PREA AUDIT REPORT ☐ Interim ☒ Final

COMMUNITY CONFINEMENT FACILITIES

Date of report: May 22, 2017

Auditor Information			
Auditor name: Barbara Jo Denison			
Address: 3113 Clubhouse Drive, Edinburg, TX 78542			
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Telephone number: 956-566-2578			
Date of facility visit: February 23-24, 2017			
Facility Information			
Facility name: Correctional Alternatives, LLC – Ocean View			
Facility physical address: 551 South 35th Street, San Diego, CA 92113			
Facility mailing address: *(if different from above)* Click here to enter text.			
Facility telephone number: 619-232-8600			
The facility is:	☐ Federal	☐ State	☐ County
	☐ Military	☐ Municipal	☒ Private for profit
	☐ Private not for profit		
Facility type:	☐ Community treatment center ☐ Halfway house ☐ Alcohol or drug rehabilitation center	☒ Community-based confinement facility ☐ Mental health facility ☐ Other Community Correctional Facility	
Name of facility's Chief Executive Officer: Dennis Morris, Facility Director			
Number of staff assigned to the facility in the last 12 months: 88			
Designed facility capacity: 483			
Current population of facility: 317			
Facility security levels/inmate custody levels: Community			
Age range of the population: 18-82			
Name of PREA Compliance Manager: Dennis Morris		**Title:** Facility Director/PREA Compliance Manager	
Email address: Dennis.Morris@corecivic.com		**Telephone number:** 619-232-8600	
Agency Information			
Name of agency: CoreCivic			
Governing authority or parent agency: *(if applicable)* Click here to enter text.			
Physical address: 10 Burton Hills Blvd., Nashville, TN 37215			
Mailing address: *(if different from above)* Click here to enter text.			
Telephone number: 615-263-3000			
Agency Chief Executive Officer			
Name: Damon Hininger		**Title:** President and Chief Executive Officer	
Email address: Damon.Hininger@corecivic.com		**Telephone number:** 615-263-3301	
Agency-Wide PREA Coordinator			
Name: Eric Pierson		Senior Director, PREA Programs and Compliance	
Email address: Eric.pierson@corecivic.com		615-263-6915	

AUDIT FINDINGS

NARRATIVE

The PREA on-site audit of Correctional Alternatives, LLC-Ocean View was conducted February 23-24, 2017 by this Department of Justice Certified PREA Auditor, Barbara Jo Denison. Pre-audit preparation included a thorough review of agency policy 14-2 CC and the Federal Bureau of Prison Program Statement 5324.12, procedures, training curriculums, Pre-Audit Questionnaire and supporting PREA-related documentation provided by the facility to demonstrate compliance to the PREA standards. Dennis Morris, Facility Director, who is designated as the facility's PREA Compliance Manager and Rebecca Perry, QA Manager answered questions during this review period.

On the first day of the audit, a brief entrance meeting was held with Dennis Morris, Facility Director, Rebecca Perry, QA Manager and Eric Pierson, Senior Director PREA Programs and Compliance in attendance. Following the entrance meeting, those in attendance of the entrance meeting and Talia Devine, Unit Manager accompanied me on a tour of the facility. During the tour, the location of cameras and mirrors, room layout including shower/toilet areas and placement of PREA posters and information was observed. PREA posters in both English and Spanish were posted throughout the facility in common areas and in the living areas. The external reporting number for the RAINN National Hotline was called on one of the resident pay telephones (1-800-656-4673) and was found to answered by San Bernardino Sexual Assault Services. Calls to this number, available 24 hours a day, are toll free and residents can remain anonymous if they choose to.

While touring B Dorm it was noted that in the restroom there were toilet stalls with doors with the exception of three toilets closest to the sinks that were in open view. Two of those toilets were next to the last toilet stall with the last stall blocking the view of those two toilets. The third toilet was next to the sinks and there were no barriers to provide privacy. It was recommended that some kind of partition be built around that toilet eliminating the opportunity for cross gender viewing.

Post Audit Note: The facility made modifications in B Dorm restroom. A photo was forwarded to me showing that a curtain with mesh around the top of the curtain was added around the toilet that was in open view. The photo showed that the curtain was hung from floor to ceiling and did not allow staff to observe if someone was behind the curtain. This concern was relayed to the PREA Coordinator who addressed my concern with the facility. The facility shortened the curtain, and resent a photo. The addition of the curtain with the adjustment provided for privacy and safety of residents using the toilet and eliminated the opportunity for cross gender viewing.

During the tour, I spoke informally to residents questioning them about their overall knowledge of the agency's zero-tolerance policy and methods of reporting. On the first day of the audit, there were 317 residents housed at CAI-Ocean View and 39 on home detention. A random selection of 35 residents that were housed at the facility on the first day of the audit were formally interviewed during the course of the audit. Of the 35 residents interviewed, four were assessed at initial PREA screening to be predators and four were assessed to be potential victims. There were no residents housed at the facility at the time of the audit that were deaf, hard of hearing, blind, had low vision, limited English proficient or who self-disclosed being gay, bisexual, transgender or intersex. There was one female resident who self-disclosed being lesbian, but because of her work schedule was not able to be interviewed. All of the residents interviewed acknowledged receiving PREA training with written information during the intake process and viewing the PREA video during a mandatory PREA class. They were familiar with the agency/facility's zero-tolerance policy against sexual abuse and sexual harassment and were able to articulate during interview the methods of reporting allegations of sexual abuse and sexual harassment available to them. Residents consistently indicated that they feel safe at this facility.

A file review of 25 resident files confirmed that residents are receiving comprehensive PREA education within the first week of arrival to the facility and sign a *Resident Right to Know* form acknowledging receipt of this training. The same 25 resident files were reviewed to ensure compliance to PREA screening requirements. The review PREA screenings revealed that the *Sexual Abuse Screening Tool* (14-2 CC-B-1) used for initial and 30-day rescreenings are not being completed correctly and not always timely generating a corrective action period to achieve compliance to standards 115.241 and standard 115.242. (see the narrative for those two standards for details)

Prior to the on-site visit, I was supplied a list of security and non-security staff who were scheduled during the on-site visit. I formally interviewed 31 staff and one volunteer who was interviewed by telephone. Of the staff members interviewed, 14 were security staff and the remaining 16 were specialized staff. The Facility Director, who is the facility's PREA Compliance Manager, is also a member of the Incident Review Team, the Sexual Abuse Response Team (SART) and is responsible for monitoring for retaliation. He was asked multiple questions as they relate to the responsibilities of each of those roles. The agency's PREA Coordinator and the Executive Vice President and Chief Corrections Officer (agency head designee) were both interviewed on another date. Staff interviewed were knowledgeable of their responsibilities of detecting, preventing and responding to sexual abuse and sexual harassment allegations. They knew how to respond if they learned that a resident was

in imminent danger of sexual abuse.

Personnel files are maintained by the Human Resource Manager who is responsible for maintaining files for this facility and CAI-Boston Avenue. The review of 15 records which included promotions, transfers and new hires in the past 12 months revealed criminal background checks for pre-employment being completed as per policy and standard requirements with repeat background checks performed in conjunction with contract renewal dates.

Twenty staff training records were reviewed to ensure compliance to training mandates. All files reviewed showed PREA training and training on cross gender searches which includes searches of transgender and intersex residents to be completed and well documented in files maintained by the Learning and Development Manager.

Volunteer and contractor files were reviewed to ensure compliance to criminal background checks and PREA training for volunteers and contractors. The facility has 20 volunteers and four contractors. Volunteer and contractor files showed that criminal background checks are being performed prior to volunteers and contractors being allowed access to the facility. Volunteers are receiving the required volunteer training and this training is documented by their signature on required forms maintained in their files. In review of the contractor files, one contractor received the required training and the other three have not which generated a corrective action period for standard 115.232 to bring this standard into compliance. (see narrative for standard 115.232 for details).

The facility has made multiple attempts to enter into a Memorandum of Understanding (MOU) with the Center for Community Solutions and continues in these efforts. The Sexual Assault Victim Advocacy Manager of the Center for Community Solutions was contacted during the audit. She shared that even though the MOU is not finalized, the residents of CAI-Ocean View can access the services of their agency at no cost to the resident. The services include victim advocacy, referrals for counseling and legal and civil services. The agency has a Sexual Abuse Response Team (SART). When the San Diego Police Department are notified of sexual abuse at CAI-Ocean View, the detective that responds to the call would contact the area forensic nurse on call. The forensic nurse would then call the Center for Community Solutions to request a victim advocate respond to either the Independent Forensic Services or to the Pomerado Hospital where the forensic exams are performed. Within 24-48 hours after the forensic exam, an advocate would contact the resident to offer services in support of the victim.

The facility has an MOU with the San Diego Police Department providing criminal investigations of allegations of sexual abuse. Telephone contact was made with an officer from the San Diego Police Department who is the liaison between the facility and the department to confirm and review the MOU. The officer shared that in the event of a sexual abuse, a patrol officer would be the first responder to the facility. The Detective Sergeant from the Sex Crime Unit of the department would be contacted and an investigator would be dispatched to the facility. The victim would be sent to one of the two forensic clinics where a forensic nurse would and an advocate would meet the victim at the clinic. An Evidence Tech would respond to the facility to gather any evidence. At the conclusion of the investigation, the evidence would be turned over to the San Diego District Attorney, who would be the prosecuting agency. The victim would be the first to know the outcome of the investigation and with the victim's permission, the facility would be informed as well.

I reviewed the personnel files of 20 employees to determine compliance with required background checks. The review revealed criminal background checks for pre-employment being completed as per policy and standard requirements with repeat background checks performed every five years in conjunction with contract renewal dates. The last contract renewal date was 6/1/16. At that time, all staff had NCIC/NLETS background checks completed by BOP.

In the 12 months preceding the audit, there were 13 allegations of sexual abuse/sexual harassment reported. The breakdown of the investigation of those allegations are as follows:

Number of Allegation	**Type of Allegation**	**Outcome of Investigation**
5	Resident-on-Resident Sexual Abuse	3 – Substantiated 2 – Ongoing
4	Staff-on-Resident Sexual Abuse	2 – Unfounded 2 – Ongoing
2	Staff-on-Resident Sexual Harassment	2 – Unsubstantiated
2	Voyeurism	2 - Unfounded

At the conclusion of the on-site audit, an exit meeting was held to discuss the audit findings with Dennis Morris, Facility, Bessy Glaske, Managing Director, Rebecca Perry, QA Manager and Eric Pierson, Senior Director PREA Programs and Compliance in

attendance. During the exit meeting, the facility was informed of the process that would follow the on-site visit including corrective actions for standards 115.232, 115.241 and 115.242. The team was complimented on their cooperation prior to the audit and during the on-site visit and their willingness to achieve PREA compliance.

Following the on-site audit, the facility entered into a correction action period to work towards compliance to standards 115.232, 115.241 and 115.242. See narrative for those standards for details of the corrective action recommended to the facility to achieve compliance and the corrective action taken. During the corrective action period, the facility staff and the PREA Coordinator worked together on the plan of action and documentation was forwarded to me for my review. At the conclusion of the corrective action period, it was determined that the facility achieved compliance to standards 115.232, 115.241 and 115.242.

DESCRIPTION OF FACILITY CHARACTERISTICS

Correctional Alternatives, LLC – Ocean View (CAI-Ocean View) is located at 551 South 35th Street, San Diego, CA. CoreCivic purchased CAI-Ocean View from Correctional Alternatives, LLC in July of 2013. CAI-Ocean View offers an alternative to jail and prisons and provides a work furlough/residential reentry facility with contracts with the Federal Bureau of Prisons (BOP), the county of San Diego courts, county probation, sheriff department and federal probation and pretrial agencies. The average length of stay of residents is 70.14 days.

The facility has a design capacity of 483 residents. CAI-Ocean View houses both male and female residents. The residents share programming, recreation and food service areas together. Alarmed doors separate the male and female living areas. Most of the residents are transitioning from jail or prison and into the community. Residents are able to leave the facility to perform job searches and obtain employment. The facility provides onsite programs and services that include substance abuse education, life skills, parenting and job readiness training. Residents attend religious services in the community.

The facility sits on approximately three acres of land in a mixed residential and commercial area. The building is a four-wing design facility with living quarters, food service/dining hall and administrative offices. Living quarters have adequate restroom facilities, TV rooms with case manager offices nearby. When entering the building, there is a Monitors Office where residents sign in and sign out of and a separate Pat Down Room and UA restroom located close to the Monitors Office. All living areas have pay telephones available for residents' use with PREA reporting options posters throughout the facility.

An outdoor covered courtyard faces the programming room and a case management office. The courtyard has picnic tables, vending machines, and palm trees for shade. There is a small outdoor weight area and a basketball court for resident use. There is one outdoor area where residents are allowed to smoke. They are not allowed to smoke inside of the facility.

The facility has a total of 143 cameras; 105 interior and 38 exterior. Every room has a camera and when the camera monitors were viewed, the cameras afford the residents privacy for showering, toileting and dressing. A DVR retains information for up to 90 days.

The facility has a total of 98 staff and currently there are seven vacancies. CAI-Ocean View has 20 volunteers and four contractors. The contractors provide an onsite substance abuse program.

The facility has an upper parking lot that is in front of the main entrance of the building. A ramp leads down to a lower parking lot that is in front of a detached building where corporate offices are located.

CoreCivic's Mission Statement is "Advancing corrections through innovative results that benefit and protect all we serve." Their vision is "To be the best full-service adult corrections system."

SUMMARY OF AUDIT FINDINGS

The initial on-site audit of CAI-Ocean View revealed that the facility was not compliant with standards 115.232, 115.241 and 115.242. An interim report was submitted to the PREA Coordinator on 3/14/17. The facility entered into a corrective action period of 30 days (3/1/17-3/30/17) for standard 115.232 and 120 days for standards 115.241 and 115.242 (3/1/17-5/1/17). The facility completed their corrective action measures at the conclusion of the established corrective action period and provided documentation for my review. Upon my review of documentation provided, the facility was found compliant with all three standards. The following is a summary of the final audit findings:

Number of standards exceeded: 6

Number of standards met: 30

Number of standards not met: 0

Number of standards not applicable: 3

Standard 115.211 Zero tolerance of sexual abuse and sexual harassment; PREA Coordinator

☒ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

CoreCivic's policy 14-2 CC and the Federal Bureau of Prison Program Statement 5324.12 were used to verify compliance to this standard, along with interview of the agency's PREA Coordinator and the facility's PREA Compliance Manager.

CoreCivic has a written policy and procedures mandating zero tolerance for all forms of sexual abuse and sexual harassment as stated on page 1, section 14-2 CC.1, paragraph 2. The policy outlines the agency's approach to preventing, detecting and responding to such conduct. The policy includes definitions of prohibited behaviors and sanctions for those found to participate in these prohibited behaviors. Upon review of policy 14-2 CC, it was found to be very comprehensive and includes a thorough description of the agency's approach to reduce and prevent sexual abuse and sexual harassment of residents, exceeding in the requirement of this standard.

CoreCivic employs an upper-level agency-wide PREA Coordinator and a facility PREA Compliance Manager. The current PREA Coordinator began employment with CoreCivic in December 2016 due to the retirement of the former PREA Coordinator. Page 2 of policy 14-2 CC outlines the responsibilities of the PREA Coordinator and the PREA Compliance Manager. In interview with the agency's PREA Coordinator and the facility's PREA Compliance Manager, both stated that they have sufficient time and authority to coordinate the facility's efforts to comply with the PREA standards as required.

Standard 115.212 Contracting with other entities for the confinement of residents

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

☒ Not Applicable

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

CoreCivic is a private provider and does not contract with other agencies for the confinement of residents; therefore, this standard is not applicable.

Standard 115.213 Supervision and monitoring

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard fo r the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Based on policy 14-2 CC, page 9, section D, 1-4 and Program Statement 5324.12, pages 14-16, the agency and facility have developed and documented a staffing plan that provides for adequate levels of staffing and uses video monitoring to protect residents against sexual abuse. The agency took into consideration the physical layout of the facility, the composition of the recent population and the prevalence of substantiated and unsubstantiated incidents of sexual abuse, and the resources the facility has available to commit to ensure adequate staffing levels in the development of the facility's staffing plan. The California Department of Corrections and Rehabilitation (CDCR) Scope of Work (SOW), pages 43 & 44 outline the requirements of CoreCivic to maintain the established staffing plan for the duration of the contract.

The facility makes its best efforts to comply with the approved PREA Staffing Plan. If there are deviations from the staffing plan, shift supervisors are to notify the PREA Compliance Manager who will in turn notifies the PREA Coordinator to include a description of any corrective actions that were taken to resolve the deviation. The facility maintains a staff to resident staffing ratio of 1:50 which meets the California standard for correctional facilities.

Based on documentation provided and upon interview with Facility Director, in the past 12 months, there were no times that there were deviations to the staffing plan. Vacated positions and call-ins are covered with the use of overtime.

The staffing plan is reviewed annually by the Facility Director in conjunction with the PREA Coordinator and documented on the 14-2 CC-I *Annual PREA Staffing Plan Assessment*. Upon completion, the 14-2 CC-I is forwarded to the PREA Coordinator for signature and approval of any recommendations made to the established staffing plan to include the deployment of video monitoring systems and other monitoring technologies or the allocations of additional resources to maintain compliance to the plan. The initial *Annual PREA Staffing Plan Assessment* under CoreCivic was completed on 4/8/16 and noted no changes to the current staffing plan.

Standard 115.215 Limits to cross-gender viewing and searches

☒ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Based on review of policy 14-2 CC, pages 14 & 15, section K, and documentation provided for review, the facility does not conduct cross-gender strip searches or cross-gender visual body cavity searches except in exigent circumstances or when performed by medical practitioners. Program Statement 5324.12, pages 18 & 19 outline the agency's requirements as it applies to this standard. A strip search is required to be performed by two staff of the same gender. The reason for the strip search must be documented. Staff are not to search or physically examine a transgender or intersex resident for the sole purpose of determining the resident's genital status.

The PREA education provided to all employees includes training on how to conduct cross-gender pat-down searches and searches of transgender and intersex residents. Staff sign a *Training Activity Enrollment/Attendance Roster* (4-2A) showing completion of this training. Receipt of this training was verified through interviews with staff and in review of staff training records. Pat searches are performed in a room close to the Monitor Station in a Pat Down Room in view of a camera and UA's are done in a restroom behind that area. Pat searches are documented on a *Daily Cross Gender Pat Search Log*.

The facility does not permit cross-gender pat-down searches of female residents, absent exigent circumstances. Females will not be restricted access to regularly available program or out-of-cell activities in order to comply with this provision. In the past 12 months, there were no cross-gender strip searches or cavity searches performed.

The agency has policies and procedures in place that enable residents to shower, perform bodily functions and change clothing without staff viewing their breast, buttocks or genitalia. Policy 14-2 CC, page 15, section 5, requires staff of the opposite gender announce their presence when they enter resident housing and restroom areas. This practice was observed while on-site at the facility and residents interviewed confirmed that this practice is being followed. Residents shared that they feel they have privacy to shower, toilet and change clothing when female staff are in their housing area.

Transgender and intersex residents are given the opportunity to shower separately from other residents. Upon request, the staff will close the shower to allow the resident to shower alone. At the time of the audit, there were no transgender or intersex residents housed at CAI-Ocean View.

The facility is doing an excellent job of ensuring the privacy of its residents, exceeding the requirements of this standard.

Standard 115.216 Residents with disabilities and residents who are limited English proficient

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Based on review of policy 14-2 CC, page 14, section I- 2 and Program Statement 5324.12, pages 19 & 20, residents are provided education in formats accessible to all residents, including those who are limited English proficient, deaf or hard of hearing, blind or have low vision, or otherwise disabled, as well as residents who have limited reading skills. A *PREA: What You Need to Know* video is viewed by residents within 72 hours of arrival to the facility and is available in both English and Spanish. Residents are given a CoreCivic PREA brochure, *Preventing Sexual Abuse & Misconduct* (14-2 CC-AA) and a *Resident Handbook,* both available in English and Spanish. PREA information posted throughout the facility is in both English and Spanish. The facility has a contract with Language Line Services, which provides for the translation of any other languages. A TTY is available for the use of deaf residents.

The initial screening of residents as well as the completion of the *CAI Needs Assessment Form* helps identify residents who may have disabilities that would prevent them from understanding the PREA information presented to them. At the time of the audit, there were no residents who were blind, had low vision, deaf, hard of hearing, limited English proficient, with limited reading skills or with cognitive deficits housed at the facility.

The agency prohibits use of resident interpreters, resident readers, or other types of resident assistants except in limited circumstances. In the past 12 months, there have been no instances where residents were used for this purpose.

Standard 115.217 Hiring and promotion decisions

☒ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Review of CoreCivic policy 14-2 CC, pages 5 & 6, section B, BOP Statement of Work for Residential Reentry Center, and Program Statement 5324.12 pages 20 & 21 and in discussion with the Human Resource and random review of employee, contractor and volunteer personnel files were used to verify compliance to this standard.

Per policy 14-2 CC, pages 5 & 6, section B, the agency 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 have engaged in sexual abuse in a prison, jail, lockup, community confinement, juvenile facility or other institution. It also prohibits hiring or promoting anyone who has been convicted of engaging or attempting to engage in sexual activity in the community or who has been civilly or administratively adjudicated to have engaged in these activities.

CoreCivic considers any incidents of sexual harassment in determining whether to hire or promote anyone, or to enlist the services of any contractor, who may have contact with residents. A *Self-Declaration of Sexual Abuse/Sexual Harassment* form (14-2 CC-H) is signed as an applicant and upon hire as an employee.

The agency requires that all applicants and employees who may have contact with residents have a criminal background check. Background checks are completed by the An effort is made to contact all prior institutional employers for information on substantiated allegations of sexual abuse or sexual harassments or any resignations during a pending investigation of an allegation of sexual abuse or sexual harassment. Verification of prior employment is completed on all applicants and if the applicant had correctional work experience, PREA questions are asked of them. NCIC/NLETS background checks are performed by BOP upon hire and every five years at the time of the contract renewal. The last contract renewal date was 6/1/16 when all staff, contracts and volunteers had criminal background checks completed.

Agency policy requires that criminal background checks be completed on any contractor who may have contact with residents. CoreCivic requires that criminal background checks be conducted every five years on current employees and contractors who may have contact with residents. In review of contractor records, all contractors have had criminal background checks.

All applicants and employees who have direct contact with residents are asked about previous misconduct as stated in section (a). The 14-2 CC-H, *Self-Declaration of Sexual Abuse/Sexual Harassment* form is completed as part of the hiring process and as part of the promotional process. At the time of annual performance evaluations, employees sign the evaluation certifying that they have disclosed all PREA allegations to their supervisors.

CoreCivic policy mandates that material omissions regarding sexual misconduct and the provision of materially giving false information are grounds for termination as required by this standard. Employees have a continuing affirmative duty to disclose any sexual misconduct.

In review of the electronic personnel files of all employees, contractors and volunteers showed that criminal background checks are being completed per agency policy and standard requirements. The Human Resources Manager is doing an excellent job of maintaining personnel files and adhering to the requirements of this standard and to the agency policy exceeding in the requirements of this standard.

Standard 115.218 Upgrades to facilities and technologies

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These

recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Based on policy 14-2 CC, page 31, section V, when designing or acquiring any new facility and in planning any substantial expansion or modification of existing facilities, CoreCivic will consider the effect of the design, acquisition, expansion or modification on the ability to protect residents from sexual abuse. The facility has not acquired any new facilities or made any substantial expansions or modifications to the existing facility since August 20, 2012, therefore this element of the standard is not applicable to this facility.

When installing or updating a video monitoring system, electronic surveillance system or other monitoring technology, CoreCivic will consider how such technology may enhance the ability to protect residents from sexual abuse. In 2016, there were updates to the video monitoring system with six additional exterior and four interior cameras purchased and installed.

In interview with the Executive Vice President and Chief Corrections Officer on 10/4/16, he explained what the agency would consider for planning for new construction or making modifications to existing facilities, which would include careful consideration to the use of monitoring technology.

Standard 115.221 Evidence protocol and forensic medical examinations

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Based on policy 14-2 CC, page 23, section O – 4 and Statement of Work, page 22-24, CoreCivic and CAI-Ocean View are responsible for conducting administrative sexual abuse investigations on both resident-on-resident and staff sexual misconduct. The Facility Director of CAI-Boston Avenue is a trained facility investigator and she responsible for conducting administrative investigations of sexual abuse and sexual harassment. A Memorandum of Understanding (MOU) effective 7/1/16 with the San Diego Police Department provides for criminal investigations of sexual abuse. BOP and OIG are also responsible for criminal investigations of allegations of sexual abuse. The investigating entities follow a uniform evidence protocol that maximizes the potential for obtaining usable physical evidence and fulfill all requirements of this standard.

The facility does not house youth, therefore element (b) of this standard is not applicable to this facility.

Victims of sexual abuse have access to forensic medical examinations. When the San Diego Police Department are notified of sexual abuse at CAI-Ocean View, the detective that responds to the call would contact the area forensic nurse on call. The forensic nurse would then call the Center for Community Solutions to request a victim advocate respond either to the Independent Forensic Services or to the Pomerado Hospital where the forensic exams are performed. Within 24-48 hours after the forensic exam, an advocate would contact the resident to offer services in support of the victim. In the past 12 months, there were no referrals of residents for SANE exams.

The facility has made multiple attempts to enter into a Memorandum of Understanding with the Center for Community Solutions to provide victim advocacy and emotional support services. Even without the MOU, residents of CAI-Ocean View can access services from the Center for Community Solutions that include victim advocacy, referrals for counseling and legal and civil services.

Standard 115.222 Policies to ensure referrals of allegations for investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Policy 14-2 CC, pages 21-22 section O and Program Statement 5324.12 page 24, outlines the agency's policy and procedures for investigating and documenting incidents of sexual abuse and sexual harassment. The agency must ensure that an administrative or criminal investigation be completed for all allegations of sexual abuse and sexual harassment. The facility is responsible for conducting administrative investigations of allegations of sexual abuse and sexual harassment. Upon receipt of an allegation, the facility is required to notify the San Diego Police Department, BOP or OIG to conduct a criminal investigation and prosecution if warranted. The agency documents all referral of allegations of sexual abuse or sexual harassment for criminal investigation in the agency's 5-1 system. In the past 12 months, there were nine allegations of sexual abuse/sexual harassment reported. None were referred for criminal investigation.

The agency's policy regarding the referral of allegations of sexual abuse or sexual harassment for criminal investigations is published on the CoreCivic website (http://www.CoreCivic.com/security-operations/prea).

Standard 115.231 Employee training

☒ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

CoreCivic employees receive training on the agency's zero-tolerance policy (14-2 CC) for sexual abuse and sexual harassment at pre-service and annually at in-service. The agency's requirement of this training is found on pages 6 & 7, section C-1 of policy 14-2 CC and pages 24-26 of Program Statement 5324.12. Between trainings, the facility has staff meetings where the policy is reviewed and staff is informed of policy changes. The employee training curriculum was reviewed and found to contain all elements of 115.231 (a) as required. The training is tailored to the gender of the residents at the facility. Employees sign a *Policy Acknowledgement* (14-2 CC-A) acknowledging that they have received and understood the training they received and they sign a *Training Acknowledgement* form. Annual training is provided online. Upon completion of the training the employee checks a box and information is automatically documented electronically on individual *Employment Education & Training Record.*

In the past 12 months, all employees of CAI-Ocean View have received this training as verified by review of all employee-training files. In interview with staff, they were able to confirm receiving this training and knew their responsibilities for preventing and responding to allegations of sexual abuse and sexual harassment.

Standard 115.232 Volunteer and contractor training

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action) ☒ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

CoreCivic policy 14-2 CC, page 8, section 2 and Program Statement 5324.12 page 26, outlines the training requirements for volunteers and contractors and the CDRC Scope of Work, C5606354, exhibit D, page 19 addresses the agency's requirement as well. The objectives of the training ensure that volunteers and contractors are notified of the agency's zero-tolerance policy regarding sexual abuse and sexual harassment and are informed on how to report such incidents. Volunteers receive the *RRC Volunteer Manual* and complete *CAI Volunteer Training and Orientation.* Upon completion of this training, volunteers sign a *Self-Declaration of Sexual Abuse/Sexual Harassment (14-2 CC-H)* form and sign an additional acknowledgement form. CAI-Ocean View has 20 volunteers who have received this training in the past 12 months. In telephone interview of one volunteer, he confirmed receiving this training annually and knew his responsibilities if a resident reported sexual abuse or sexual harassment to him.

The facility has four contractors who provide outpatient substance abuse treatment programs to the residents of CAI-Ocean View. In review of contractor files, it was revealed that three of the four contractors have not received any PREA training, finding that the facility did not meet the requirements of this standard. The one contractor who did receive the training is overdue for annual retraining. Several attempts were made to reach a contractor for a telephone interview were unsuccessful. The following was the corrective action plan recommended to the facility:

Recommended Corrective Action Plan:
For the facility to achieve compliance to this standard, all contractors will need to complete PREA training and sign the required Training Acknowledgement form acknowledging receipt and understanding of agency policy 14-2B CC, sign a training roster and a *Self-Declaration of Sexual Abuse/Sexual Harassment* (14-2 CC-H) upon completion of this training. The documentation of completion of the training will need to be forwarded to the agency's PREA Coordinator who will review the documentation and forward to me for my review. Corrective action period to continue for 30 days for this standard beginning 3/1/17.

Corrective Action Taken:
Three of the four facility contractors received PREA training between 3/14/17-3/16/17 and signed a *Policy Acknowledgement* form (14-2 CC-A), a training acknowledgement form, and a *Self-Declaration of Sexual Abuse/Sexual Harassment* form (14-2 CC-H). The one contractor who did not receive the training during that time completed PREA training on 7/28/16, so her training is current until that day. The facility forwarded me the 14-2-CC-A, the 14-2 CC-H and training acknowledgement forms for all four contractors. To ensure that volunteer and contractor training remains in compliance, the Assistant Director will conduct regular audits of the volunteer and contractor training files for compliance. Upon my review of the documentation of contractor PREA training, it was determined that the facility has achieved compliance to this standard.

Standard 115.233 Resident education

☒ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Based on CoreCivic policy 14-2 CC, pages 13 & 14, section I and the Program Statement 5324.12 pages 26-28, all residents receive information at time of intake about the zero-tolerance policy and how to report incidents of sexual abuse or sexual harassment, their rights to be free from retaliation for reporting such incidents and are informed of the agency policy and

procedures for responding to such incidents.

Upon intake, residents receive a *Preventing Sexual Abuse & Misconduct* pamphlet and by their signature on a *Residents Right to Know* form acknowledging that they have received the pamphlet given to them upon arrival. Comprehensive PREA classes for are offered twice a week in both English and Spanish for all new arrivals to the facility that week. Residents receive another *Preventing Sexual Abuse & Misconduct* pamphlet and view the *PREA: What You Need to Know* video with verbal information provided by the facilitator. Residents sign a roster upon completion of the video.

Ongoing information is provided continuously on posters, both in English and Spanish, prominently displayed in various locations throughout the facility

Thirty-five residents interviewed were aware of the zero-tolerance policy and methods of reporting sexual abuse and sexual harassment available to them. The facility is doing an excellent job of conveying PREA information to all residents as was evident in review of resident records and the level of knowledge of residents when interviewed.

Standard 115.234 Specialized training: Investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Based on CoreCivic policy 14-2 CC, page 7, section b and Program Statement 5324.12, page 28, in addition to general training provided to all employees, CoreCivic ensures that facility investigators receive training on conducting sexual abuse investigations in confinement settings. The training includes techniques for interviewing sexual abuse victims, proper use of the Miranda and Garrity warnings, sexual abuse evidence collection in confinement settings and the criteria and evidence required to substantiate a case for administrative action or referral for prosecution.

At this facility, there are no trained facility investigators. The Facility Director from CAI-Boston Ave is a trained investigator and is called upon to conduct administrative investigations at this facility. Documentation provided showed she completed the *PREA Update, Investigation Standards and Required Specialty Training* webinar on 11/20/13 and signed a *Training Acknowledgement/Attendance Roster* (4-2A) upon completion of this training.

Standard 115.235 Specialized training: Medical and mental health care

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

☒ Not Applicable

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

CAI-Ocean View does not have medical or mental health staff; therefore, this standard is not applicable to this facility.

Standard 115.241 Screening for risk of victimization and abusiveness

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Per policy 14-2 CC, pages 12 & 13, section H and Program Statement 5324.12, pages 30-32, upon admission to CAI-Ocean View or upon transfer to another facility, residents are screened for their risk of being sexually abused or sexually abusive towards others. The *Sexual Abuse Screening Tool* (14-2 CC-B-1) is used for this purpose. The 14-2 CC-B-1 form was reviewed and found to contain all requirements of 115.241 (a) of this standard. The screening considers prior acts of sexual abuse and prior convictions for violent offenses. The Senior Security Monitors, the Security Monitor's II or the Security Monitor I's complete the initial screening upon the resident's arrival to the facility. The forms are then forwarded to the Case Manager for their review and signature and then to the Unit Manager. Prior to the resident's arrival to the facility, the Case Manager reviews prior institutional records and inputs this information on the 14-2 CC-B-1 form.

In review of the initial rescreenings of 25 residents, it was found that the 14-2 CC-B-1 forms are not being completed in their entirety or incorrectly completed. Dates of the screening were missing or incorrect, the scoring sections were not completed, comments were not added to questions that the resident answered "yes" to as required and Security Monitors were not signing the forms. In a few cases, initial screenings were completed using an old screening form. In four resident records reviewed, initial screenings were completed several days after the resident's arrival date. Following the Case Manager's review, the Case Manager is required to enter a note in the Facility Management System (FMS) indicating special notes that identify the resident as being a victim, potential victim or potential predator as well as any other pertinent information obtained from the screening. In review of a Special Monitoring binder maintained by the Chief of Security, not all required notes were entered into the FMS.

Within 30 days of the resident's arrival to the facility, the resident is rescreened by their Case Manager using the 14-2 CC-B-1 form. The reassessment includes any additional relevant information received by the facility since the initial intake screening. A resident's risk level is also reassessed when warranted due to a referral, request, incident of sexual abuse, or receipt of additional information. Residents may not be disciplined for refusing to answer, or for not disclosing complete information in response to questions asked. In review of the same 25 resident records, it was found that five 30-day reassessments were never completed and several were completed incorrectly showing some of the same errors that were found in the initial screenings.

Due to the random review of 25 resident records, the facility was found to not meet this standard. The following is the recommended corrective action plan to bring this standard into compliance:

Recommended Corrective Action Plan:

The recommended corrective action plan to bring standard 115.241 into compliance, is for the facility to develop a lesson plan on the correct procedure to complete the *Sexual Abuse Risk Assessment* (14-2 CC-B-1) form and forward the lesson plan to the agency PREA Coordinator for his review and approval. Upon his approval, all Security Monitors and Case Managers will need to be trained on the new procedure and indicate by their signature on a training roster that they have completed this training. Following training of all staff responsible for the completion of the 14-2 CC-B-1 forms, a review of all 14-2 CC-B-1 forms for the current population needs to be done to determine which residents need to be rescreened due to incomplete or incorrect completion of the forms. Thirty-day rescreenings for those residents that have been at the facility for longer than 30 days need to be completed if records show they were not completed as required.

The corrective action period will be 120 days beginning on 3/1/17 and end on 5/1/17. During this corrective action period, the lesson plan, the training roster indicating training on the new procedure and all 14-2 CC-B-1 forms completed during this period are to be forwarded to the Agency PREA Coordinator for his review, who will forward all required documentation to me.

Corrective Action Taken:

During the corrective action period, all monitor and case management staff were trained on the initial and 30-day reassessment screening procedures. The procedure was sent to me for my review which included a roster that staff signed upon completion of the training. These trainings were offered on different days from 3/28-3/31 to ensure that all staff had an opportunity to attend. Staff signed a *Training Activity Enrollment/Attendance Roster* at the completion of this training. Included in this training were measures to monitor adherence to the new procedure through FMS reports and named the person responsible for this monitoring. The PREA Coordinator forwarded to me a listing of identification numbers, names and dates of initial screenings and corresponding lists with the same information for 30-day rescreenings, as well as completed *Sexual Abuse Risk Assessment* forms (14-2 CC-B-1) for both initial and 30-day reassessment screenings. Upon review of this documentation, I confirmed that the facility has achieved compliance with standard 115.241.

Standard 115.242 Use of screening information

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Policy 14-2 CC, pages 13 & 14, section H-1, and Program Statement 5324.12, page 33 addresses the use of the information obtained during the screening process. The agency uses the information from the risk screening form to make housing, bed, work, education and program assignments with the goal of separating residents at high risk of being sexually victimized from residents with those at high risk of being sexually abusive. Individualized determinations are made about how to ensure the safety of each resident.

Guidelines on housing and program assignments for the management of transgender and intersex residents are outlined in policy 14-2 CC, page 14, section J. Transgender and intersex residents are reassessed at least twice per year to review any threats to safety experienced by the resident as required by this standard and takes into consideration their own views regarding their own safety. Placement is made on a case-by-case basis to ensure the health and safety of the resident. Transgender and intersex residents are given the opportunity to shower separately from other residents. The agency does not place lesbian, gay bisexual, transgender or intersex residents in dedicated facilities, units or wings solely based on such identification. At the time of the audit there were no self-disclosed gay, bisexual, transgender or intersex residents housed at the facility. There was one self-disclosed lesbian. The Chief of Security uses a pin map to help keep victims and predators separated.

Due to the random resident file review revealing incorrect completion of the 14-CC 2-B-1 forms, the necessary information obtained from several of these screenings were found to be inaccurate or incomplete. The scoring of the risk assessments were not always completed or incorrectly completed so that residents were not always properly assessed for their risk of victimization or abusiveness. In cases where they were scored correctly, Case Managers did not always enter information into the FMS which did not allow for tracking of these residents to ensure their proper housing and sexual safety. Due to the findings in the resident file review, the facility did not meet compliance to this standard. The following is the recommended corrective action:

Recommended Corrective Action:

In order for the facility to achieve compliance to this standard, the facility must ensure completion of all recommended corrective action as outlined in standard 115.241, in addition to requiring Case Managers to review all rescreenings of the current population and identify any residents that are identified from rescreening to be victims, potential victims or potential predators. Once identified, Case Managers are to ensure this information is entered into the FMS and that this information is relayed to the Chief of Security for proper housing of these residents ensuring that victims and potential victims are housed separately from potential predators. In addition to the 14-CC 2-B-1 forms that will be forwarded to me (see *Recommended Corrective Action* section of standard 115.241), the notes entered into the FMS through the 120-day corrective action period are required to be forwarded to the agency PREA Coordinator for his review and then forwarded to me.

Corrective Action Taken:

During the corrective action period, all monitor and case management staff were trained on the initial and 30-day reassessment screening procedures. These trainings were offered on different days from 3/28-3/31 to ensure that all staff had an opportunity to attend. The procedure was sent to me for my review which included a roster that staff signed upon completion of the training. Staff signed a *Training Activity Enrollment/Attendance Roster* at the completion of this training. Included in this training were measures to monitor adherence to the new procedure through FMS reports and named the person responsible for this monitoring. The PREA Coordinator forwarded to me a listing of identification numbers, names and dates of initial screenings and corresponding list with the same information for 30-day rescreenings, as well as completed *Sexual Abuse Risk Assessment* forms (14-2 CC-B-1) for both initial and 30-day reassessment screenings.

Modifications were made to the *Sexual Abuse Risk Assessment* form that computes the score when the form is completed and notes on the form whether the resident is assessed at risk for victimization, abusiveness or not applicable.

Due to the incorrect completion of the 14-CC- 2-B-1 forms, some of the information obtained from the assessments were not accurate and residents were not properly assessed for their risk of victimization or abusiveness. The training on the procedure for completion of the *Sexual Abuse Risk Assessment* included the Monitor II or Shift Leader being responsible for reviewing every initial PREA assessment prior to the end of the shift to ensure residents are classified appropriately. When 30-day reassessment screenings are completed, the assigned Case Manager will ensure that an email is sent to the Unit Manager, Case Manager Supervisor, Captain and Senior Monitor to notify if a change in the resident's classification is required in FMS. Upon review of this documentation, I confirmed that the facility is compliant with standard 115.242.

Standard 115.251 Resident reporting

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

CoreCivic policy 14-2 CC, pages 15 & 16, section L and Program Statement 5324.12, page 35, outlines the procedures for resident reporting of allegations of sexual abuse and sexual harassment, retaliation by other residents or staff or staff neglect or violation of responsibilities that may have contributed to such incidents. Residents can report verbally to any staff member, write a letter to the Facility Director or any other employee, to the agency PREA Coordinator or have a family member or friend make a report for them. Residents are instructed on page 24 of the Resident Handbook that they can call the San Diego County Domestic Violence and Sexual Abuse 24-Hour Crisis Hotline at 888-385-4657, the San Diego County Mental Health at 1-888-724-7240, SART at 619-285-6429, Center for Community Solutions at 858-272-5777, the National Sexual Abuse Hotline at 1-800-656-4673 or the Center for Women Studies and Services at 619-233-3088.

Residents receive a *Preventing Sexual Abuse & Misconduct* pamphlet, available in both English and Spanish, in the *Resident Handbook* (page 23) upon intake and are made aware of reporting options continuously through posters displayed throughout the facility. In addition, residents can contact BOP at 310-732-5179 and the US Probation Office at 619-557-5739. Residents interviewed were aware of methods available to them to report sexual abuse and sexual harassment and staff neglect or

violation of responsibilities that may have contributed to such incidents.

Employees must take all allegations of sexual abuse and harassment seriously whether they be made verbally, in writing, anonymously and from third parties and are required to document all reports. Employees may privately report sexual abuse and sexual harassment of residents by forwarding a letter, sealed and marked "confidential" to the Facility Director or contact the CoreCivic Ethics and Compliance Hotline. Staff interviewed were aware of their method of privately reporting sexual abuse and sexual harassment of residents. Reporting methods can be found on the CoreCivic's website.

Standard 115.252 Exhaustion of administrative remedies

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

☒ Not Applicable

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

CAI-Ocean View does not have an administrative procedure for addressing residents' grievances regarding sexual abuse. All PREA allegations received as a grievance are submitted to the Facility Director for immediate initiation of the PREA protocol; therefore, this standard is not applicable. In the past 12 months, the facility has not received any grievances alleging sexual abuse.

Standard 115.253 Resident access to outside confidential support services

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

CoreCivic policy 14-2 CC, page 10, section F and Program Statement 5324.12, page 36, outlines the agency's policy on providing residents with access to outside victim advocates for emotional support services related to sexual abuse. Residents are given mailing addresses and telephone numbers, including toll-free hotline numbers of local, state or national victim advocacy or rape crisis organizations.

This information is provided to residents on posters displayed throughout the facility, in the *Resident Handbook* and in the Preventing *Sexual Abuse & Misconduct* pamphlet. Residents are informed prior to giving them access, of the extent to which communications will be monitored and to the extent to which reports of abuse will be forwarded to authorities.

The facility has made multiple attempts to enter into an MOU with the Center for Community Solutions and continues in these efforts. The Sexual Assault Victim Advocacy Manager of the Center for Community Solutions was contacted during the audit. She shared that even though the MOU is not finalized, the residents of CAI-Ocean View can access the services of their agency at no cost to the resident. The services include victim advocacy, referrals for counseling and legal and civil services.

Standard 115.254 Third-party reporting

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The agency has a method to receive third-party reports of sexual abuse and sexual harassment. Family members or other individuals may report verbally or in writing to the PREA Coordinator or to the Facility Director. Per CoreCivic policy 14-2 CC, page 17, section L-4 and Program Statement 5324.12, page 37, information for third party reporting is made available on the CoreCivic website with instructions for outside parties to contact the National Sexual Assault Hotline at 1-800-656-4673 or send a letter to the facility's acting Facility Director. Visitors are informed of the agency/facility's zero-tolerance policy and are instructed report any prohibited sexual behavior on the top portion of the *Guest Log.* Visitors' signature on the log certifies that they have read and understand the information provided to them on the log.

Residents are made aware of this method of reporting in the *Preventing Sexual Abuse & Misconduct* pamphlet and in the *Resident Handbook*. Residents interviewed were knowledgeable of this method of reporting. During the past 12 months, there have been no reports of sexual abuse or sexual harassment made to the facility by a third party.

Standard 115.261 Staff and agency reporting duties

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The agency/facility policy 14-2 CC on staff reporting duties was found on pages 16 & 17, section L-2 and on pages 37 & 38 of Program Statement 5324.12. Staff must take all allegations of sexual abuse and sexual harassment seriously. All staff are required to report immediately to the PREA Compliance Manager any knowledge, suspicion or information regarding an incident of sexual abuse or sexual harassment and any retaliation against residents or staff who reported such an incident. All allegations of sexual abuse and sexual harassment, including third party and anonymous reports, are reported to the facility's investigator. Staff are also required to report, according to policy, any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation. Interview with staff revealed that staff is very knowledgeable of their responsibilities to report incidents of sexual abuse or harassment and know not to reveal any information about a sexual abuse incident to anyone other than to the extent necessary.

CAI-Ocean View does not employ medical or mental health staff; therefore, subsection 115.261(c) does not apply to this facility.

CAI-Ocean View houses adult male and female residents only, none of whom according to their classified level of care are considered vulnerable adults under the State Vulnerable Persons Statue; therefore, subsection 115.261 (d) is not applicable to this facility.

Standard 115.262 Agency protection duties

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

When the agency learns that a resident is subject to a substantial risk of imminent sexual abuse, it takes immediate action to protect the resident. Policy 14-2 CC, page 1, paragraph 2 and page 17, section 2-c and Program Statement 5324.12, pages 37 & 38, requires that when it is learned that a resident is subject to a substantial risk of imminent sexual abuse, immediate action shall be taken to protect the resident.

In interview with the Facility Director, there were no times during the past 12 months that it was necessary for the agency to take immediate action in regards to a resident being in substantial risk of sexual abuse. Residents at risk of sexual abuse would be tracked on a *Correctional Alternatives, Inc. (OV) Special Monitoring Report*. Staff interviewed were aware of their responsibilities if they felt a resident was at risk for sexual abuse.

Standard 115.263 Reporting to other confinement facilities

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Policy 14-2 CC, page 19, section M-3 and Program Statement 5324.12, pages 39 & 40 were used to verify compliance to this standard. Upon receiving an allegation that a resident was sexually abused while confined at another facility, the Facility Director will notify the head of the facility where the sexual abuse was alleged to have occurred and document that notification was provided. This notification is to occur as soon as possible, but no later than 72 hours of receiving the allegation. If the allegation was reported and investigated at the facility where the sexual abuse was alleged to occur, the Facility Director is to document such and no further investigation or notification is necessary. If the allegation was not reported or not investigated, a copy of the resident's statement and any other details obtained from contact with the facility where the alleged abuse took place and the facility's response is documented on the 5-1B form. If an allegation is received from another facility, the Facility Director will ensure that the allegation is investigated according to PREA standards.

In the past 12 months, there have been no reports of allegations of sexual abuse received from other facilities that were alleged to have occurred at CAI-Ocean View and no reports received from residents of sexual abuse that occurred while confined at other facilities. Upon interview, the Facility Director was aware of his responsibilities of reporting if allegations are received.

Standard 115.264 Staff first responder duties

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Policy 14-2 CC, page 18 section M and Program Statement 5324.12, page 40, outlines the procedure for first responders to allegations of sexual abuse and sexual harassment whether that person is a security or non-security staff member. Per policy, upon learning of an allegation of sexual abuse, the first staff member to respond to keep the alleged victim safe with no contact with the alleged perpetrator and immediately escorted to a private area and ensure that the crime scene is preserved. If the abuse was alleged to have occurred within a time frame that allow for the collection of physical evidence, staff shall ensure that the victim does not wash, shower, toilet, eat, drink or brush his teeth. Policy mandates that if the first responder to an allegation of sexual abuse is a non-security staff member, they shall advise the alleged victim not to take any actions that could destroy physical evidence and then notify security staff immediately. Staff are instructed to assess any immediate medical needs and call 911 if necessary. Notification is to be made to the Facility Director or the administrative duty designee who notify the oversight agency. All allegations of sexual abuse are reported to the San Diego Police Department.

Staff carry with them a First Responder Card that highlights their responsibilities in response to allegations of sexual abuse and sexual harassment. Staff interviews with security and non-security staff revealed that they knew the policy and practice to follow if they were the first responder to an allegation of sexual abuse or sexual harassment. They reported that they knew that the alleged victim and abuser must be separated and knew how to preserve the crime scene and the physical evidence.

In the past 12 months, there were five allegations of resident-on-resident sexual abuse and four allegations of staff-on resident sexual abuse reported, none of which required first responder duties to be implemented.

Standard 115.265 Coordinated response

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Policy 14-2 CC pages 18-20 outline the agency's/facility's coordinated response to an incident of sexual abuse. A Sexual Abuse Response Team (SART) is established at this facility that includes the Facility Director, Chief of Security, a Program Manager, two Unit Managers and the QA Manager The responsibilities of the team are to respond to reported incidents of sexual abuse, review the facility's response to sexual abuse allegations, serve as a primary liaison with local law enforcement, ensure completion of the 14-2 CC-C, *Sexual Abuse Incident Checklist* and ensure that 30/60/90-day monitoring is conducted. When interviewed, members of the SART knew their responsibilities in response to sexual abuse allegations.

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

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Policy 14-2 CC, page 26, section 2-d, was used to verify compliance to this standard. Employees are subject to disciplinary sanctions up to termination for violating CoreCivic policies on sexual abuse and sexual harassment. Since August 20, 2012, CoreCivic has not entered into or renewed any collective bargaining agreement that limits the agency's ability to remove alleged staff sexual abusers from contact with residents pending the outcome of an investigation. There are no restrictions to keep the agency from removing an alleged staff sexual abusers from contact with residents pending the outcome of an investigation.

In interview with the Executive Vice President and Chief Corrections Officer on 10/4/16, any agreements that CoreCivic enters into would not limit the agency from removing alleged staff sexual abusers from contact with residents pending the outcome of an investigation and not disciplining employees up to and including termination.

Standard 115.267 Agency protection against retaliation

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

CoreCivic has as policy to protect residents who report sexual abuse or sexual harassment or cooperate with sexual abuse or sexual harassment investigations from retaliation by other residents or staff as outlined on page 11, section 3, a-iv – vi and in Program Statement 5324.12, pages 42 & 43. The agency has multiple protection measures, such as housing changes or transfers for residents, victims or abusers, removal of alleged staff or resident abusers from contact with victims and emotional support services for residents or staff that fear retaliation for reporting sexual abuse or sexual harassment or for cooperating with investigations.

The Facility Director is responsible for monitoring for retaliation. Monitoring shall be documented on the 14-2 CC-D, *PREA Retaliation Monitoring Report* form. Monitoring is required 30/60/90 days following an allegation and can continue beyond 90 days if there is a continuing need. If any other individual who cooperates with an investigation expresses a fear of retaliation, appropriate measures to protect that individual against retaliation are put in place. When interviewed, the Facility Director knew his responsibilities for monitoring for retaliation per policy and this standard.

In review of investigative files, retaliation monitoring is being done. In the past 12 months, there were no incidents of retaliation that occurred.

Standard 115.271 Criminal and administrative agency investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance

determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The agency/facility conducts an investigation immediately when notified of an allegation of sexual abuse and sexual harassment including third party and anonymous reports. The facility investigators are responsible for conducting administrative investigations of sexual abuse and sexual harassment at the facility.

The agency's policy on administrative and criminal investigations is outlined in policy 14-2 CC, pages 21 & 22, section O and in Program Statement 5324.12, pages 43-45. The administrative investigation shall include an effort to determine whether staff actions or failures to act contributed to the abuse. The administrative investigation shall be documented in a written report.

All allegations of sexual abuse are referred to the San Diego Police Department for criminal investigation who conducts investigations pursuant to the requirements of this standard. The facility shall cooperate with outside investigators and remain informed of the progress of the investigation through communication with outside investigators. A criminal investigation shall be documented in a written report that contains a thorough description of physical, testimonial and documentary evidence.

The credibility of an alleged victim, suspect or witness is assessed on an individual basis and is not determined by the person's status as resident or staff. A resident who alleges sexual abuse is not required to submit to a polygraph examination. CoreCivic retains all written reports pertaining to administrative investigations of sexual abuse and sexual harassment for as long as the alleged abuser is incarcerated or staff member is employed by the agency, plus five years. When interviewed, the Facility Director knew his responsibilities in the conduct of administrative investigations and referral of sexual abuse allegations to the San Diego Police Department.

In the past 12 months, there were no allegations that appeared to be criminal referred for prosecution.

Standard 115.272 Evidentiary standard for administrative investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Based on policy 14-2 CC, page 23 & 24, section O-5 and Program Statement 5324.12, page 45, the agency shall impose no standard higher than the preponderance of evidence in determining whether allegations of sexual abuse or sexual harassment are substantiated. When the Facility Director responsible for administrative investigations was asked what standard of evidence was used in determining if an allegation is substantiated, he confirmed the agency's policy.

Standard 115.273 Reporting to residents

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion

must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Policy 14-2 CC, pages 24 & 25, section Q and Program Statement 5324.12, page 46, was used to verify compliance to this standard. The policy indicates that following an investigation of sexual abuse of a resident, the resident shall be informed as to whether the allegation has been determined to be substantiated, unsubstantiated or unfounded. If the facility did not conduct the investigation, the facility shall request the relevant information from the investigative agency in order to inform the resident. The policy further states that following a resident's allegation that an employee has committed sexual abuse against the resident; the facility is required to inform the resident of the outcome of the investigation, unless the facility has determined that the allegation was unfounded. Following a resident's allegation that another resident sexually abused him, the agency shall inform the resident of the outcome of the investigation.

All resident notifications or attempted notifications shall be documented on the 14-2 CC-E, *Inmate/Resident Allegation Status Notification* form. The resident shall sign the 14-2 CC-E and the form is to be filed in the resident's institutional file. The facility's obligation to notify the resident shall terminate if the resident is released from custody. In the past 12 months, there were five allegations of resident-on-resident sexual abuse reported. Two of those allegations are still being investigated. Two *Inmate/Resident Allegation Status Notification* forms presented to residents who reported sexual abuse. Two of the other residents who alleged sexual abuse were removed from the program the following day and one resident escaped. There were four staff-on-resident sexual abuse allegations reported, two of those investigations are ongoing and other two allegations were determined to be unfounded so no notice was required to be given to the alleged victim.

The Facility Director when interviewed knew his responsibilities following an investigation when the outcome of the investigation is determined to be substantiated, unsubstantiated or unfounded and if the allegation involved an employee, notification is required when the allegation is determined to be substantiated or unsubstantiated, but not unfounded.

Standard 115.276 Disciplinary sanctions for staff

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Staff shall be subject to disciplinary sanctions up to and including termination for violating agency sexual abuse policy as outlined in policy 14-2 CC, page 26, section 2 and Program Statement 5324.12, page 47. Termination shall be the presumptive disciplinary sanction for staff who have engaged in sexual abuse. Disciplinary sanctions for violation of agency policies related to sexual abuse or sexual harassment shall commensurate with the nature and circumstances of the acts committed, the staff member's disciplinary history and other sanctions imposed for comparable offenses by other staff with similar histories. All terminations for violations of the agency's policies on sexual abuse and sexual harassment, or resignation, shall be reported to law enforcement agencies unless the activity was clearly not criminal, and to relevant licensing bodies. In the past 12 months, no staff has been disciplined or terminated for violating the agency's sexual abuse or sexual harassment policy.

Standard 115.277 Corrective action for contractors and volunteers

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Based on review of policy 14-2 CC, page 26 & 27, section 3 and Program Statement 5324.12, page 47, any volunteer or contractor who engages in sexual abuse is prohibited from contact with residents and shall be reported to law enforcement agencies or licensing boards, unless the activity was clearly not criminal. Any other violation of CoreCivic's sexual abuse or sexual harassment policies by a volunteer or contractor will result in further prohibitions. In interview with the Facility Director and documentation provided by the facility, in the past 12 months CAI-Ocean View has not received any reports of sexual abuse of residents by contractors or volunteers.

Standard 115.278 Disciplinary sanctions for residents

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Per policy 14-2 CC, page 25, section R-1 and Program Statement 5324.12, page 48, residents will be subject to disciplinary sanctions following an administrative finding that the resident engaged in resident-on-resident sexual abuse or following a criminal finding of guilt for resident-on-resident sexual abuse. 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. The disciplinary process considers whether a resident's mental disabilities or mental illness contributed to his behavior in determining what type of sanction, if any should be imposed.

A resident may be disciplined for sexual conduct with an employee only upon a finding that the employee did not consent to such conduct. Residents who allege false claims of sexual abuse can be disciplined. A report of sexual abuse made in good faith based on a reasonable belief that the alleged contact occurred does not constitute falsely reporting an incident or lying, even if the investigation does not establish evidence sufficient to substantiate the allegation.

Upon entering the facility, residents are given a *Resident Handbook*, which states sexual misconduct is a violation against the facility's rules and regulations and describes what constitutes sexual misconduct.

In the past 12 months, there were three substantiated cases of resident-on-resident sexual abuse. In all cases, the residents were removed from the facility by the oversight body before disciplinary action could be taken.

Standard 115.282 Access to emergency medical and mental health services

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These

recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Resident victims of sexual abuse will receive timely, unimpeded access to emergency medical treatment and crisis intervention services. Medical and mental health services are not provided on-site at CAI-Ocean View. Victims of sexual abuse have access to forensic medical examinations. When the San Diego Police Department are notified of sexual abuse at CAI-Ocean View, the detective that responds to the call would contact the area forensic nurse on call. The forensic nurse would then call the Center for Community Solutions to request a victim advocate respond either to the Independent Forensic Services or to the Pomerado Hospital where the forensic exams are performed. Within 24-48 hours after the forensic exam, an advocate would contact the resident to offer services in support of the victim. In the past 12 months, there were no referrals of residents for SANE exams.

The facility has made multiple attempts to enter into a Memorandum of Understanding with the Center for Community Solutions to provide victim advocacy and emotional support services. Even without the MOU, residents of CAI-Ocean View can access services from the Center for Community Solutions that include victim advocacy, referrals for counseling and legal and civil services.

In the past 12 months, there have been no sexual abuse cases requiring emergency medical or mental health services.

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

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The facility will offer ongoing medical and mental health care to all CAI-Ocean View residents who have been victimized by sexual abuse as stated in policy 14-2 CC and Program Statement 5324.12, pages 51 & 52. The evaluation will include follow-up services, treatment plans and referrals for continued care consistent with the community level of care upon their release from the facility when necessary.

The facility attempts to conduct a mental health evaluation of all known resident-on-resident abusers within 60 days of learning of such abuse history and offers treatment when deemed appropriate. Resident victims of sexual abuse are offered tests for sexually transmitted infections as medically appropriate. Mental health services are provided by referral to the Center of Community Solutions.

Medical services are provided at local hospitals. Female victims of sexually abusive vaginal penetration will be offered pregnancy tests. If pregnancy results from sexual abuse, victims would receive timely and comprehensive information about access to all lawful pregnancy-related medical services.

In the past 12 months, there were no residents who required ongoing medical or mental health treatment due to sexual abuse.

Standard 115.286 Sexual abuse incident reviews

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Based on policy 14-2 CC, pages 20 & 21 , section N and Program Statement 5324.12, pages 52 & 53, the acting Facility Director will ensure that a post investigation review of a sexual abuse incident is conducted within 30 days of the conclusion of every sexual abuse investigation, unless the allegation was determined to be unfounded. The Facility Director, Chief of Security, two Unit Managers and the QA Manager make up the SART and are responsible incident reviews. Per policy, the review team will consider requirements of 115.286 (d) of this standard when reviewing an incident of sexual abuse. The SART meets after the conclusion of every investigation. All findings and recommendations for improvement will be documented on the 14-2 CC-F, *Sexual Abuse or Sexual Assault Incident Review Form*, and completed forms will be forwarded to the PREA Coordinator. The facility will implement the recommendations for improvement or will document reasons for not doing so.

In review of investigative files, sexual abuse incident reviews are being completed. When interviewed, members of the SART knew their responsibilities as they relate to the review of sexual abuse incidents.

Standard 115.287 Data collection

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Information on data collection is found on page 27, section T-1 and section 2-a & b of policy 14-2 CC and in Program Statement 5324.12, pages 54 & 55. CoreCivic collects uniform data for every allegation of sexual abuse at all facility under their control. The data collected, will be 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 (DOJ).

The facility will ensure that incidents of sexual abuse are entered into the Incident Reporting Database System (IRD) as required by CoreCivic. This information is reported on the *Incident Tracking Form.* At least annually, the PREA Coordinator aggregates this data. Upon request, or no later than June 30th, the agency provides aggregated data information for the previous calendar year to DOJ. DOJ has not requested information from the previous calendar year from CAI-Ocean View.

Element (e) of this standard is not applicable to this facility. The agency does not contract for the confinement of its residents.

Standard 115.288 Data review for corrective action

☒ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific

corrective actions taken by the facility.

Based on policy 14-2 CC, page 28, section 3, and on interview with the PREA Coordinator, the agency reviews all of the data collected from all of its facilities and aggregates that data annually to assess and improve the effectiveness of its sexual abuse prevention, detection and response policies, practices and training. The PREA Coordinator prepares an annual report that provides the problem areas and corrective actions for each facility and as the agency as a whole. The report includes a comparison of the current year's data and corrective actions with those from prior years and provides an assessment of the agency's progress in addressing sexual abuse.

The PREA Coordinator forwards the annual report to the Chief of Corrections Officer for approval. The report is then made public on the CoreCivic website and can be accessed at http://CoreCivic.com/security-operations/prea. Before making aggregated sexual abuse data public, all personal identifiers are redacted. The most current annual report, prepared by the PREA Coordinator for 2015 data, was very well written and showed a breakdown of data from this audit cycle (2013/2014/2015) in an easy to read table according to the type of allegations and the investigative findings as well as a narrative overview of this information. Highlights of corrective actions taken from prior years showed a good overall picture of the progress of CoreCivic's PREA program, exceeding in the requirements of this standard.

Standard 115.289 Data storage, publication, and destruction

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

According to policy 14-2 CC, page 27, section T-2-c-i, the agency ensures that the data collected is securely retained. According to *CoreCivic's Retention Schedule* (1-15-B), the entire PREA packet including aggregated sexual abuse data is retained for five years after the inmate releases or post-employment of alleged abuser and 5-1 PREA incident reports are retained for 10 years.

CoreCivic makes all aggregated sexual abuse data, from facilities under its direct control readily available to the public annually on their website at http://CoreCivic.com/security-operations/prea. Before making aggregated sexual abuse data publicly available, all personal identifiers are redacted.

AUDITOR CERTIFICATION

I certify that:

☒ The contents of this report are accurate to the best of my knowledge.

☒ No conflict of interest exists with respect to my ability to conduct an audit of the agency under review, and

☒ I have not included in the final report any personally identifiable information (PII) about any inmate or staff member, except where the names of administrative personnel are specifically requested in the report template.

Barbara Jo Denison May 22, 2017

Auditor Signature Date