy and how to report incidents or suspicions of sexual abuse or sexual harassment, at intake. This information is presented in the PREA video, an intake packet CC tri-fold pamphlet, and the Resident handbook. The interviewee asserts he reads relevant provisions of the PREA pamphlet to residents. Orientation instruction is generally provided following arrival. The interviewee also asserts PREA documentation is posted throughout the facility.

All seven random resident interviewees self report they received information about the facility's rules against sexual abuse/harassment during intake. All seven random resident interviewees self report they were told about the following when they arrived at CTC:

Their right not to be sexually abused or sexually harassed;
How to report sexual abuse or sexual harassment; and
Their right not to be punished for reporting sexual abuse or sexual harassment.

All seven interviewees self report they received the information on the date of arrival. Interviewees confirmed the materials provided to them were consistent with staff assertions as reflected above. Of note, three of the seven interviewees reported receipt of the Blue Bench pamphlet, in addition to the aforementioned, during intake.

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

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

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

A signed and dated (by the resident) PREA Orientation form addresses zero tolerance for sexual abuse/harassment, reporting options, and rape crisis counseling. The same also stipulates the resident viewed the PREA video, received a PREA Orientation, and the PREA: Prevent. Detect. Respond brochure. Additionally, a completed 2020 Resident Intake Orientation and Case Manager Orientation Checklist reveals the respective resident reviewed the PREA video and signed and dated the aforementioned PREA Acknowledgment.

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

The auditor's on-site review of three of seven random interviewee and seven additional resident files reveals requisite information was received on the date of arrival. Review of records further validates orientation was received in all cases on the date of arrival at the facility.

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 LCTC from a different community confinement facility within the last 12 months and they have received refresher training.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 11, section H(5)addresses 115.233(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.

Four of seven random resident interviewees reported being transferred to LCTC from state correctional facilities or county jail(s).

All incoming residents were provided PREA education as described in the narrative for 115.233(a). One PREA Advisement and one PREA Orientation form (relative to the same resident received from another community confinement facility) validates 115.233(a) and (b) compliance.

The auditor's review of three of seven random resident interviewee files validates their self reports, as previously mentioned. All three files reveal the resident received timely and comprehensive PREA education pursuant to 115.233(a).

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 11, section H(2) addresses 115.233(c).

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

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

Substantiating documentation is referenced in the narrative for 115.233(a) above. Executed documents, as discussed above, are applicable to one resident, in addition to the on-site random resident file reviews.

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

The auditor's review of numerous documents referenced throughout the narrative for 115.233 reveals substantial compliance with 115.233(e). Additionally, the auditor's review of one poster submitted with PAQ information reveals zero tolerance towards resident-on-resident sexual abuse/harassment, reporting options, and information regarding rape crisis counseling is contained therein. Four additional posters address staff-on-resident sexual abuse.

The auditor validated the preceding statement during the facility tour. Posters are positioned in strategic locations throughout the facility.

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

Standard 115.234: Specialized training: Investigations

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

115.234 (a)

- In addition to the general training provided to all employees pursuant to §115.231, does the agency ensure that, to the extent the agency itself conducts sexual abuse investigations, its investigators receive training in conducting such investigations in confinement settings? (N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.221(a).)

  X□ Yes □ No □ NA

115.234 (b)

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

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

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

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

115.234 (c)

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

115.234 (d)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

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

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

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

Pursuant to the PAQ, the Director 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 6, section C(5) addresses 115.234(a).

The auditor's review of the training syllabus for the National Institute of Corrections (NIC)/PREA Resource Center (PRC) course entitled PREA: Investigating Sexual Abuse in Confinement Settings addresses the requirements of 115.234(a) and (b).

According to the investigative staff interviewee, he completed a three hour on-line NIC training course entitled PREA: Conducting Sexual Abuse Investigations in a Confinement Setting. Some scenario based training was included in the same.

The course included topics such as interviewing techniques relative to victims in a confinement setting, execution of Miranda and Garrity warnings, evidence collection in sexual abuse cases, and the evidence standard necessary to substantiate a case for administrative action or prosecution referral.

In addition to the above, the interviewee asserts he observed the Director facilitate a sexual abuse investigation. While not extensive, he did observe some of the interview process.

The auditor's review of three NIC certificates reveals three (two LCTC staff and the Division Managing Director) have completed the NIC course entitled PREA: Investigating Sexual Abuse in a Confinement Setting course.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 6, section C(5)(a) addresses 115.234(b).

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

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 6, section C(5)(b) addresses 115.234(c).

Documentation substantiating completion of requisite training is addressed in the narrative for 115.234(a).

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

Standard 115.235: Specialized training: Medical and mental health care

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

115.235 (a)

- Does the agency ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in: How to detect and assess signs of sexual abuse and sexual harassment? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners who work regularly in its facilities.)
  □ Yes □ No X□ NA

- Does the agency ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in: How to preserve physical evidence of sexual abuse? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners who work regularly in its facilities.) □ Yes □ No X□ NA

- Does the agency ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in: How to respond effectively and professionally to victims of sexual abuse and sexual harassment? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners who work regularly in its facilities.) □ Yes □ No X□ NA

- Does the agency ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in: How and to whom to report allegations or suspicions of sexual abuse and sexual harassment? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners who work regularly in its facilities.)
  □ Yes □ No X□ NA

115.235 (b)

- If medical staff employed by the agency conduct forensic examinations, do such medical staff receive appropriate training to conduct such examinations? (N/A if agency does not employ medical staff or the medical staff employed by the agency do not conduct forensic exams.)

  □ Yes □ No X□ NA

115.235 (c)

- Does the agency maintain documentation that medical and mental health practitioners have received the training referenced in this standard either from the agency or elsewhere? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners who work regularly in its facilities.) □ Yes □ No X□ NA

115.235 (d)

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

- Do medical and mental health care practitioners contracted by and volunteering for the agency also receive training mandated for contractors and volunteers by §115.232? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners contracted by or volunteering for the agency.) □ Yes □ No X□ NA

Auditor Overall Compliance Determination

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

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

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

Pursuant to the PAQ, the Director self reports the agency has a policy related to the training of medical and mental health practitioners who work regularly in its facilities. However, no medical or mental health staff work at LCTC.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 6, section C(6)(a-e) addresses 115.235(a).

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

In view of the above, the auditor finds LCTC 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 9, section G(1) addresses 115.241(a).

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

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

The auditor's on-site review of 10 random resident files reveals sexual victimization/sexual abusiveness screening was conducted in a timely and comprehensive manner in all cases.

The auditor observed the office wherein new commitments are screened and finds no evidence of deviation from standard or policy as a result.

Pursuant to the PAQ, the Director self reports 115.241(a) screening shall ordinarily take place within 72 hours of arrival at the facility. The below policy requires that screening is conducted within 24 hours of arrival at LCTC. The Director self reports during the last 12 months, 148 residents entering the facility (either through intake or transfer) whose length of stay in the facility was 72 hours or more, were screened for risk of sexual victimization or risk of sexually abusing other residents, within 72 hours of their entry into the facility. This equates to 100% of residents admitted to the facility during the last 12 months, for 72 hours or more.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, pages 9, section G(2) addresses 115.241(b).

The auditor notes 150 residents were received at LCTC during the last 12 months while the PAQ also reflects 148 residents were initially screened during that same period. The Director/PCM reports the other two residents were returned to custody within 24 hours of arrival and accordingly they were not screened.

The auditor's review of one each initial assessment and a corresponding 30-day reassessment, conducted during 2019, 2020, and 2021 reveals substantial compliance with 115.241(b). CoreCivic policy requires completion of the initial assessment within 24 hours of arrival and the same was comprehensive/timely. Two of the three reassessments (exception is the 2019 reassessment) were likewise comprehensive and timely.

Pursuant to the 115.241(a) narrative, the auditor's on-site review of 10 random resident files reveals timely and comprehensive completion of initial victimization/aggressor screenings within 24 hours of arrival at the facility. Review of 30-day reassessments related to the same residents reveals one was untimely (within ten days of the due date), eight were completed in a timely manner, and one was not yet due in view of the recency of arrival at LCTC.

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

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 9, section G(3) 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 non-conforming;
8) Whether the resident has previously experienced sexual victimization; and
9) The resident's own perception of vulnerability.

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

1) Whether the resident has a mental, physical, or developmental disability;
2) Whether the resident has previously experienced sexual victimization;
3) Whether the resident has previously been incarcerated;
4) Whether the resident's criminal history is exclusively nonviolent;
5) Whether the resident has prior convictions for sex offenses against an adult or child; and
6) Whether the resident is or is perceived to be gay, lesbian, bisexual, transgender, intersex, or gender non-conforming.

According to the interviewee who conducts such assessments, a pre-screening packet is reviewed by the screener prior to the conduct of the screening. If there are discrepancies between the resident's statements and the pre-screening packet, improprieties are documented in resident responses within the screening tool. The client is taken to the back security office with the door closed. There is a window in the office and accordingly, one can observe the process. The interview is conducted one-on-one and she reads the questions to the resident, documenting responses. Additionally, the interviewee provides the Advisement during the screening process.

Following completion of the screening, the PREA video is shown and the Case Manager Orientation ensues.

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

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 9, section G(5) addresses 115.241(e).

Pursuant to the PAQ, the Director self reports the policy requires the facility to reassess 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 (until the date on which the PAQ was completed), 120 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 asserts 33 residents were housed at the facility for less than 30 days. 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 10, section G(12) addresses 115.241(f).

The auditor's review of a document entitled PREA Tracker reveals an electronic method in which LCTC staff track the date of arrival, intake date, 24 hour date, and 30-day reassessment date.

According to the staff who performs screening for risk of victimization and abusiveness interviewee, re-assessments are conducted within 30 days of arrival at LCTC by case managers and then annually there-

after. She documents due dates on her Day Planner and white board. She completes reassessments within 25-30 days of arrival at LCTC.

Two of seven random resident interviewees report they were asked the questions reflected in the narrative for 115.241(a) above since arrival at LCTC. The questions were allegedly asked within 30 days of arrival at the facility. Of note, one additional reassessment was not yet due as of the dates of the on-site audit.

The auditor's review of two of four resident files related to those interviewees who assert they were not re-assessed at LCTC reveals one reassessment was conducted in an untimely manner (outside the prescribed 30-day window). Two applicable interviewee files were not reviewed at the time of the on-site audit.

Pursuant to the PAQ, the Director self reports policy requires 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 10, section G(13 and 14) addresses 115.241(g).

According to the Director, additional sexual abuse or sexual victimization information has not been received regarding residents during the last 18 months which triggered a re-assessment pursuant to the parameters of 115.241(g). However, the auditor's review of a sexual abuse investigation revealed the allegation was substantiated. The auditor's review of the victim's victimization/aggressor reassessment with respect to the incident reveals substantial compliance with 115.241(g). The perpetrator had been removed from the facility based on safety issues and accordingly, his reassessment was not possible.

The staff responsible for risk screening interviewee relates she knew she had to reassess the resident referenced in the preceding paragraph and she did so accordingly.

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

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

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 10, section G(7) addresses 115.241(h).

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

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

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 10, section G(10)(a-d) addresses 115.241(i).

According to the LCTC Director/PCM, the agency has outlined who should have access to a resident's risk assessment within the facility in order to protect sensitive information from exploitation. Initial PREA Assessment information is available to all staff on the LCTC intranet via the shared drive. Access to this sys-

tem is password protected. The Director advises she feels comfortable with this distribution and the ability to protect sensitive information from exploitation as all staff have a "Need to Know".

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

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

Standard 115.242: Use of screening information

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

115.242 (a)

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

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

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

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

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

115.242 (b)

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

115.242 (c)

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

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

115.242 (d)

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

115.242 (e)

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

115.242 (f)

- Unless placement is in a dedicated facility, unit, or wing established in connection with a consent decree, legal settlement, or legal judgment for the purpose of protecting lesbian, gay, bisexual, transgender, or intersex residents, does the agency always refrain from placing: lesbian, gay, and bisexual residents in dedicated facilities, units, or wings solely on the basis of such identification or status? (N/A if the agency has a dedicated facility, unit, or wing solely for the placement of LGBT or I residents pursuant to a consent decree, legal settlement, or legal judgement.) X□ Yes □ No □ NA

- Unless placement is in a dedicated facility, unit, or wing established in connection with a consent decree, legal settlement, or legal judgment for the purpose of protecting lesbian, gay, bisexual, transgender, or intersex residents, does the agency always refrain from placing: transgender residents in dedicated facilities, units, or wings solely on the basis of such identification or status? (N/A if the agency has a dedicated facility, unit, or wing solely for the placement of LGBT or I residents pursuant to a consent decree, legal settlement, or legal judgement.) X□ Yes □ No □ NA

- Unless placement is in a dedicated facility, unit, or wing established in connection with a consent decree, legal settlement, or legal judgment for the purpose of protecting lesbian, gay, bisexual, transgender, or intersex residents, does the agency always refrain from placing: intersex residents in dedicated facilities, units, or wings solely on the basis of such identification or status? (N/A if the agency has a dedicated facility, unit, or wing solely for the placement of LGBT or I residents pursuant to a consent decree, legal settlement, or legal judgement.) X□ Yes □ No □ NA

Auditor Overall Compliance Determination

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

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

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

Pursuant to the PAQ, the Director self reports the facility uses information from the risk screening to inform housing, bed, work, education, and program assignments with the goal of keeping separate those residents at high risk of being sexually victimized from those at high risk of being sexually abusive.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 11, section I(1) addresses 115.242(a-g).

The Director/ PCM asserts the agency uses information gleaned from the risk screening during intake to keep residents safe from being sexually victimized or sexually abusive. This information is used primarily with housing decisions as the facility is open in terms of structure, etc. Potential and known victims (PVs/

KVs) are separated from potential and known abusers (PAs/KAs). Residents classified as "NA" may be placed with PVs/KVs or PAs/KAs.

Each resident is keyed into a grid reflecting the aforementioned designations. This ensures placements are specific to resident sexual safety. Additionally, resident housing assignments are documented on a white board located in the security office area.

Staff supervise residents during the conduct of programs. Sexual offenders are monitored relative to safe community work assignments.

According to the staff who performs screening for risk of victimization and abusiveness interviewee, PVs/KVs are physically separated (housing only) from PAs/KAs in terms of housing. Any classification can be housed with an individual who scores as "NA". Programming activities are supervised by staff and work assignments are generally off-site.

The auditor's review of a housing schematic (date unknown) entitled Correct Tech PREA Notes reveals consistency in terms of geographic separation (by room) of KVs/PVs and KAs/PAs. Additionally, the auditor's review of one initial victimization/abuser assessment (scored as NA) compared against the above document, reveals the individual is housed pursuant to 115.242(a).

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

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 12, section I(3) addresses 115.242(b).

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 12, section I(7)(b) addresses 115.242(c).

The Director/PCM asserts all incoming residents are placed in a sexually safe situation based on screening results. PVs/KVs and PAs/KAs are housed with NAs or the same classification can be housed together. However, KVs/PVs are not housed with KAs/PAs.

There are no designated location(s) for transgender/intersex resident housing. Room assignments are based on careful matching to ensure assignments are properly made pursuant to the aforementioned formula. Programming is supervised by staff.

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 concerns.

The transgender interviewee reports she has been asked questions about her safety in terms of housing, programming, and work. Additionally, she has not been placed in a housing area designated only for transgender or intersex residents nor has she been strip-searched for the sole purpose of determining genital status.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 12, section I(7)(c) addresses 115.242(d).

The Director/PCM asserts the transgender/intersex resident's own views with respect to his/her own safety are given serious consideration in placement and programming assignments.

The staff who conducts screening for risk of victimization and abusiveness interviewee confirms the PCM's statement in this regard.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 14, section J(10)(h)(i-iii) addresses 115.242(e).

According to the Director/PCM, transgender and intersex residents are given the opportunity to shower separately from other residents. Showers can be provided in the staff shower located near the security office.

The staff responsible for risk screening interviewee asserts that the resident can alert staff she is ready to shower at a predetermined time. In that instance, security staff clear the bathroom/shower and the same is subsequently monitored by staff.

During the facility tour, the auditor examined the shower, in question, and finds the same to provide adequate security and safety to the user.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 12, section I(7)(d) addresses 115.242(f).

The Director/PCM asserts the facility is not subject to a consent decree, legal settlement, or legal judgment requiring that it establish a dedicated facility, unit, or wing for LGBTI residents. The Director/PCM further asserts she and the os closely monitor the aforementioned grid on a daily basis to preclude placement of LGBTI residents in specific locations, etc.

Transgender and bisexual resident interviewees report they are not housed in specific wings, units, etc.

The auditor's cursory review of room/bed assignments reveals no deviation from standard.

In view of the above, the auditor finds LCTC 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 that occurred in any facility;

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, page 15, section K(1)(a and b)(i-iii) addresses 115.251(a).

The auditor's review of the CoreCivic Resident Handbook, PREA Advisement, and CoreCivic PREA- Prevent. Detect. Respond. tri-fold pamphlet reveals multiple methods for private resident reporting of sexual abuse and sexual harassment incidents and is also available in Spanish.

All 10 random staff interviewees are able to cite at least two methods available to residents for reporting sexual abuse/harassment, retaliation by other residents/staff for reporting sexual abuse/harassment, or staff neglect/violation of responsibilities that may have contributed to an incident of sexual abuse/harassment. Methods of reporting include the Hotline (DOC TIPS Hotline), verbal report to staff, call LPD, submit anonymous note, submit an Emergency Grievance, contact the CC Ethics Line, and facilitation of a third-person report.

All seven random resident interviewees are able to cite at least one method available to them to report. Options include a verbal report to staff, contact the Hotline (DOC TIPS), submit a kite to staff, submit an Emergency Grievance.

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

Pursuant to the PAQ, the Director self reports the agency provides at least one way for residents to report sexual abuse or sexual harassment to a public or private entity or office that is not part of the agency.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 15, section K(1)(c) addresses 115.251(b).

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

According to the Director/PCM, the DOC-TIPS Line serves as one way for residents to report sexual abuse/harassment to a public or private entity or office that is not part of the agency. Operators are CDOC employees. As there has been no incidents (within the last 12 months) wherein sexual abuse incidents were reported via the DOC-TIPS Line, the Director/PCM asserts the timeline for TIPS-Line reporting to the Director is unknown. This service is offered pursuant to CDOC contract.

All seven random resident interviewees assert they are allowed to make a report without having to give their name.

The auditor did test the DOC-TIPS-Line on May 6, 2021, making contact with a recorded voice. He advised of the test of the Hotline and was subsequently notified of receipt of the test call, in a timely manner during the morning hours of May 7, 2021, by DOC-TIPS Line staff.

In addition to the above, the auditor noted a DOC-TIPS Line reporting notice is posted in each resident room.

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 also self reports staff are required to document verbal reports "immediately" following receipt of the same.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 15, section K(2)(b) addresses 115.251(c).

All 10 random staff interviewees assert when a resident alleges sexual abuse, he/she can do so verbally, in writing, anonymously, and from third parties. Eight of 10 interviewees assert they immediately document any verbal reports of sexual abuse/harassment received from residents.

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

Pursuant to the PAQ, the Director self reports the agency has established procedures for staff to privately report sexual abuse and sexual harassment of residents. Of note, the telephone number for the 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 and Compliance 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 K(2)(f) addresses 115.251(d).

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

All 10 random staff interviewees are able to cite at least two methods of privately reporting sexual abuse/harassment of residents. Methods cited are placement of a telephone call or e-mail to a supervisor/Director/os, closed door meeting, report to Director via her cell phone during non-regular business hours (phone list is available on Sharepoint), Ethics Hotline, DOC-TIPS Line, or submit a written report.

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

Standard 115.252: Exhaustion of administrative remedies

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

115.252 (a)

- Is the agency exempt from this standard? NOTE: The agency is exempt ONLY if it does not have administrative procedures to address resident grievances regarding sexual abuse. This does not mean the agency is exempt simply because a resident does not have to or is not ordinarily expected to submit a grievance to report sexual abuse. This means that as a matter of explicit policy, the agency does not have an administrative remedies process to address sexual abuse. X□ Yes □ No

115.252 (b)

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

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

115.252 (c)

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

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

115.252 (d)

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

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

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

115.252 (e)

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

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

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

115.252 (f)

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

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

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

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

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

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

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

115.252 (g)

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

Auditor Overall Compliance Determination

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

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

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

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

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

The Director relates there has been no residents, within the last 12 months, who filed or attempted to file a sexual abuse allegation pursuant to the facility grievance policy.

In view of the above, the auditor finds no deviation(s) and the facility is exempt from the standard. Accordingly, the auditor finds LCTC 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; and
Enabling reasonable communication between residents and these organizations in as confidential manner as possible.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 8, section F(3 and 4) addresses 115.253(a).

The auditor's review of the afore-mentioned brochure identified in the narrative for 115.251 establishes some compliance with 115.253.

The auditor's review of a PAQ poster and a case manager Orientation that is completed by staff, reveals substantial compliance with 115.253(a).

As previously mentioned, at least two of seven random resident interviewees report they received a copy of the Blue Bench [VAs who provide 115.253(a) services at LCTC pursuant to an MOU] during intake.

The Director asserts an informative pamphlet from Blue Bench is available to residents pursuant to provision to them at intake and posting on a bulletin board. During the on-site audit, the auditor validated the same. Accordingly, residents have substantial access to information provided in the same.

All seven random resident interviewees assert there are services available outside the facility for dealing with sexual abuse, if the resident needed the same. Two interviewees specifically cited LPD, three cited counseling through MESA or other agencies, and one cited Blue Bench VAs as the service provided. Four interviewees report such information is available in the CC Resident Handbook or review of posters throughout the facility. Six interviewees assert the telephone calls are free of charge and six interviewees assert the calls can be accessed at any time.

Both residents who reported a sexual abuse interviewees were aware that Blue Bench provided requisite 115.253(a) services and they were aware of the address and telephone number. One interviewee had accessed Blue Bench services following the victimization and the telephone call was free. The other interviewee also reports the telephone call is free. Both interviewees report contact can be made anytime.

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 disclosures of sexual abuse made to outside victim advocates, including any limits to confidentiality under relevant federal, state, or local law.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 9, section F(5)(a and b) addresses 115.253(b).

The auditor's review of the CoreCivic PREA- Prevent. Detect. Respond. tri-fold reveals compliance with 115.253(b).

Six of seven random resident interviewees assert that what is said to people from the outside services remains private. Five interviewees assert such conversations could be told to or listened to by someone else if someone is in danger (law enforcement concern), there is a threat of self harm, or a potential criminal matter (inclusive of child abuse).

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.

In view of the above, the auditor is confident LCTC residents have been properly educated regarding the subject-matter of 115.253(b).

Both residents who reported a sexual abuse interviewees report that what is said to people from outside services remains confidential. However, exceptions occur if someone is in danger (law enforcement concern), there is a threat of self harm, and/or a potential criminal matter (inclusive of child abuse).

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 LCTC 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, addressing reporting via the 1-877-DOC-TIPS line.

Additionally, the auditor's review of a Visitation Log narrative reveals substantial information regarding third-party reporting options. This narrative is scripted at the top of the page for all LCTC entrants to read.

The auditor did observe a poster as he entered the facility lobby. Additionally, the Third Party PREA Alleged Incident Reporting memorandum (English and Spanish) is located at the facility entrance.

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

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

OFFICIAL RESPONSE FOLLOWING A RESIDENT REPORT

Standard 115.261: Staff and agency reporting duties

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

115.261 (a)

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

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

- Does the agency require all staff to report immediately and according to agency policy any knowledge, suspicion, or information regarding any staff neglect or violation of responsibilities that may have contributed to an incident of sexual abuse or sexual harassment or retaliation? X□ Yes □ No

115.261 (b)

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

115.261 (c)

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

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

115.261 (d)

- If the alleged victim is under the age of 18 or considered a vulnerable adult under a State or local vulnerable persons statute, does the agency report the allegation to the designated State or local services agency under applicable mandatory reporting laws? 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 10 random staff assert the agency requires all staff to report any knowledge, suspicion, or information they receive regarding an incident of sexual abuse or sexual harassment that occurred in any facili-

ty; any retaliation against residents or staff who reported such an incident; and any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation. All interviewees assert policy requires immediate reporting to the Director, PCM, os, senior monitor (sm), or on-call administrator.

Pursuant to the PAQ, the Director self reports apart from reporting to designated supervisors or officials and designated state or local service agencies, agency policy prohibits staff from revealing any information related to a sexual abuse report to anyone other than to the extent necessary to make treatment, investigation, and other security and management decisions.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 15, section K(2)(d) addresses 115.261(b).

Of note, the auditor's review of investigations reveals no deviation from either standard or relevant policies.

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

As noted in the narrative for 115.235, medical and mental health providers are not employed at LCTC. Accordingly, such interviews were not facilitated.

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

According to the Director/PCM, no residents under the age of 18 are housed at LCTC. With respect to a vulnerable adult being subjected to sexual abuse or sexual harassment, if such a situation did present, county or CDOC representatives, whichever is appropriate, would be notified.

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. The Director further self reports zero vulnerable adults have been subjected to sexual abuse at LCTC during the last 18 months.

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

The Director asserts all allegations of sexual abuse and sexual harassment, including those from third-party and anonymous sources, are reported directly to the designated facility investigator. The Director asserts she receives all reports of sexual abuse/harassment and she delegates investigations accordingly.

In view of the above, the auditor finds LCTC 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 last 12 months, there were zero 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 17, section M(1) addresses 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/she is removed from the danger zone and placed in other housing under staff supervision while the fact pattern is developed. If there is substantial evidence, contact with community partners would be facilitated in an effort to remove the alleged perpetrator from the LCTC resident population.

All 10 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 LCTC 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 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 last 12 months, the facility received zero allegations that a resident was sexually abused while confined at another facility.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 21, section M(16)(a)(i) addresses 115.263(a).

As the result of documentation review and staff and resident interviews, the auditor has not discovered any violations of 115.263.

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

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 21, section M(16)(a)(i) addresses 115.263(b).

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

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 21, section M(16)(a)(iii) 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 last 12 months, zero allegations of sexual abuse originating at LCTC, were received from other facilities.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 21, section M(16)(b)(i-iii) addresses 115.263(d).

The Director reports zero sexual abuse allegation(s) that allegedly originated at LCTC have been reported to LCTC executive staff during the last 18 months. One such case was revealed during 2019 and the auditor's review of the investigation and associated documents reveals substantial compliance with 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 LPD to initiate a criminal investigation.

According to the Director/PCM, when an allegation is received from another facility regarding an incident that allegedly occurred at LCTC, a full investigation would be initiated pursuant to standard procedure. The alleged victim is interviewed at the facility at which housed to secure a statement even, if necessary, telephonically.

In view of the above, the auditor finds LCTC 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 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 LCTC during the last 12 months. The fact pattern of that alleged incident allowed only for separation of the alleged victim and abuser. Of note, steps 3 and 4 of 115.264(a) were not accommodated based on the fact pattern of the incident. The auditor's review of the same validates facility staff assessment.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 17, section M(2)(a-d), (5 and 6), addresses 115.264(a). The steps articulated in this policy provision follow a chronological sequence with specific duties assigned (e.g the crime scene is secured by the highest ranking authority on-site and the safety of the victim is likewise ensured by this individual).

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

The security and non-security staff first responder interviewees were split in terms of their narratives regarding first responder duties. One interviewee was able to identify all 115.264(a) responsibilities while the other employee was unable to identify steps 3 and 4 as articulated in 115.264(a).

One of the two residents who reported a sexual abuse interviewees reports staff came to help him/her four months following the alleged incident. Specifically, he/she reports the initial report was made four months prior (to two staff no longer employed at LCTC) to his/her report to the current Director. He/she further reports neither staff member addressed his/her report however, the current Director did address the same. The auditor's review of the investigation related to the interviewee's report reveals 115.264(a) tasks were not applicable to his/her narrative. The investigator was unable to substantiate the alleged victim's allegation.

In regard to the second interviewee, the incident occurred off-campus. The Director did make provisions to move the alleged perpetrator to another location for safety concerns. Accordingly, the first 115.264(a) step was accomplished and the remaining steps were not applicable.

The auditor's review of six 2019, 2020, and 2021 sexual abuse investigations reveals none of the fact patterns are consistent with the time period that allows for the collection of physical evidence.

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

1) Request the alleged victim not take any actions that could destroy physical evidence; and
2) Notify security staff.
The Director further self reports one incident of sexual abuse occurred within the last 12 months. The fact pattern of that incident differs substantially from 115.264(b) requirements.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 17, section M(3) addresses 115.264(b).

The auditor's review of a 5-1A packet dated June 13, 2019 (surrounding an alleged sexual abuse case) clearly illustrates 115.264 and 115.265 requirements.

The auditor notes all staff receive the same First Responder training as all staff receive the same PREA training, both Pre-Service and PREA ART.

Random staff interviews regarding First Responder duties are addressed in the narrative for 115.221(a).

In view of the above, the auditor finds LCTC 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 16 through 19, sections L through M(13) addresses 115.265(a).

The auditor's review of this plan, in addition to the aforementioned policy citations, reveals a comprehensive and substantive plan to enable proper staff response to an incident of sexual abuse.

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. As she is involved in "all matters PREA" and is in the decision-making loop, she can oversee the process from start to finish.

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

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

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

115.266 (a)

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

115.266 (b)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

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

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

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

Pursuant to the PAQ, the Director self reports the facility is not involved in any collective bargaining process, either currently or since the last PREA audit. During the on-site audit, the auditor confirmed this assertion.

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

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

Standard 115.267: Agency protection against retaliation

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

115.267 (a)

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

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

115.267 (b)

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

115.267 (c)

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

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

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

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

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

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

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

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

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

115.267 (d)

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

115.267 (e)

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

115.267 (f)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

☐ **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 PAQ, the Director self reports she is designated as the retaliation monitor at LCTC. The same is articulated in a memorandum memorandum included in the PAQ materials.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 19, section M(14)(b) addresses 115.267(a).

The auditor's review of an investigation surrounding a reported incident on June 11, 2019 reveals that retaliation monitoring commenced on July 1, 2019 and subsequently concluded on July 9, 2019 when the resident was placed into custody. Another resident involved in a similar investigation was placed into retaliation monitoring on July 1, 2019 and concluded on July 2, 2019 when the resident was placed into custody.

A resident involved in an alleged incident reported on May 25, 2020 was discharged on the date of discovery and accordingly, retaliation monitoring could not be effected. This is validated in documentation. In a related incident, another victim was discharged from the program prior to completion of retaliation monitoring.

In a fifth case, it appears the investigation was determined to be administratively unfounded however, the 115.273 Notice to the resident reveals the same was unsubstantiated. Retaliation monitoring was not conducted.

With respect to the last investigation, the sexual abuse was substantiated both administratively and criminally. The 30-day and 60-day retaliation meetings were facilitated however, the 90-day meeting is not yet due.

The auditor's on-site review of three additional investigations reveals retaliation monitoring was completed in one case.

In view of the above, the auditor finds LCTC substantially compliant with 115.267(a). The auditor notes that in the three cases where retaliation monitoring was not facilitated, it appears the allegation was unfounded in one matter and accordingly, pursuant to 115.267(f), retaliation monitoring was not warranted.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 19, section M(14)(a) addresses 115.267(b).

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

According to the Director/Staff member charged with monitoring retaliation, she follows up and checks in with both resident and staff victims. Housing changes, administrative removal of the perpetrator, recommended Employee Assistance Program (EAP) for staff and increased emotional support services for residents, and formal 30/60/90 day retaliation meetings with victim(s) with random check-ins are some of the strategies that may be employed pursuant to retaliation monitoring.

Relocation of the perpetrator is the primary response and secondarily, the victim, dependent upon the circumstances. Staff perpetrators are removed from contact with resident victims pursuant to placement on administrative leave or they may be moved to another facility, dependent upon the circumstances. Minimally, the victim's housing within the facility, is considered and if appropriate, the same would be changed. With respect to staff victims, the perpetrator may be moved to a different shift and/or post assignment, minimally.

Both residents who reported a sexual abuse interviewees report they feel protected enough against possible revenge from staff or other residents because they reported what happened to them.

The auditor's review of the Protection Against Retaliation-Inmates and Staff form reveals several actions that can be taken and accounted for throughout the retaliation monitoring process.

Pursuant to the PAQ, the Director self reports the facility monitors the conduct or treatment of residents or staff who reported sexual abuse/harassment 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 further self 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 19 and 20, section M(14)(c), (d)(iv), (e)(i and ii), (f) addresses 115.267(c).

The Director/Staff member charged with retaliation monitoring interviewee asserts she monitors change(s) in resident behavior(s) (increase in receipt of misconduct reports, frequency of room change requests, hygiene changes, isolation, withdrawal, demeanor, staying away from public areas, and change in associations). In regard to staff victims, a decrease in work productivity, decreased hygiene, frequent shift or post change requests, transfer requests, increase in call-offs, increase in corrective actions, and isolation, are key indicators.

Monitoring is continued for a minimum of 90 days however, the same may be extended dependent upon circumstances. There is no maximum time frame for retaliation monitoring as the same is based on progress and circumstances.

The auditor notes CC policy requires the conduct of 30/60/90 retaliation monitoring in sexual abuse situations. The auditor notes 90-day retaliation monitoring was required in one 2019 case and the same was completed. The auditor's review of this PREA documentation reveals substantial compliance with 115.267. Remaining cases are addressed in the narrative for 115.267(a).

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, pages 19 and 20, section M(14)(d)(iv)/(g) addresses 115.267(d).

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 20, section M(14)(i) addresses 115.267(e).

Pursuant to contact with the PCM, she is not aware of any other incidents that occurred during the last 24 months wherein other individual(s) who cooperated with an investigation, expressed a fear of retaliation.

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

In view of the above, the auditor finds LCTC 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 23, section N(4) addresses 115.271(a).

The auditor's review of four 2019, one 2020, and one 2021 sexual abuse investigations reveals substantial compliance with 115.271. Additionally, the auditor's on-site review of three additional 2018 investigations reveals substantial compliance with 115.271.

Investigations appear to be substantive and inclusive of all requirements of 115.271. The auditor finds LCTC substantially compliant with 115.271(a), (b), (c), (e), (f), (i), (j), and (l).

According to the administrative investigative staff interviewee, an investigation is initiated within 15 minutes following receipt of an allegation of sexual abuse if he is on-site. If the sexual abuse allegation is reported during off-duty hours, he would immediately report to the facility to commence a sexual abuse investigation. Dependent upon the circumstances, he may report to the facility for a sexual harassment allegation however, minimally, he would direct on-duty staff regarding separation of the involved and housing, any evidence issues, etc., commencing the investigation the next day.

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

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 23, section N(5) addresses 115.271(b).

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

According to the administrative investigative staff interviewee, he completed a three hour on-line National Institute of Corrections (NIC)/PREA Resource Center (PRC) training course regarding the Conduct of Sexual Abuse Investigations in a Confinement Setting.

This course included topics such as interviewing techniques relative to victims and perpetrators in a confinement setting, execution of Miranda and Garrity warnings, evidence collection in sexual abuse cases, and the evidence standard necessary to substantiate a case for administrative action or prosecution referral.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 24, section O(6)(a) addresses 115.271(c).

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

Ensure first responder duties have been completed (five minutes);
Check crime scene if the incident occurred in the facility, inclusive of taking photographs (30 minutes);
Preliminary questioning of victim (15-30 minutes);
Review written reports (15-30 minutes);
Video review (one hour- ?);
Review files (30 minutes- one hour);
Facilitate in-depth interviews of victim and witnesses (two hours- ?);
Thorough interview of victim (one hour- ?);
Interview perpetrator, unless criminal (0- ?); and
Write report (two hours).

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

Direct and circumstantial evidence the interviewee is responsible for collecting entails written statements, video, and files. All physical evidence is collected by LPD investigator(s).

A discussion of standards compliance as compared against reviewed investigations is articulated in the narrative for 115.271(a).

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 24, section O(6)(b) addresses 115.271(d).

The administrative investigative staff interviewee asserts compelled interviews are not conducted by LCTC staff. The same would be facilitated by LPD investigator(s) and accordingly, they would maintain contact with prosecutors.

The auditor's review of the aforementioned investigations reveals five of the six were referred for criminal investigation to LPD following the administrative finding. The one case that was not referred was addressed with the Colorado Department of Public Safety as video review negated the allegation.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 24, section O(6)(c) addresses 115.271(e).

In regard to credibility assessments relative to staff and resident witnesses, the administrative investigative staff interviewee asserts credibility is established on whether their statement matches the totality of evidence. The interviewee 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.

Both residents who reported a sexual abuse at LCTC interviewees report they were not required to take a polygraph test as a condition for proceeding with a sexual abuse investigation.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 23, section N(6)(a-f) addresses 115.271(f).

With respect to determining whether staff actions or failure to act contributed to the incident of sexual abuse, the investigative staff interviewee asserts he assesses known facts against policy or ethical considerations?

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

General synopsis of the allegation(s);
Chronological timeline of interviews/evidence until conclusion of the incident;
Physical and circumstantial evidence;
Interview results;
Credibility and physical evidence assessments are addressed in the timeline; and
Conclusion, including finding.

The auditor's review of the afore-mentioned administrative sexual abuse investigations reveals an assessment of staff actions was clearly facilitated as the same is the focal point of the investigation. The assessment is prevalent throughout the administrative investigations. Of note, the alleged perpetrator resigned from employment prior to completion of the administrative and criminal investigations.

The administrative 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). Physical evidence credibility is also addressed in the criminal investigative report.

The Director asserts zero LPD criminal investigation reports have been provided to her during this audit period.

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 was zero administrative or criminal findings that were referred for prosecution since the last PREA audit.

One of the staff-on-resident allegations was referred for prosecution consideration as substantiated by PAQ documentation. The same was referred by LPD.

The administrative investigative staff interviewee asserts cases are referred for criminal investigation whenever the evidence points to the existence of a criminal code violation. Referrals for prosecution are generally facilitated by LPD when it appears the evidentiary standard has been met.

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 24, section O(6)(g) and page 4 of Attachment 1-15B-CC address 115.271(i).

The auditor's review of the CCA Record Retention Schedule reveals compliance with 115.271(i).

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 24, section O(6)(d) addresses 115.271(j).

Pursuant to the CCPC, standard practice requires continuation of an investigation into a PREA allegation even if a resident is terminated from the program.

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

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, page 24, section O(5) addresses 115.271(l).

Pursuant to the auditor's review of emails dated July 31, 2019 and September 9, 2019, it is clear that the Director (investigator) did attempt to remain abreast of the status of the aforementioned criminal sexual abuse investigation.

The Director/PCM asserts she periodically follows up with the LPD investigator by either email or telephone, checking on the status of criminal investigations. Follow-up contact is documented.

As previously referenced above, the e-mail thread(s) regarding the one sexual abuse investigation facilitated during the last year, substantiates attempts to be informed regarding the status of the investigation.

According to the administrative investigative staff interviewee, he acts as a liaison or facilitator (e.g. addresses any evidentiary needs, interview coordination/scheduling, etc.) whenever LPD investigators investigate sexual abuse incident(s). He is a liaison throughout the process.

In view of the above, the auditor finds LCTC 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 23, section N(8) addresses 115.272(a).

The auditor's review of the seven 2019/2020 sexual abuse/harassment investigations referenced in the narrative for 115.271(a) reveals substantial compliance with 115.272(a) as the preponderance of evidence standard was met. The auditor's review of other investigations referenced in the narrative for 115.267 also reveals substantial compliance with 115.272(a).

The investigative staff interviewee asserts he relies on a preponderance of evidence to substantiate allegations of sexual abuse/harassment. He asserts this equates to "more evidence is available leading to the conclusion the incident happened, than not."

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

Standard 115.273: Reporting to residents

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

115.273 (a)

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

115.273 (b)

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

115.273 (c)

- Following a resident's allegation that a staff member has committed sexual abuse against the resident, unless the agency has determined that the allegation is unfounded, or unless the resident has been released from custody, does the agency subsequently inform the resident whenever: The staff member is no longer posted within the resident's unit? X□ Yes □ No

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

dent 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 or she suffered sexual abuse in an agency facility is informed, verbally or in writing, as to whether the allegation has been determined to be substantiated, unsubstantiated, or unfounded following an investigation by the agency. The Director self reports two criminal/administrative sexual abuse/harassment investigations were completed during the last 12 months.

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, pages 25 and 26, section R(1) addresses 115.273(a).

The auditor's review of four 2019, one 2020, and one 2021 sexual abuse investigations reveals two of six requisite 115.273(a) notifications were completed. None of the 115.273(c) or (d) notifications were

completed. Additionally, the auditor's on-site review of two resident-on-resident and one staff-on resident investigations reveals no evidence substantiating that 115.273(a), (c), and/or (d) notifications were completed.

In view of the above, the auditor finds LCTC non-compliant with 115.273(a) and (c). Accordingly, the auditor imposes a 180-day corrective action period wherein LCTC will implement corrective action, ensuring compliance with these provisions.

To demonstrate institutionalization of the aforementioned provisions, the Director/PCM will provide training to the os (secondary administrative sexual abuse investigator) regarding the nuances of 115.273(a), (c), and (d). Upon completion of the training, the Director/PCM will provide the auditor with a copy of the lesson syllabus and training documentation substantiating the requisite training was provided to the os. Additionally, the Director/PCM will provide to the auditor a copy of investigations conducted during the corrective action period, inclusive of requisite 115.273 notifications to residents.

The corrective action period will conclude on or before November 12, 2021. The auditor will review evidence submitted and determine if closure of the finding is appropriate.

September 14, 2021 Update:

The auditor’s review of a training syllabus addressing the nuances of 115.273(a), (c), and (d) and review of a Training Activity/Attendance Roster dated August 20, 2021 reveals substantial compliance with requisite corrective action. The attendee and the trainer both affixed their signatures on the document. The date of training is also typed on the same.

The CCPC advises that zero sexual abuse allegations were received during the corrective action period. In view of the above, the auditor now finds LCTC substantially compliant with 115.273.

According to the Director, the facility does notify a resident who makes an allegation of sexual abuse when the allegation has been determined to be substantiated, unsubstantiated, or unfounded following an investigation. She asserts notifications are accomplished pursuant to a Resident Notification Form. The investigative staff interviewee substantiates the Director's statement.

Both residents who reported a sexual abuse at LCTC interviewees self reported they were notified by the FBI in one case and LPD in the other.

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, in the last 12 months, zero investigations were completed by an outside agency. However, the auditor finds that in the most recent matter, the same was facilitated by LPD investigator(s).

CC Policy 14-2 CC entitled Sexual Abuse Prevention and Response, pages 25 and 26, section R(1) addresses 115.273(b).

The auditor notes with respect to the above investigations, contact between the facility investigator and LPD was clearly accomplished.

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

The staff member is no longer posted within the resident's unit;
The staff member is no longer employed at the facility;
The agency learns the staff member has been indicted on a charge related to sexual abuse within the facility; or

The agency learns the staff member has been convicted on a charge related to sexual abuse within the facility.
The Director asserts substantiated or unsubstantiated staff-on-resident sexual abuse or sexual misconduct allegation(s) have been received during during the last 12 months.

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

The two residents who reported a sexual abuse interviewees report their assailants were other residents.

Pursuant to the PAQ, following a resident's allegation he or she has been sexually abused by another resident at LCTC, 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 R(3)(a and b) addresses 115.273(d).

The auditor finds no investigations regarding resident-on-resident sexual abuse conducted wherein 115.273(d) notification was appropriate. However, 115.273(a) notifications were completed in two cases.

Neither resident who reported a sexual abuse at LCTC interviewee reports receipt of a 115.273(d) notification in follow-up to their allegation.

In view of the above, the auditor finds LCTC substantially compliant with 115.273(d).

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

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

In view of the above, the auditor finds LCTC 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, page 27, section S(2)(a) addresses 115.276(a).

Pursuant to the PAQ, the Director self reports in the last 12 months, one facility staff member was alleged to have violated agency sexual abuse/ harassment policies. The Director further self reports one employee was either terminated or resigned prior to termination for violating agency sexual abuse or sexual harassment.

CC Policy 14-2 CC entitled Sexual Abuse Prevention, page 27, section S(2)(b) addresses 115.276(b).

The auditor's review of a document entitled CoreCivic Facility Standards of Conduct and two training schedules clearly substantiates staff training regarding 115.276(b) subject-matter.

The auditor's review of an Employment Data Change Form and accompanying letter reveals one employee was terminated based on a Code of Ethics violation, as sexual abuse was not substantiated.

Pursuant to the PAQ, the Director self reports disciplinary sanctions for violations of agency policies relating to sexual abuse or sexual harassment (other than actually engaging in sexual abuse) are commensurate with the nature and circumstances of the acts committed, the staff member's disciplinary history, and the sanctions imposed for comparable offenses by other staff with similar histories. The Director further self reports that in the last 12 months, zero 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, page 27, section S(2)(c) 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 for a Code of Conduct violation [see the narrative for 115.276(b)]. Specifically, the matter was referred to LPD for criminal investigation however, termination was based on a non-sexual abuse reason.

CC Policy 14-2 CC entitled Sexual Abuse Prevention, page 27, section S(2)(d) addresses 115.276(d).

The auditor notes the staff member alleged to have been involved in incidents of sexual abuse/harassment was a monitor and therefore, reporting to any relevant licensing bodies was not relevant.

In view of the above, the auditor finds LCTC 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 any contractor or volunteer who engages in sexual abuse be prohibited from contact with residents. According to the Director, in the last 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, page 27, section S(2)(e) addresses 115.277(a). In addition to the above, the CoreCivic Zero Tolerance Policy- Prohibited Sexual Behavior document, signed and dated by each contractor/volunteer, reflects the requirements of 115.277 in the section entitled Corrective Action for Contractors and Volunteers that Engage in Prohibited Sexual Behavior.

The auditor's review of one contractor CORECIVIC PREA POLICY ACKNOWLEDGEMENT AND/OR TRAINING ACKNOWLEDGMENT and one Zero-tolerance Policy- Prohibited Sexual Behaviors documents reveals all were signed and dated by the volunteer prior to contact with residents. Accordingly, the auditor finds LCTC substantially compliant with 115.232 and clearly, contractors/volunteers are provided substantial training regarding the consequences of sexual abuse/sexual harassment of residents [115.277(a)].

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

Pursuant to the PAQ, the Director self reports the facility takes appropriate remedial measures and considers whether to prohibit further contact with residents in the case of any other violation of agency sexual abuse or sexual harassment policies by a contractor or volunteer.

CC Policy 14-2 CC entitled Sexual Abuse Prevention, page 27, section S(2)(f) addresses 115.277(b).

The Director asserts she automatically suspends contractor/volunteer privileges and eliminates contact with residents, pending the results of an investigation, should a contractor/volunteer be involved in a sexual abuse/harassment incident with a resident. She terminates the contract/volunteer contact with residents if the investigation is substantiated.

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

115.278 (e)

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

115.278 (f)

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

115.278 (g)

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

Auditor Overall Compliance Determination

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

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

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

Pursuant to the PAQ, the Director self reports residents are subject to disciplinary sanctions only pursuant to a formal disciplinary process following an administrative finding that the resident engaged in resident-on-resident sexual abuse. The Director further 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 last 12 months, there was zero administrative and/or criminal findings of resident-on-resident sexual abuse that occurred at the facility. Note: The auditor's review of one 2021 investigation reveals that the incident occurred outside the environs of the facility. Additionally, the perpetrator was immediately moved to another facility.

CC Policy 14-2 CC entitled Sexual Abuse Prevention, page 26, section S(1)(a) addresses 115.278(a).

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

CC Policy 14-2 CC entitled Sexual Abuse Prevention, page 26, section S(1)(c) addresses 115.278(b).

According to the Director, residents who facilitate a resident-on-resident sexual abuse incident may normally be recommended, during an administrative disciplinary process, for termination from the program following a substantiated administrative or criminal investigation. The perpetrator is normally recommended for administrative removal from the facility at the onset. Normally, facility staff do not facilitate major sanction hearings.

As such a hearing is not generally facilitated by LCTC staff, it is unknown whether sanctions are commensurate with the nature and circumstances of the offense committed. Additionally, the hearing body considers any mental health issues.

CC Policy 14-2 CC entitled Sexual Abuse Prevention, page 26, section S(1)(d) addresses 115.278(c).

Pursuant to the PAQ, the Director self reports the facility does not offer therapy, counseling, or other interventions designed to address and correct the underlying reasons or motivations for abuse. Specifically, in the case of substantiated abuse, the perpetrator would be placed into custody and terminated from the program. Additionally, the alleged perpetrator is separated from the victim. In view of the above, facility staff do not consider whether to require the offending resident to participate in such interventions as a condition of access to programming or other benefits.

CC Policy 14-2 CC entitled Sexual Abuse Prevention, page 27, section S(1)(i) addresses 115.278(d).

As previously mentioned in the narrative for 115.235, according to the Director and the auditor's observations, medical and mental health staff are not employed at LCTC.

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, page 26, section S(1)(e) addresses 115.278(e).

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

According to the Director, during the last 12 months, there were no allegations or investigations relative to resident sexual contact with staff meeting the parameters 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, pages 26 and 27, section S(1)(g) addresses 115.278(f).

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, page 26, section S(1)(f) addresses 115.278(g).

The auditor did not find any incidents of resident discipline for sexual abuse linked to consensual sex.

In view of the above, the auditor finds LCTC 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. Such services are provided by community providers at a designated location. The Director self reports that as medical and mental health care are not provided at LCTC, such secondary materials are maintained at the respective hospital.

CC Policy 14-2 CC entitled Sexual Abuse Prevention, page 20, section M(15)(a) addresses 115.282(a).

The Director/PCM asserts an MOU with UC Health is a work in progress. Forensic examinations are available at that facility.

As previously indicated, the auditor observed there are no medical/mental health providers on board at LCTC. Accordingly, interview(s) could not be facilitated.

The residents who reported a sexual abuse at LCTC interviewees report they declined both medical and mental health services following their report of sexual abuse. The auditor also notes neither incident involved penetration.

In view of the above, the auditor finds LCTC substantially compliant with 115.282(a).

CC Policy 14-2 CC entitled Sexual Abuse Prevention, page 20, section M(15)(b) addresses 115.282(b).

The interview narratives for security and non-security first responders, as reflected in 115.221 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 in 115.265.

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

Pursuant to the PAQ, the Director self reports resident victims of sexual abuse while incarcerated are offered timely information about and timely access to emergency contraception and sexually transmitted infections prophylaxis, in accordance with professionally accepted standards of care, where medically appropriate. The same is addressed in the SANE interview reflected in the narrative for 115.221(c). The Director self reports that as medical and mental health care is not provided at LCTC, such secondary materials are maintained at the hospital.

CC Policy 14-2 CC entitled Sexual Abuse Prevention, page 20, section M(15)(c) addresses 115.282(c).

The residents who reported a sexual abuse at LCTC interviewees report provision of information about and access to emergency contraception/sexually transmitted infection prophylaxis was not applicable to their allegations as neither were subjected to penetration and they declined medical intervention.

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, page 20, section M(15)(d) addresses 115.282(d).

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

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

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

115.283 (a)

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

115.283 (b)

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

115.283 (c)

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

115.283 (d)

- Are resident victims of sexually abusive vaginal penetration while incarcerated offered pregnancy tests? (N/A if "all-male" facility. *Note: in "all-male" facilities, there may be residents who identify as transgender men who may have female genitalia. Auditors should be sure to know whether such individuals may be in the population and whether this provision may apply in specific circumstances.*) X□ Yes □ No □ NA

115.283 (e)

- If pregnancy results from the conduct described in paragraph § 115.283(d), do such victims receive timely and comprehensive information about and timely access to all lawful pregnancy-related medical services? (N/A if "all-male" facility. *Note: in "all-male" facilities, there may be residents who identify as transgender men who may have female genitalia. Auditors should be sure to know whether such individuals may be in the population and whether this provision may apply in specific circumstances.*) X□ Yes □ No □ 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 14-2 CC entitled Sexual Abuse Prevention, page 21, section M(15)(e) addresses 115.283(a).

The Director/PCM asserts zero residents have reported, at intake during their initial sexual abuse victimization screening, that they were sexually abused at a prior confinement facility.

CC Policy 14-2 CC entitled Sexual Abuse Prevention, page 21, section M(15)(f) addresses 115.283(b) and (c).

As reflected in the narrative for 115.235, medical and mental health staff are not employed at LCTC. Medical and mental health care is provided at community facilities.

As previously indicated, the residents who reported a sexual abuse at LCTC interviewees report they declined medical/mental health care following their report of sexual abuse.

The auditor has not been provided nor has he discovered any evidence substantiating 115.283(a) and (b) issues. This information is validated pursuant to interviews and review of random resident files.

CC Policy 14-2 CC entitled Sexual Abuse Prevention, page 21, section M(15)(g) addresses 115.283(c).

Provision of medical and mental health care at community hospitals equates to the community standard of care.

Pursuant to the PAQ, the Director self reports female victims of sexually abusive vaginal penetration while incarcerated are offered pregnancy tests.

CC Policy 14-2 CC entitled Sexual Abuse Prevention, page 21, section M(15)(h) addresses 115.283(d).

The one female resident who reported a sexual abuse at LCTC reports she was not offered a pregnancy test as she did not experience any vaginal penetration.

Pursuant to the PAQ, the Director self reports if pregnancy results from sexual abuse while incarcerated, victims receive timely and comprehensive information about, and timely access to, all lawful pregnancy-related medical services.

CC Policy 14-2 CC entitled Sexual Abuse Prevention, page 21, section M(15)(h) addresses 115.283(e).

The one female resident who reported a sexual abuse at LCTC reports she was not offered a pregnancy test as she did not experience any vaginal penetration.

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 14-2 CC entitled Sexual Abuse Prevention, page 21, section M(15)(i) addresses 115.283(f).

As previously stated, neither resident who reported a sexual abuse at LCTC interviewee reports any penetration. Neither interviewee was offered tests for sexually transmitted infections. Additionally, both interviewees declined medical treatment. The above is validated by the auditor's review of the relevant investigations.

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

CC Policy 14-2 CC entitled Sexual Abuse Prevention, page 21, section M(15)(j) addresses 115.283(g).

Neither of the residents who reported a sexual abuse at LCTC report payment for treatment related to their respective incident of sexual abuse.

Pursuant to the PAQ, the Director self reports the facility does not attempt 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. However, pursuant to a separate on-site conversation, the Director asserts they would refer such resident-on-resident sexual abusers for a mental health evaluation within 60 days of learning of such abuse history. Additionally, treatment, as deemed appropriate by mental health practitioners, would be offered.

CC Policy 14-2 CC entitled Sexual Abuse Prevention, page 10, section G(15) addresses 115.283(h).

In a separate conversation, the Director advised no resident-on-resident sexual abusers have been housed at LCTC during the last 18 months.

Pursuant to the interviews and the auditor's random review of resident files, he has not discovered any incidents wherein 115.283(h) requirements were invoked.

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

DATA COLLECTION AND REVIEW

Standard 115.286: Sexual abuse incident reviews

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

115.286 (a)

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

115.286 (b)

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

115.286 (c)

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

115.286 (d)

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

115.286 (e)

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

Auditor Overall Compliance Determination

☐ **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 last 12 months, two criminal or administrative sexual abuse investigations were facilitated at LCTC.

CC Policy 14-2 CC entitled Sexual Abuse Prevention, page 25, section P(1) addresses 115.286(a).

The auditor's review of the SAIR report relative to a substantiated administrative sexual abuse case (2019) referenced throughout this report reveals the requisite committee membership was present at the review and the report is comprehensive, addressing all requisite areas. The review was completed in a timely manner (upon completion of the administrative investigation).

The auditor's review of one applicable sexual abuse investigation and applicable Sexual Abuse Incident Review (SAIR) reveals substantial compliance with 115.286(a-e). As reflected in the narrative for 115.271(a), one of the remaining investigations was deemed to be sexual harassment and the other investigation was determined to be unfounded.

The auditor's review of four additional 2019 SAIR reports reveals a timely and comprehensive meeting was facilitated and timely/substantive report was issued in accordance with 115.286(a-d) in three cases. The final sexual abuse investigation was determined to be unfounded and accordingly, such review is not required.

The auditor's on-site review of three additional SAIRs reveals substantial compliance with 115.286(a-d).

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 during the last 12 months, two criminal or administrative sexual abuse investigations were facilitated at LCTC.

CC Policy 14-2 CC entitled Sexual Abuse Prevention, page 25, section P(3) addresses 115.286(b).

Pursuant to the PAQ, the Director self reports the sexual abuse incident review 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 LCTC.

CC Policy 14-2 CC entitled Sexual Abuse Prevention, page 25, section P(2) addresses 115.286(c).

The auditor finds the composition of the SAIR review team, in question, to be commensurate with standard expectations. Commensurate with a memorandum included in the PAQ documentation, the Senior Director for the Division, the Director, and the os comprise the membership of the SAIR team.

The Director asserts the facility does have a sexual abuse incident review team. The team is comprised of the Director, Senior Director (Division 7), and os, allowing for input from line supervisors, and investigators.

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 PCM.

CC Policy 14-2 CC entitled Sexual Abuse Prevention, page 25, section P(3)(a-e), and (4) addresses 115.286(d).

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

According to the Director, the team assesses whether the alleged incident was the result of a policy, technology, inadequate staffing, or performance failure and if corrective strategies are required. If required, the same are implemented unless determined to be impractical. In that case, the reason for non-implementation is documented.

During the review, the team assesses those facets which were correctly accomplished and those that were incorrectly accomplished. The process is designed to enhance the PREA program and resident sexual safety at LCTC.

The team considers:

Does the allegation or investigation indicate a need to change policy or practice to better prevent, detect, or respond to sexual abuse;
Was the incident motivated by race, ethnicity, gender identity, LGBTI identification status or perceived status or perceived status, or gang affiliation, or was it motivated or otherwise caused by other group dynamics at the facility;
Physical examination of the area, in the facility, where the incident allegedly occurred to assess whether physical barriers in the area may enable abuse;
Assessment of the adequacy of staffing levels in the area during different shifts; and
Assessment of whether monitoring technology should be deployed or augmented to supplement staff supervision.
Of note, the Director/PCM was also interviewed pursuant to the incident review team questionnaire and accordingly, response is incorporated in the Director/PCM's response.

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, page 25, section P(5) addresses 115.286(e).

The auditor notes an additional camera was positioned in the Food Service area as the result of a SAIR.

The auditor's review of meeting minutes reveals recommended corrective action was completed with respect to two 2019 SAIR reviews pursuant to presentation of training in a staff meeting and subsequently, a resident meeting. Corrective action was also completed with respect to two 2020 and one 2021 SAIRs via the same methods. The auditor finds that in two of three cases reviewed on-site, corrective action was not completed and there is no justification for failure to implement corrective action.

In view of the above, the auditor finds LCTC 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.) X□ Yes □ No □ NA

115.287 (f)

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

CC Policy 14-2 CC entitled Sexual Abuse Prevention, pages 27 and 28, section T(1) and (3) addresses 115.287(a/c).

The auditor's review of the CC Incident Reporting Definitions (IRD) and CC 5-1E forms reveals substantial compliance with 115.287(a/c).

Pursuant to the PAQ, the Director self reports the agency aggregates the incident-based sexual abuse data at least annually.

CC Policy 14-2 CC entitled Sexual Abuse Prevention, page 28, section T(3) 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, page 28, section T(2) addresses 115.287(d).

Based on the PAQ review and on-site review of documents, the auditor finds LCTC substantially compliant with 115.287(d).

LCTC does not contract with any other facility(ies) for confinement of residents committed to the custody and care of the facility. Accordingly, the auditor finds 115.287(e) not applicable to LCTC.

According to the Director, CoreCivic has provided sexual abuse/sexual harassment data to the U.S. Department of Justice for the 2018 SSV. Accordingly, the same is not applicable to 115.287(f).

In view of the above, the auditor finds LCTC 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, page 28, section T(4 and 5) addresses 115.288(a).

The auditor's review of the 2019 CC Annual Report reveals substantial compliance with 115.288(a), (b), and (c). The CC 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 SAIR 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 LCTC to exceed compliance expectations with respect to 115.288. This procedure is representative of CC's commitment and zeal in terms of enhancement of inmate sexual safety within facilities.

While the CCPC interviewee was minimally interviewed during this audit, his statement with respect to previous CC audits is noteworthy. He asserts the agency does review data collected and aggregated in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies and training. Such data is securely retained in password protected programs at both the facility and CCPC's office. Access to this information is limited.

Auditor's Note: PREA investigation reports and ancillary documentation are electronically generated. The auditor observed this process throughout the on-site audit.

The CCPC further advises the agency takes corrective action on an ongoing basis based on this data. For example, anything identified pursuant to a mock audit or SAIR review is considered for implementation.

The Director/PCM asserts the agency reviews data collected and aggregated pursuant to 115.287 in order to assess and improve effectiveness of its sexual abuse prevention, detection, response policies, and training. Data is maintained electronically by the Director/PCM and CCPC. The data is maintained in a password protected system with access by the Director/PCM only. Hard files are maintained by the Director/PCM in a locked file cabinet in her office. Of note, the auditor validated the Director/PCM's statement.

The Director/PCM also asserts the agency prepares an annual report of findings from its data review and any corrective actions for each facility, as well as, the agency as a whole. The CCPC actually compiles the report.

Pursuant to the PAQ, the Director self reports the annual report includes a comparison of the current year's data and corrective actions with those from prior years. The Director further self reports the annual report provides an assessment of the agency's progress in addressing sexual abuse.

CC Policy 14-2 CC entitled Sexual Abuse Prevention, page 28, section T(5) addresses 115.288(b).

Pursuant to the PAQ, the Director self reports the agency makes its annual report readily available to the public at least annually through its website and the reports are approved by the agency head.

CC Policy 14-2 CC entitled Sexual Abuse Prevention, page 28, section T(8) addresses 115.288(c).

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 Executive Vice President and Chief Operating 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 Director self reports the nature of the material redacted, is documented.

CC Policy 14-2 CC entitled Sexual Abuse Prevention, page 28, section T(6) addresses 115.288(d).

According to the Director/PCM, personal names/identifiers and security information are typically redacted from the annual report and the agency indicates the nature of the redacted material. The report is generated by the CCPC.

In view of the above, the auditor finds LCTC substantially compliant with 115.288(d).

In view of the above, the auditor finds LCTC exceeds standard expectations with respect to 115.288.

Standard 115.289: Data storage, publication, and destruction

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

115.289 (a)

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

115.289 (b)

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

115.289 (c)

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

115.289 (d)

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

Auditor Overall Compliance Determination

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

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

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

Pursuant to the PAQ, the Director self reports the agency ensures incident-based and aggregate data are securely retained.

CC Policy 14-2 CC entitled Sexual Abuse Prevention, page 28, section T(11) addresses 115.289(a).

The PCM asserts the agency reviews data collected and aggregated pursuant to 115.287 in order to assess and improve effectiveness of its sexual abuse prevention, detection, and response policies, and training. Data is maintained electronically by the Director/PCM and CCPC. The data is maintained in a password protected system with access by the Director/PCM only. Hard files are maintained in a locked file cabinet in the Director's office.

The auditor's on-site review validates the Director/PCM's assertion regarding information security.

Pursuant to the PAQ, the Director self reports agency policy requires aggregated sexual abuse data from facilities under its direct control and private facilities with which it contracts be made readily available to the public, at least annually through its website.

CC Policy 14-2 CC entitled Sexual Abuse Prevention, page 28, section T(8) addresses 115.289(b).

The auditor's review of the CC website reveals aggregated sexual abuse data regarding CC facilities is available on an annual basis. CC does not contract with other agencies for housing of residents designated to CC custody and control.

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, page 28, section T(7) 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.

CC Policy 14-2 CC entitled Sexual Abuse Prevention, page 28, section T(10) addresses 115.289(d).

The auditor's review of the CC Records Retention Schedule reveals substantial compliance with 115.289(d).

In view of the above, the auditor finds LCTC 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*.) X□ Yes □ No

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

- If this is the third year of the current audit cycle, did the agency ensure that at least two-thirds of each facility type operated by the agency, or by a private organization on behalf of the agency, were audited during the first two years of the current audit cycle? (N/A if this is **not** the *third* year of the current audit cycle.) □ 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*)

Facility staff provided excellent service in terms of audit facilitation. Interviews were facilitated in rapid fashion as interviewees were always available in an expeditious fashion. Accommodations were exceptional.

Standard 115.403: Audit contents and findings

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

115.403 (f)

- The agency has published on its agency website, if it has one, or has otherwise made publicly available. The review period is for prior audits completed during the past three years PRECEDING THIS AGENCY AUDIT. The pendency of any agency appeal pursuant to 28 C.F.R. § 115.405 does not excuse noncompliance with this provision. (N/A if there have been no Final Audit Reports issued in the past three years, or in the case of single facility agencies that there has never been a Final Audit Report issued.) X□ Yes □ No □ NA

Auditor Overall Compliance Determination

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

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

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

NA

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 **September 23, 2021**

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.