PREA Facility Audit Report: Final

Name of Facility: Pioneer Fellowship House
Facility Type: Community Confinement
Date Interim Report Submitted: 10/02/2024
Date Final Report Submitted: 04/19/2025

Auditor Certification	
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.	☑
I have not included in the final report any personally identifiable information (PII) about any inmate/resident/detainee or staff member, except where the names of administrative personnel are specifically requested in the report template.	☑
Auditor Full Name as Signed: Kenneth E Arnold	**Date of Signature:** 04/19/2025

AUDITOR INFORMATION	
Auditor name:	Arnold, Kenneth
Email:	kenarnold220@gmail.com
Start Date of On-Site Audit:	06/12/2024
End Date of On-Site Audit:	06/13/2024

FACILITY INFORMATION	
Facility name:	Pioneer Fellowship House
Facility physical address:	220 11th Avenue, Seattle, Washington - 98122
Facility mailing address:	

Primary Contact

Name:	nicholas moreau
Email Address:	nicholas.moreau@p-h-s.com
Telephone Number:	360-920-8963

Facility Director	
Name:	Trinetta Thompkins
Email Address:	Trinetta.Thompkins@p-h-s.com
Telephone Number:	206-667-9674

Facility PREA Compliance Manager	
Name:	Diana Graves
Email Address:	diana.graves@p-h-s.com
Telephone Number:	(206) 667-9674 x4120

Facility Characteristics	
Designed facility capacity:	60
Current population of facility:	44
Average daily population for the past 12 months:	42
Has the facility been over capacity at any point in the past 12 months?	No
What is the facility's population designation?	Both womens/girls and mens/boys
In the past 12 months, which population(s) has the facility held? Select all that apply (Nonbinary describes a person who does not identify exclusively as a boy/man or a girl/woman. Some people also use this term to describe their gender expression. For	

definitions of “intersex” and “transgender,” please see https://www.prearesourcecenter.org/standard/115-5)	
Age range of population:	27-70
Facility security levels/resident custody levels:	residential - low level
Number of staff currently employed at the facility who may have contact with residents:	23
Number of individual contractors who have contact with residents, currently authorized to enter the facility:	1
Number of volunteers who have contact with residents, currently authorized to enter the facility:	0

AGENCY INFORMATION	
Name of agency:	Pioneer Human Services, Inc.
Governing authority or parent agency (if applicable):	
Physical Address:	7440 West Marginal Way South, Seattle, Washington - 98108
Mailing Address:	
Telephone number:	2067681990

Agency Chief Executive Officer Information:	
Name:	Karen Lee
Email Address:	karen.lee@p-h-s.com
Telephone Number:	206-768-1990

Agency-Wide PREA Coordinator Information

Name:	Nicholas Moreau	**Email Address:**	Nicholas.Moreau@p-h-s.com

Facility AUDIT FINDINGS

Summary of Audit Findings

The OAS automatically populates the number and list of Standards exceeded, the number of Standards met, and the number and list of Standards not met.

Auditor Note: In general, no standards should be found to be "Not Applicable" or "NA." A compliance determination must be made for each standard. In rare instances where an auditor determines that a standard is not applicable, the auditor should select "Meets Standard" and include a comprehensive discussion as to why the standard is not applicable to the facility being audited.

Number of standards exceeded:	
1	• 115.231 - Employee training
Number of standards met:	
40	
Number of standards not met:	
0	

POST-AUDIT REPORTING INFORMATION

GENERAL AUDIT INFORMATION

On-site Audit Dates

1. Start date of the onsite portion of the audit:	2024-06-12
2. End date of the onsite portion of the audit:	2024-06-13

Outreach

10. Did you attempt to communicate with community-based organization(s) or victim advocates who provide services to this facility and/or who may have insight into relevant conditions in the facility?	(●) Yes ( ) No
a. Identify the community-based organization(s) or victim advocates with whom you communicated:	Assistant Director for Harborview Center for Abuse and Traumatic Stress (HATC).

AUDITED FACILITY INFORMATION

14. Designated facility capacity:	60
15. Average daily population for the past 12 months:	42
16. Number of inmate/resident/detainee housing units:	2
17. Does the facility ever hold youthful inmates or youthful/juvenile detainees?	( ) Yes ( ) No (●) Not Applicable for the facility type audited (i.e., Community Confinement Facility or Juvenile Facility)

Audited Facility Population Characteristics on Day One of the Onsite Portion of the Audit	
Inmates/Residents/Detainees Population Characteristics on Day One of the Onsite Portion of the Audit	
18. Enter the total number of inmates/ residents/detainees in the facility as of the first day of onsite portion of the audit:	28
19. Enter the total number of inmates/ residents/detainees with a physical disability in the facility as of the first day of the onsite portion of the audit:	1
20. Enter the total number of inmates/ residents/detainees with a cognitive or functional disability (including intellectual disability, psychiatric disability, or speech disability) in the facility as of the first day of the onsite portion of the audit:	1
21. Enter the total number of inmates/ residents/detainees who are Blind or have low vision (visually impaired) in the facility as of the first day of the onsite portion of the audit:	2
22. Enter the total number of inmates/ residents/detainees who are Deaf or hard-of-hearing in the facility as of the first day of the onsite portion of the audit:	0
23. Enter the total number of inmates/ residents/detainees who are Limited English Proficient (LEP) in the facility as of the first day of the onsite portion of the audit:	0
24. Enter the total number of inmates/ residents/detainees who identify as lesbian, gay, or bisexual in the facility as of the first day of the onsite portion of the audit:	1

25. Enter the total number of inmates/ residents/detainees who identify as transgender or intersex in the facility as of the first day of the onsite portion of the audit:	0
26. Enter the total number of inmates/ residents/detainees who reported sexual abuse in the facility as of the first day of the onsite portion of the audit:	0
27. Enter the total number of inmates/ residents/detainees who disclosed prior sexual victimization during risk screening in the facility as of the first day of the onsite portion of the audit:	1
28. Enter the total number of inmates/ residents/detainees who were ever placed in segregated housing/isolation for risk of sexual victimization in the facility as of the first day of the onsite portion of the audit:	0
29. Provide any additional comments regarding the population characteristics of inmates/residents/detainees in the facility as of the first day of the onsite portion of the audit (e.g., groups not tracked, issues with identifying certain populations):	None.
Staff, Volunteers, and Contractors Population Characteristics on Day One of the Onsite Portion of the Audit	
30. Enter the total number of STAFF, including both full- and part-time staff, employed by the facility as of the first day of the onsite portion of the audit:	18
31. Enter the total number of VOLUNTEERS assigned to the facility as of the first day of the onsite portion of the audit who have contact with inmates/residents/detainees:	0

32. Enter the total number of CONTRACTORS assigned to the facility as of the first day of the onsite portion of the audit who have contact with inmates/residents/detainees:	0
33. Provide any additional comments regarding the population characteristics of staff, volunteers, and contractors who were in the facility as of the first day of the onsite portion of the audit:	Of note, the PHS PC notes that one contractor is utilized at PFH RRC however, the auditor notes that this individual is a vendor who stocks vending machines under staff supervision. Accordingly, the auditor finds that this individual does not qualify as a contractor in the literal sense.

INTERVIEWS

Inmate/Resident/Detainee Interviews

Random Inmate/Resident/Detainee Interviews

34. Enter the total number of RANDOM INMATES/RESIDENTS/DETAINEES who were interviewed:	6
35. Select which characteristics you considered when you selected RANDOM INMATE/RESIDENT/DETAINEE interviewees: (select all that apply)	☑ Age ☑ Race ☑ Ethnicity (e.g., Hispanic, Non-Hispanic) ☑ Length of time in the facility ☑ Housing assignment ☑ Gender ☐ Other ☐ None
36. How did you ensure your sample of RANDOM INMATE/RESIDENT/DETAINEE interviewees was geographically diverse?	Interviewees were selected from various wings and units throughout the facility.

37. Were you able to conduct the minimum number of random inmate/ resident/detainee interviews?	(●) Yes ( ) No
38. Provide any additional comments regarding selecting or interviewing random inmates/residents/detainees (e.g., any populations you oversampled, barriers to completing interviews, barriers to ensuring representation):	None.
Targeted Inmate/Resident/Detainee Interviews	
39. Enter the total number of TARGETED INMATES/RESIDENTS/DETAINEES who were interviewed:	6
As stated in the PREA Auditor Handbook, the breakdown of targeted interviews is intended to guide auditors in interviewing the appropriate cross-section of inmates/residents/detainees who are the most vulnerable to sexual abuse and sexual harassment. When completing questions regarding targeted inmate/resident/detainee interviews below, remember that an interview with one inmate/resident/detainee may satisfy multiple targeted interview requirements. These questions are asking about the number of interviews conducted using the targeted inmate/ resident/detainee protocols. For example, if an auditor interviews an inmate who has a physical disability, is being held in segregated housing due to risk of sexual victimization, and disclosed prior sexual victimization, that interview would be included in the totals for each of those questions. Therefore, in most cases, the sum of all the following responses to the targeted inmate/resident/detainee interview categories will exceed the total number of targeted inmates/ residents/detainees who were interviewed. If a particular targeted population is not applicable in the audited facility, enter "0".	
40. Enter the total number of interviews conducted with inmates/residents/ detainees with a physical disability using the "Disabled and Limited English Proficient Inmates" protocol:	1
41. Enter the total number of interviews conducted with inmates/residents/ detainees with a cognitive or functional disability (including intellectual disability, psychiatric disability, or speech disability) using the "Disabled and Limited English Proficient Inmates" protocol:	1

42. Enter the total number of interviews conducted with inmates/residents/ detainees who are Blind or have low vision (i.e., visually impaired) using the "Disabled and Limited English Proficient Inmates" protocol:	2
43. Enter the total number of interviews conducted with inmates/residents/ detainees who are Deaf or hard-of-hearing using the "Disabled and Limited English Proficient Inmates" protocol:	0
43. Select why you were unable to conduct at least the minimum required number of targeted inmates/residents/ detainees in this category:	■ Facility said there were "none here" during the onsite portion of the audit and/or the facility was unable to provide a list of these inmates/residents/detainees. ☐ The inmates/residents/detainees in this targeted category declined to be interviewed.
43. Discuss your corroboration strategies to determine if this population exists in the audited facility (e.g., based on information obtained from the PAQ; documentation reviewed onsite; and discussions with staff and other inmates/residents/detainees).	Pursuant to random conversations with residents during the facility tour and resident interviewees and random conversations with staff, the auditor was not alerted to the presence of any hearing impaired residents at PFH RRC.
44. Enter the total number of interviews conducted with inmates/residents/ detainees who are Limited English Proficient (LEP) using the "Disabled and Limited English Proficient Inmates" protocol:	0
44. Select why you were unable to conduct at least the minimum required number of targeted inmates/residents/ detainees in this category:	■ Facility said there were "none here" during the onsite portion of the audit and/or the facility was unable to provide a list of these inmates/residents/detainees. ☐ The inmates/residents/detainees in this targeted category declined to be interviewed.

44. Discuss your corroboration strategies to determine if this population exists in the audited facility (e.g., based on information obtained from the PAQ; documentation reviewed onsite; and discussions with staff and other inmates/residents/detainees).	Pursuant to random conversations with residents during the facility tour and resident interviewees and random conversations with staff, the auditor was not alerted to the presence of any LEP residents at PFH RRC.
45. Enter the total number of interviews conducted with inmates/residents/ detainees who identify as lesbian, gay, or bisexual using the "Transgender and Intersex Inmates; Gay, Lesbian, and Bisexual Inmates" protocol:	1
46. Enter the total number of interviews conducted with inmates/residents/ detainees who identify as transgender or intersex using the "Transgender and Intersex Inmates; Gay, Lesbian, and Bisexual Inmates" protocol:	0
46. Select why you were unable to conduct at least the minimum required number of targeted inmates/residents/ detainees in this category:	■ Facility said there were "none here" during the onsite portion of the audit and/or the facility was unable to provide a list of these inmates/residents/detainees. ☐ The inmates/residents/detainees in this targeted category declined to be interviewed.
46. Discuss your corroboration strategies to determine if this population exists in the audited facility (e.g., based on information obtained from the PAQ; documentation reviewed onsite; and discussions with staff and other inmates/residents/detainees).	Throughout the facility tour and staff/resident interviews, the auditor found no evidence of the presence of transgender/intersex residents housed at PFH RRC.
47. Enter the total number of interviews conducted with inmates/residents/ detainees who reported sexual abuse in this facility using the "Inmates who Reported a Sexual Abuse" protocol:	0

47. Select why you were unable to conduct at least the minimum required number of targeted inmates/residents/ detainees in this category:	■ Facility said there were "none here" during the onsite portion of the audit and/or the facility was unable to provide a list of these inmates/residents/detainees. ☐ The inmates/residents/detainees in this targeted category declined to be interviewed.
47. Discuss your corroboration strategies to determine if this population exists in the audited facility (e.g., based on information obtained from the PAQ; documentation reviewed onsite; and discussions with staff and other inmates/residents/detainees).	The auditor notes that 0 sexual abuse investigations were facilitated at PFH RRC during the last 12 months.
48. Enter the total number of interviews conducted with inmates/residents/ detainees who disclosed prior sexual victimization during risk screening using the "Inmates who Disclosed Sexual Victimization during Risk Screening" protocol:	1
49. Enter the total number of interviews conducted with inmates/residents/ detainees who are or were ever placed in segregated housing/isolation for risk of sexual victimization using the "Inmates Placed in Segregated Housing (for Risk of Sexual Victimization/Who Allege to have Suffered Sexual Abuse)" protocol:	0
49. Select why you were unable to conduct at least the minimum required number of targeted inmates/residents/ detainees in this category:	■ Facility said there were "none here" during the onsite portion of the audit and/or the facility was unable to provide a list of these inmates/residents/detainees. ☐ The inmates/residents/detainees in this targeted category declined to be interviewed.

49. Discuss your corroboration strategies to determine if this population exists in the audited facility (e.g., based on information obtained from the PAQ; documentation reviewed onsite; and discussions with staff and other inmates/residents/detainees).	Segregated housing is not available at PFH RRC. Furthermore, zero allegations of sexual abuse were reported at PFH RRC during the last 12 months.
50. Provide any additional comments regarding selecting or interviewing targeted inmates/residents/detainees (e.g., any populations you oversampled, barriers to completing interviews):	None.

Staff, Volunteer, and Contractor Interviews

Random Staff Interviews

51. Enter the total number of RANDOM STAFF who were interviewed:	9
52. Select which characteristics you considered when you selected RANDOM STAFF interviewees: (select all that apply)	☑ Length of tenure in the facility ☑ Shift assignment ☑ Work assignment ☑ Rank (or equivalent) ☑ Other (e.g., gender, race, ethnicity, languages spoken) ☐ None
If "Other," describe:	Gender and ethnicity.
53. Were you able to conduct the minimum number of RANDOM STAFF interviews?	○ Yes ◉ No

53. Select the reason(s) why you were unable to conduct the minimum number of RANDOM STAFF interviews: (select all that apply)	☐ Too many staff declined to participate in interviews. ☑ Not enough staff employed by the facility to meet the minimum number of random staff interviews (Note: select this option if there were not enough staff employed by the facility or not enough staff employed by the facility to interview for both random and specialized staff roles). ☑ Not enough staff available in the facility during the onsite portion of the audit to meet the minimum number of random staff interviews. ☐ Other
54. Provide any additional comments regarding selecting or interviewing random staff (e.g., any populations you oversampled, barriers to completing interviews, barriers to ensuring representation):	None.
Specialized Staff, Volunteers, and Contractor Interviews	
Staff in some facilities may be responsible for more than one of the specialized staff duties. Therefore, more than one interview protocol may apply to an interview with a single staff member and that information would satisfy multiple specialized staff interview requirements.	
55. Enter the total number of staff in a SPECIALIZED STAFF role who were interviewed (excluding volunteers and contractors):	14
56. Were you able to interview the Agency Head?	◉ Yes ○ No
57. Were you able to interview the Warden/Facility Director/Superintendent or their designee?	◉ Yes ○ No

58. Were you able to interview the PREA Coordinator?	(●) Yes ( ) No
59. Were you able to interview the PREA Compliance Manager?	(●) Yes ( ) No ( ) NA (NA if the agency is a single facility agency or is otherwise not required to have a PREA Compliance Manager per the Standards)

60. Select which SPECIALIZED STAFF roles were interviewed as part of this audit from the list below: (select all that apply)	☐ Agency contract administrator ☐ Intermediate or higher-level facility staff responsible for conducting and documenting unannounced rounds to identify and deter staff sexual abuse and sexual harassment ☐ Line staff who supervise youthful inmates (if applicable) ☐ Education and program staff who work with youthful inmates (if applicable) ☐ Medical staff ☐ Mental health staff ☑ Non-medical staff involved in cross-gender strip or visual searches ☑ Administrative (human resources) staff ☑ Sexual Assault Forensic Examiner (SAFE) or Sexual Assault Nurse Examiner (SANE) staff ☑ Investigative staff responsible for conducting administrative investigations ☑ Investigative staff responsible for conducting criminal investigations ☑ Staff who perform screening for risk of victimization and abusiveness ☐ Staff who supervise inmates in segregated housing/residents in isolation ☑ Staff on the sexual abuse incident review team ☑ Designated staff member charged with monitoring retaliation ☑ First responders, both security and non-security staff ☑ Intake staff

	☑ Other
If "Other," provide additional specialized staff roles interviewed:	One staff member was interviewed regarding her role in the assignment of room(s)/bed(s).
61. Did you interview VOLUNTEERS who may have contact with inmates/ residents/detainees in this facility?	○ Yes ◉ No
62. Did you interview CONTRACTORS who may have contact with inmates/ residents/detainees in this facility?	○ Yes ◉ No
63. Provide any additional comments regarding selecting or interviewing specialized staff.	Although the Directors of two facilities provide some PREA Compliance Manager (PCM) responsibilities, the auditor has learned that operationally, the PHS PREA Coordinator (PC) facilitates day-to day PCM responsibilities at both facilities. As reflected in the Director's interview, the PHS PC is always in the loop on "all things PREA" and he provides direction accordingly. The PHS PC validated the above. In view of the above, the auditor interviewed the PHS PC as the PCM.

SITE REVIEW AND DOCUMENTATION SAMPLING

Site Review

PREA Standard 115.401 (h) states, "The auditor shall have access to, and shall observe, all areas of the audited facilities." In order to meet the requirements in this Standard, the site review portion of the onsite audit must include a thorough examination of the entire facility. The site review is not a casual tour of the facility. It is an active, inquiring process that includes talking with staff and inmates to determine whether, and the extent to which, the audited facility's practices demonstrate compliance with the Standards. Note: As you are conducting the site review, you must document your tests of critical functions, important information gathered through observations, and any issues identified with facility practices. The information you collect through the site review is a crucial part of the evidence you will analyze as part of your compliance determinations and will be needed to complete your audit report, including the Post-Audit Reporting Information.

64. Did you have access to all areas of the facility?	(●) Yes ( ) No
Was the site review an active, inquiring process that included the following:	
65. Observations of all facility practices in accordance with the site review component of the audit instrument (e.g., signage, supervision practices, cross-gender viewing and searches)?	(●) Yes ( ) No
66. Tests of all critical functions in the facility in accordance with the site review component of the audit instrument (e.g., risk screening process, access to outside emotional support services, interpretation services)?	(●) Yes ( ) No
67. Informal conversations with inmates/ residents/detainees during the site review (encouraged, not required)?	(●) Yes ( ) No
68. Informal conversations with staff during the site review (encouraged, not required)?	(●) Yes ( ) No
69. Provide any additional comments regarding the site review (e.g., access to areas in the facility, observations, tests of critical functions, or informal conversations).	None.
Documentation Sampling	
Where there is a collection of records to review-such as staff, contractor, and volunteer training records; background check records; supervisory rounds logs; risk screening and intake processing records; inmate education records; medical files; and investigative files-auditors must self-select for review a representative sample of each type of record.	
70. In addition to the proof documentation selected by the agency or facility and provided to you, did you also conduct an auditor-selected sampling of documentation?	(●) Yes ( ) No

71. Provide any additional comments regarding selecting additional documentation (e.g., any documentation you oversampled, barriers to selecting additional documentation, etc.).	Employee Human Resources (HR) Files- 10 Staff Training Files- 10 Resident Files- 42

SEXUAL ABUSE AND SEXUAL HARASSMENT ALLEGATIONS AND INVESTIGATIONS IN THIS FACILITY

Sexual Abuse and Sexual Harassment Allegations and Investigations Overview

Remember the number of allegations should be based on a review of all sources of allegations (e.g., hotline, third-party, grievances) and should not be based solely on the number of investigations conducted. Note: For question brevity, we use the term “inmate” in the following questions. Auditors should provide information on inmate, resident, or detainee sexual abuse allegations and investigations, as applicable to the facility type being audited.

72. Total number of SEXUAL ABUSE allegations and investigations overview during the 12 months preceding the audit, by incident type:

	# of sexual abuse allegations	# of criminal investigations	# of administrative investigations	# of allegations that had both criminal and administrative investigations
Inmate-on-inmate sexual abuse	0	0	0	0
Staff-on-inmate sexual abuse	0	0	0	0
Total	0	0	0	0

73. Total number of SEXUAL HARASSMENT allegations and investigations overview during the 12 months preceding the audit, by incident type:

	# of sexual harassment allegations	# of criminal investigations	# of administrative investigations	# of allegations that had both criminal and administrative investigations
Inmate-on-inmate sexual harassment	0	0	0	0
Staff-on-inmate sexual harassment	0	0	0	0
Total	0	0	0	0

Sexual Abuse and Sexual Harassment Investigation Outcomes

Sexual Abuse Investigation Outcomes

Note: these counts should reflect where the investigation is currently (i.e., if a criminal investigation was referred for prosecution and resulted in a conviction, that investigation outcome should only appear in the count for “convicted.”) Do not double count. Additionally, for question brevity, we use the term “inmate” in the following questions. Auditors should provide information on inmate, resident, and detainee sexual abuse investigation files, as applicable to the facility type being audited.

74. Criminal SEXUAL ABUSE investigation outcomes during the 12 months preceding the audit:

	Ongoing	Referred for Prosecution	Indicted/ Court Case Filed	Convicted/ Adjudicated	Acquitted
Inmate-on-inmate sexual abuse	0	0	0	0	0
Staff-on-inmate sexual abuse	0	0	0	0	0
Total	0	0	0	0	0

75. Administrative SEXUAL ABUSE investigation outcomes during the 12 months preceding the audit:

	Ongoing	Unfounded	Unsubstantiated	Substantiated
Inmate-on-inmate sexual abuse	0	0	0	0
Staff-on-inmate sexual abuse	0	0	0	0
Total	0	0	0	0

Sexual Harassment Investigation Outcomes

Note: these counts should reflect where the investigation is currently. Do not double count. Additionally, for question brevity, we use the term “inmate” in the following questions. Auditors should provide information on inmate, resident, and detainee sexual harassment investigation files, as applicable to the facility type being audited.

76. Criminal SEXUAL HARASSMENT investigation outcomes during the 12 months preceding the audit:

	Ongoing	Referred for Prosecution	Indicted/ Court Case Filed	Convicted/ Adjudicated	Acquitted
Inmate-on-inmate sexual harassment	0	0	0	0	0
Staff-on-inmate sexual harassment	0	0	0	0	0
Total	0	0	0	0	0

77. Administrative SEXUAL HARASSMENT investigation outcomes during the 12 months preceding the audit:

	Ongoing	Unfounded	Unsubstantiated	Substantiated
Inmate-on-inmate sexual harassment	0	0	0	0
Staff-on-inmate sexual harassment	0	0	0	0
Total	0	0	0	0

Sexual Abuse and Sexual Harassment Investigation Files Selected for Review

Sexual Abuse Investigation Files Selected for Review

78. Enter the total number of SEXUAL ABUSE investigation files reviewed/ sampled:	0
78. Explain why you were unable to review any sexual abuse investigation files:	As previously reported, zero sexual abuse/ harassment reports were received during the last 12 months.

79. Did your selection of SEXUAL ABUSE investigation files include a cross-section of criminal and/or administrative investigations by findings/outcomes?	○ Yes ○ No ◉ NA (NA if you were unable to review any sexual abuse investigation files)
Inmate-on-inmate sexual abuse investigation files	
80. Enter the total number of INMATE-ON-INMATE SEXUAL ABUSE investigation files reviewed/sampled:	0
81. Did your sample of INMATE-ON-INMATE SEXUAL ABUSE investigation files include criminal investigations?	○ Yes ○ No ◉ NA (NA if you were unable to review any inmate-on-inmate sexual abuse investigation files)
82. Did your sample of INMATE-ON-INMATE SEXUAL ABUSE investigation files include administrative investigations?	○ Yes ○ No ◉ NA (NA if you were unable to review any inmate-on-inmate sexual abuse investigation files)
Staff-on-inmate sexual abuse investigation files	
83. Enter the total number of STAFF-ON-INMATE SEXUAL ABUSE investigation files reviewed/sampled:	0
84. Did your sample of STAFF-ON-INMATE SEXUAL ABUSE investigation files include criminal investigations?	○ Yes ○ No ◉ NA (NA if you were unable to review any staff-on-inmate sexual abuse investigation files)

85. Did your sample of STAFF-ON-INMATE SEXUAL ABUSE investigation files include administrative investigations?	○ Yes ○ No ◉ NA (NA if you were unable to review any staff-on-inmate sexual abuse investigation files)
Sexual Harassment Investigation Files Selected for Review	
86. Enter the total number of SEXUAL HARASSMENT investigation files reviewed/sampled:	0
86. Explain why you were unable to review any sexual harassment investigation files:	As previously reported, zero sexual abuse/ harassment reports were received during the last 12 months.
87. Did your selection of SEXUAL HARASSMENT investigation files include a cross-section of criminal and/or administrative investigations by findings/outcomes?	○ Yes ○ No ◉ NA (NA if you were unable to review any sexual harassment investigation files)
Inmate-on-inmate sexual harassment investigation files	
88. Enter the total number of INMATE-ON-INMATE SEXUAL HARASSMENT investigation files reviewed/sampled:	0
89. Did your sample of INMATE-ON-INMATE SEXUAL HARASSMENT files include criminal investigations?	○ Yes ○ No ◉ NA (NA if you were unable to review any inmate-on-inmate sexual harassment investigation files)

90. Did your sample of INMATE-ON-INMATE SEXUAL HARASSMENT investigation files include administrative investigations?	○ Yes ○ No ◉ NA (NA if you were unable to review any inmate-on-inmate sexual harassment investigation files)
Staff-on-inmate sexual harassment investigation files	
91. Enter the total number of STAFF-ON-INMATE SEXUAL HARASSMENT investigation files reviewed/sampled:	0
92. Did your sample of STAFF-ON-INMATE SEXUAL HARASSMENT investigation files include criminal investigations?	○ Yes ○ No ◉ NA (NA if you were unable to review any staff-on-inmate sexual harassment investigation files)
93. Did your sample of STAFF-ON-INMATE SEXUAL HARASSMENT investigation files include administrative investigations?	○ Yes ○ No ◉ NA (NA if you were unable to review any staff-on-inmate sexual harassment investigation files)
94. Provide any additional comments regarding selecting and reviewing sexual abuse and sexual harassment investigation files.	None.

SUPPORT STAFF INFORMATION

DOJ-certified PREA Auditors Support Staff

95. Did you receive assistance from any DOJ-CERTIFIED PREA AUDITORS at any point during this audit? REMEMBER: the audit includes all activities from the pre-onsite through the post-onsite phases to the submission of the final report. Make sure you respond accordingly.	○ Yes ◉ No

Non-certified Support Staff

96. Did you receive assistance from any NON-CERTIFIED SUPPORT STAFF at any point during this audit? REMEMBER: the audit includes all activities from the pre-onsite through the post-onsite phases to the submission of the final report. Make sure you respond accordingly.	○ Yes ◉ No

AUDITING ARRANGEMENTS AND COMPENSATION

97. Who paid you to conduct this audit?	◉ The audited facility or its parent agency ○ My state/territory or county government employer (if you audit as part of a consortium or circular auditing arrangement, select this option) ○ A third-party auditing entity (e.g., accreditation body, consulting firm) ○ Other

Standards
Auditor Overall Determination Definitions
• Exceeds Standard (Substantially exceeds requirement of standard) • Meets Standard (substantial compliance; complies in all material ways with the stand for the relevant review period) • Does Not Meet Standard (requires corrective actions)
Auditor Discussion Instructions
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.

115.211	Zero tolerance of sexual abuse and sexual harassment; PREA coordinator
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	115.211(a) Pursuant to the PAQ, the Director self reports the agency has a written policy mandating zero tolerance toward all forms of sexual abuse and sexual harassment in facilities it operates directly or under contract. The facility has a written policy outlining how it will implement the agency's approach to preventing, detecting, and responding to sexual abuse and sexual harassment. Definitions of prohibited behaviors regarding sexual abuse and sexual harassment are articulated in policy and policy does include sanctions for those found to have participated in prohibited behaviors. The Director further self reports the policy includes a description of agency strategies and responses to reduce and prevent sexual abuse and sexual harassment of residents. Pioneer Human Services (PHS) Policy entitled Prison Rape Elimination Act (PREA) Prevention, Investigation, and Reporting, page 1, sections entitled Purpose and Policy 1(a) addresses 115.211(a)-1. Of note, this policy clearly defines both sexual

abuse and harassment as sexual victimization. Pioneer Human Services (PHS) Policy entitled Prison Rape Elimination Act (PREA) Prevention, Investigation, and Reporting, pages 1-23 addresses 115.211(a)-2. PHS Policy entitled Prison Rape Elimination Act (PREA) Definitions for Pioneer Human Services, pages 1 and 2 addresses 115.211(a)-3. PHS Policy entitled Prison Rape Elimination Act (PREA) Zero Tolerance Facility Policy (PFH RRC), pages 3 and 4 addresses 115.211(a)-4. Pioneer Human Services (PHS) Policy entitled Prison Rape Elimination Act (PREA) Prevention, Investigation, and Reporting, pages 1-23 addresses 115.211(a)-5. PREA definitions are clearly articulated in the PREA Definitions for PHS attachment to the aforementioned Pioneer Human Services (PHS) Policy entitled Prison Rape Elimination Act (PREA) Prevention, Investigation, and Reporting policy.

The auditor's review of completed PREA Acknowledgment Prior To Training forms pertaining to three staff hired during 2023 and 2024 reveals some of the information provided in the aforementioned policy citations. The employee signs and dates the same, acknowledging understanding of relevant information.

In view of the above, the auditor finds PFH RRC substantially compliant with 115.211(a).

115.211(b)

Pursuant to the PAQ, the Director self reports the agency employs or designates an upper-level, agency-wide PREA Coordinator (PC). The auditor's review of the PHS Senior Director of Compliance & Risk Management Position Description reveals that the employee assigned to this position serves as the PHS PC. The position description does include some specificity in terms of duties and responsibilities. In addition to the above, PC duties are articulated in several of the policies mentioned in the narrative for 115.211(a).

Pursuant to the PAQ, the Director self reports the PC has sufficient time and authority to develop, implement, and oversee agency efforts to comply with the PREA standards in all of its community confinement facilities. The auditor's review of the PHS Behavioral Health/Residential Services Organizational Chart and position description for the Senior Director of Compliance and Risk Management reveals the PC reports directly to the Vice President (VP) of Behavioral Health/Residential Services. With respect to this audit and from a functional perspective, the VP of Behavioral Health/Residential Services is the agency head. The auditor finds the chain of command conducive with proper reporting and PREA management.

According to the PC, each Director assumes duties as PREA Compliance Manager (PCM) at their respective facility. As the PCM's PREA duties and responsibilities are very general and the PC's duties and responsibilities are clearly specific, as articulated in PHS Policy entitled Prison Rape Elimination Act (PREA) Prevention, Investigation, and Reporting, pages 23 and 24, the auditor's informational and interview source for PFH RRC is the PC. Pursuant to the PAQ, the Director self reports the position of the PC is in the agency's organizational structure.

	The PC asserts he has sufficient time to manage all of his PREA-related responsibilities. Three PREA Compliance Managers (PCMs) (Facility Directors) work indirectly with him on a daily basis. He facilitates teleconferences with all three PCMs regarding PREA issues at each facility. Discussions often times focus on common audit deficiencies, among other PREA related matters. He facilitates facility tours in each of the three facilities on a quarterly basis, minimally, and maintains deliberate communication with all three Directors. If a PREA issue is identified at any of the three facilities, a corrective action plan is developed with established time frames for completion and action steps to facilitate the same. Required expenditures are also identified however, the same must be approved through the corporate chain of command. The PC can recommend policy changes through respective committees and track the same. The PC, in conjunction with the PCMs, reviews facility resident handbooks and operational manuals for PREA compliance. During Management by Wandering Around (MBWA) tours during quarterly facility visits, he assesses poster placements/ camera placements and sufficiency/efficiency, and staffing sufficiency and efficiency. The PC also facilitates unannounced spot checks of each facility with the goal of enhancing PREA efficiency at all times. In view of the above, the auditor finds PFH RRC substantially compliant with 115.211(b). Given the evidence presented and reviewed, the auditor finds PFH RRC substantially compliant with 115.211.

115.212	**Contracting with other entities for the confinement of residents**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	115.212(a) Pursuant to the PAQ, the Director self reports the agency has not entered into or renewed a contract for the confinement of residents assigned to PHS custody on or after the date of the last PREA audit. During the on-site visit and subsequent to interview with the Agency Head interviewee, the auditor validated the same. Accordingly, 115.212 is not applicable to PFH RRC. Since there is/are no deviations from standard or policy, the auditor finds PFH RRC substantially compliant with 115.212.

115.213	Supervision and monitoring
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	115.213(a) Pursuant to the PAQ, the Director self reports for each facility, the agency develops and documents a staffing plan that provides for adequate levels of staffing and, where applicable, video monitoring to protect residents against sexual abuse. The Director further self reports that the average daily number of residents since the last PREA audit has been 42 while the staffing plan has been predicated on 60 residents per day. PHS Policy entitled Prison Rape Elimination Act (PREA) Prevention, Investigation, and Reporting, page 2, section Staffing Practices a(1-11) addresses 115.213(a). The auditor's review of the Employee Staffing Pattern included in the Personnel Resources Plan [Statement of Work (SOW)] reveals substantial compliance with 115.213(a). Hours of work, staff titles, staff assigned to each of the three shifts, training matters, amongst other issues, are addressed in this document. The staffing plan generally remains the same unless sexual abuse incident reviews (SAIRs), external reviews, a sexual abuse investigation, or other circumstances dictate otherwise. The Director asserts there is a staffing plan at PFH RRC and staffing levels are adequate to protect residents against sexual abuse. Video monitoring is considered in the staffing plan submitted pursuant to the Statement of Work (SOW) to the Federal Bureau of Prisons (FBOP). The staffing plan is documented and maintained by the Director and assistant director (AD), as well as, corporate executives. When questioned regarding specific characteristics of staffing plan development, the Director asserts the first priority is to ensure adequate staffing on the floor. The Director asserts there are four counts per shift and each rover facilitates staggered and unannounced rounds in between counts. Ordinarily, three staff are assigned per shift. Staggered work shifts (by one hour) are employed to ensure better coverage. The staffing plan is designed to address blind spots and infrastructure deficiencies. The combination of staff rounds, cameras, and mirrors are used to monitor the facility physical layout. The Director asserts that staffing plan development starts with submission of an initial plan (Technical Proposal and bi-weekly staffing rosters) to the Federal Bureau of Prisons (FBOP). Pursuant to the SOW, one staff member is assigned to the control center while another employee is assigned as a rover. Staffing is based on a minimum of two staff per shift (staggered shifts to ensure comprehensive coverage) and the rover makes 30 minute non-routine rounds throughout the facility.

	The afore-described staffing plan and implementation of the same is assessed during FBOP Full Monitoring visits conducted during mid-November each year. The staffing plan is likewise assessed during unannounced FBOP monitoring visits. The auditor notes that zero cameras are placed in resident rooms or bathrooms. The Director asserts that line of sight issues are addressed and cameras and/or mirrors are placed to offset deficiencies. There is a 30-day recall with respect to camera images. This is consistent with auditor observations during the facility tour. In regard to composition of the resident population, one validated gang member is housed at PFH RRC. There are no issues with sexual abuse exploitation of elderly or LGBTI residents (one bisexual resident). The facility ethnic balance is stable with no concerns noted. To offset any population concerns should the same occur, safety rounds may be increased and use of additional staff to saturate areas for supervision purposes, are two strategies that may be implemented. In regard to the prevalence of substantiated and unsubstantiated incidents of sexual abuse, there has been zero incidents during the last 12 months. The Director asserts one of the keys to effective resident supervision and resident sexual safety is MBWA or meaningful and intentional facility tours by all staff, inclusive of command staff. Knowledge of individual residents, listening to and talking with residents and staff, and employment of keen observation skills lead to better outcomes. In response to the same issues as discussed above, the PC asserts that the staffing plan is developed in accordance with the SOW. If there is/are deficiency(ies), the interviewee, Director, AD, and division staff assess camera needs based on facility dynamics. Pursuant to a deliberate annual review of each of the three facilities, minimally, there is a constant attempt to offset blind spots, providing the best resident sexual safety outcome. In view of the above, the auditor finds PFH RRC substantially compliant with 115.213(a). 115.213(b) Pursuant to the PAQ, the Director self reports there has been zero occurrences during the last 12 months wherein staffing plan compliance has not been maintained. Accordingly, 115.213(b) is deemed not applicable to PFH RRC. The Director asserts that if there was a deviation from the staffing plan, the Director would email the Residential Reentry Manager [RRM- FBOP (over sight manager)] to report the vacancy and corrective action taken, as well as, PHS Human Resources (HR) staff. Corrective action would also be noted on the daily roster. An email would also be forwarded to the PC and VPCRS regarding the vacancy and any corrective action attempts.

	In view of the above, the auditor finds PFH RRC substantially compliant with 115.213(b). 115.213(c) Pursuant to the PAQ, the Director self reports at least once every year, the facility reviews the staffing plan to see whether adjustments are needed in: The staffing plan; Prevailing staffing patterns; The deployment of video monitoring systems and other monitoring technologies; or The allocation of facility/agency resources to commit to the staffing plan to ensure compliance with the same. The PC asserts the staffing plan for the facility is reviewed on an annual basis and he is consulted regarding any necessary adjustments. The AD facilitates the initial review and the same is reviewed by the PFH RRC Director and the PC. The auditor's review of the 2022 and 2023 FBOP Full Monitoring Reports (Staffing excerpts) reveals PFH RRC is substantially compliant with staffing expectations as previously identified. The auditor notes that the PC's memorandum dated June 18, 2024 reflects the PC's description of the annual staffing review process/issues considered and that cumulatively, zero changes to the staffing plan were required throughout the audit period. While the aforementioned memorandum marginally addresses annual review requirements, the auditor strongly recommends that the PC implement an annual review process wherein each of the staffing plan requirements is addressed on an annual basis with a separate report generated each year. The annual document will require requisite signatures, as required by standard provision, as well as, the date(s) of review. In view of the above, the auditor finds PFH RRC substantially compliant with 115.213(c). Based on the above evidence and findings, the auditor finds PFH RRC substantially compliant with 115.213.

115.215	**Limits to cross-gender viewing and searches**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion

	115.215(a) Pursuant to the PAQ, the Director self reports the facility does not conduct cross-gender strip or cross-gender visual body cavity searches of residents. During the last 12 months, zero cross-gender strip or cross-gender visual body cavity searches of residents have been conducted. PHS Policy entitled Prison Rape Elimination Act (PREA) Prevention, Investigation, and Reporting, page 3, section Limits to Cross-Gender Viewing and Searches (a) addresses 115.215(a). The auditor notes that cross-gender strip or visual body cavity searches can be conducted under exigent circumstances. The auditor has not discovered any incidents wherein cross-gender strip or cross-gender visual body cavity searches of residents were facilitated during the audit period. The auditor notes that if a strip search was facilitated, the same would be completed in the Urinalysis Room bathroom. A camera is located above the entrance door however, the same does not cover the bathroom interior. Reportedly, same sex staff would facilitate strip search(es) unless a transgender resident requested otherwise. The non-medical staff who may be involved in cross-gender strip or visual searches states that operationally, such searches are not authorized at PFH RRC. However, policy allows for such searches pursuant to exigent circumstances such as weapons or drugs secreted in the rectum. In view of the above, the auditor finds PFH RRC substantially compliant with 115.215(a). 115.215(b) Pursuant to the PAQ, the Director self reports the facility does not permit cross-gender pat-down searches of female residents, absent exigent circumstances. Additionally, the facility does not restrict female resident access to regularly available programming or other outside opportunities in order to comply with this provision. PHS Policy entitled Prison Rape Elimination Act (PREA) Prevention, Investigation, and Reporting, page 3, section Limits to Cross-Gender Viewing and Searches (b) addresses 115.215(b). The two female resident interviewees (one random resident interviewee and one specialty interviewee) state there has been zero occasions wherein they have been unable to participate in outside activities or programs because female staff were unavailable to conduct pat-down searches. All nine random staff interviewees corroborated the statement of the random female residents as articulated above and they noted that female staff are always on shift. In view of the above, the auditor finds PFH RRC substantially compliant with

115.213(b).

115.215(c)

Pursuant to the PAQ, the Director self reports facility policy requires that all cross-gender strip searches and cross-gender visual body cavity searches are documented. Additionally, all cross-gender pat searches of female residents by male staff must be documented.

PHS Policy entitled Prison Rape Elimination Act (PREA) Prevention, Investigation, and Reporting, page 3, section Limits to Cross-Gender Viewing and Searches (c) addresses 115.215(c). Of note, this policy requires documentation of all cross-gender pat searches.

The PC asserts that all pat searches are logged in the PFH RRC Facility Management System. There is an individual log sheet for each resident wherein all events related to the resident's programming are maintained. The auditor's review of such logs for 2023 and 2024 reveals substantial compliance with the above narratives. Zero cross-gender pat searches of female residents occurred based on the documents reviewed. Additionally, all cross-gender strip searches would be logged in the same manner.

In view of the above, the auditor finds PFH RRC substantially compliant with 115.215(c).

115.215(d)

Pursuant to the PAQ, the Director self reports the facility has implemented policies and procedures that enable residents to shower, perform bodily functions, and change clothing without non-medical staff of the opposite gender viewing their breasts, buttocks, or genitalia, except in exigent circumstances or when such viewing is incidental to routine cell checks (this includes viewing via video camera). Additionally, the Director self reports that policies and procedures require staff of the opposite gender to announce their presence when entering an area where residents are likely to be showering, performing bodily functions, or changing clothing.

PHS Policy entitled Prison Rape Elimination Act (PREA) Prevention, Investigation, and Reporting, pages 3 and 4, section Limits to Cross-Gender Viewing and Searches (d) addresses 115.215(d). PHS Policy entitled Prison Rape Elimination Act (PREA) Zero Tolerance Facility Policy (PFH RRC), page 2, Prevention (5) also addresses 115.215(d).

During the facility tour, the auditor noted that the single shower in the female resident bathroom(s) is shielded by a shower curtain. The toilet(s) is/are shielded by metal partition(s). Cameras are not located in either bathrooms or resident

	rooms. The same conditions were prevalent in the male resident bathrooms. All six random resident interviewees state that staff of the opposite gender announce their presence when entering their housing area. Similarly, all six interviewees state they and other residents are never naked in full view of staff of the opposite gender (excluding medical staff such as doctors, nurses) when showering, toileting, or changing clothes. All nine random staff interviewees likewise state they and other staff announce their presence when entering a housing unit that houses residents of the opposite gender. Likewise, residents are able to shower, toilet, and change clothes without being viewed by staff of the opposite gender. During the facility tour and throughout the on-site audit, the auditor noted vigilance on the part of opposite gender staff to announce their presence (by gender) prior to entering wings and rooms. No deviations from governing policy and consequently, standard provision, were observed. In view of the above, the auditor finds PFH RRC substantially compliant with 115.215(d). 115.215(e) Pursuant to the PAQ, the Director self reports the facility has a policy prohibiting staff from searching or physically examining a transgender or intersex resident for the sole purpose of determining the resident's genital status. The Director self reports zero such searches were facilitated during the last 12 months. PHS Policy entitled Prison Rape Elimination Act (PREA) Zero Tolerance Facility Policy (PFH RRC), page 2, Prevention (6) addresses 115.215(e). PHS Policy entitled Prison Rape Elimination Act (PREA) Prevention, Investigation, and Reporting, page 4, section Limits to Cross-Gender Viewing and Searches (e) also addresses 115.215(e). All nine random staff interviewees state that the facility prohibits staff from searching or physically examining a transgender or intersex resident for the sole purpose of determining the resident's genital status. According to the Director, zero transgender residents were housed at PFH RRC during the on-site visit and accordingly, that interview was not facilitated. In view of the above, the auditor finds PFH RRC substantially compliant with 115.215(e). 115.215(f) Pursuant to the PAQ, the Director self reports 23 staff have received training on conducting cross-gender pat-down searches and searches of transgender and intersex residents in a professional and respectful manner, consistent with security

	needs. The PC asserts that cross-gender pat search training is conducted both during new hire training and on an annual basis. The auditor's review of three applicable (staff hired on or after August 22, 2021) random staff training files reveals that staff received the requisite pre-service and/or annual cross-gender pat-down searches/searches of transgender and intersex residents in a professional and respectful manner, consistent with security needs training prior to contact with residents, training. Onsite review of 10 random staff training files, inclusive of the aforementioned applicable staff files, reveals the staff received requisite training during 2024 PREA Annual Refresher Training (ART). Six of nine random staff interviewees state they received this training during 2023 or 2024. All interviewees state the training was provided in a Power Point/video/ demonstration/ question and answer format. Review of training files pertaining to two of the three interviewees who state they have not received the requisite training reveals they received the same during 2024 PREA ART classes. In view of the above, the auditor finds PFH RRC substantially compliant with 115.215(f). In view of the above, the auditor finds PFH RRC substantially compliant with 115.215.

115.216	**Residents with disabilities and residents who are limited English proficient**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	115.216(a) Pursuant to the PAQ, the Director self reports the agency has established procedures to provide disabled residents equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment. PHS Policy entitled Prison Rape Elimination Act (PREA) Prevention, Investigation, and Reporting, page 7, section Resident education (a) and (c) addresses 115.216(a). The auditor's review of the Dynamic Language Center (DLC) Limited contract reveals the same encompasses 300 languages, as well as, sign language. The PC asserts the DLC contract is based on fee for services. All Directors are trained and made aware of the DLC contract. The PC and Director asset that all PFH RRC residents must be able to meet a

	minimal level of self care. With this said, PFH RRC does not accept residents who cannot perform basic self care functions or who present with acute special needs. The intake staff interviewee states that all PFH RRC residents are provided one-on-one PREA training and education during their initial intake (facilitated by their case manager), inclusive of an initial victimization/aggressor screening or risk assessment. She does read and explain the zero tolerance policy regarding sexual abuse/harassment and she generally explains PREA procedures to the incoming resident. A PREA brochure is provided to each resident during intake and if a PFH RRC Handbook has not been mailed to the resident while confined in prison, the same is provided at intake. The intake staff interviewee states that she does present the PREA video at intake. The auditor's review of the PREA brochure and PFH RRC Handbook reveals substantial compliance with 115.216(a). The auditor notes that sufficient tools are available to low vision/blind residents as staff provide verbal training to them and low hearing/deaf residents can read PREA documentation and/or have sign language available to them. The Agency Head interviewee asserts the agency has established procedures to provide residents with disabilities and residents who are limited English proficient (LEP) equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment. Specifically, the interviewee asserts PHS contracts with various provider(s) to ensure compliance with this provision. Generally, acute mental health cases are not received at PFH RRC as FBOP and a PHS screening committees screen cases to ensure that residents can function. Materials are generally provided in English and Spanish. Translation services may also be utilized for those residents who are limited English proficient (LEP). Staff read materials to blind residents and a TTTY is also available. Hard of hearing or deaf residents read the materials provided. Extra time is devoted to those residents who present with minimal cognitive impairment. The four disabled residents (two low vision, physically disabled, and ADHD) state the facility provides information about sexual abuse and sexual harassment that they are able to understand. In view of the above, the auditor finds PFH RRC substantially compliant with 115.216(a). 115.216(b) Pursuant to the PAQ, the Director self reports the agency has established procedures to provide Limited English Proficient (LEP) residents equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment.

	PHS Policy entitled Prison Rape Elimination Act (PREA) Prevention, Investigation, and Reporting, page 4, section Residents with disabilities and residents who are limited English proficient (b) addresses 115.216(b). The auditor's review of the Dynamic Language Center (DLC) Limited contract reveals the same encompasses 300 languages, as well as, sign language. The PC asserts the DLC contract is based on fee for services. All Directors are trained and made aware of the DLC contract. The auditor notes a Spanish PREA reporting poster is included in the PAQ materials. The Director advises that zero LEP residents were housed at PFH RRC at the time of the on-site visit and this is consistent with the auditor's observations. Accordingly, the same interview questionnaire could not be administered. The auditor notes that the PREA poster was inaccurate at the time of the onsite visit in terms of the reporting line number. During the post audit phase, the PREA poster has been updated to include the correct telephone number (1-855-800-4305 vs 1-855-800-4385) and subsequently posted to as a replacement. In view of the above, the auditor finds PFH RRC substantially compliant with 115.216(b). 115.216(c) Pursuant to the PAQ, the Director self reports agency policy prohibits the use of resident interpreters, resident readers, or other types of resident assistants except in limited circumstances where an extended delay in obtaining an effective interpreter could compromise the resident's safety, the performance of first response duties under §115.264, or the investigation of the resident's allegations. PHS Policy entitled Prison Rape Elimination Act (PREA) Prevention, Investigation, and Reporting, page 4, section Residents with disabilities and residents who are limited English proficient (c) addresses 115.216(c). Pursuant to the PAQ, the Director self reports the facility documents the limited circumstances in individual cases where resident interpreters, readers, or other types of resident assistants are used. During the last 12 months, zero instances of use of resident interpreters, readers, or other types of resident assistants to translate sexual abuse/harassment issues have occurred and it was not the case that an extended delay in obtaining another interpreter could compromise the resident’s safety, the performance of first response duties under § 115.264, or the investigation. Six of nine random staff interviewees state agency policy prohibits the use of resident interpreters, resident readers, or other types of resident assistants, except in limited circumstances where an extended delay in obtaining an effective interpreter could compromise the resident's safety, the performance of first response duties under §115.264, or the investigation of the resident's allegations,

	during sexual abuse/harassment interviews. Furthermore, all six interviewees state the strategy can be invoked to preclude further physical injury to the victim. All six interviewees state they are not aware of any such scenarios within the last 12 months, minimally. The Director advises that zero LEP residents were housed at PFH RRC at the time of the on-site visit and this is consistent with the auditor's observations. Accordingly, the same interview questionnaire could not be administered. Additionally, the four disabled residents (two low vision, physically disabled, and ADHD) state the facility provides information about sexual abuse and sexual harassment that they are able to understand. They cited no incidents wherein they were not able to report a sexual abuse or harassment incident. In view of the above, the auditor finds PFH RRC substantially compliant with 115.216(c). In view of the evidence cited throughout this narrative, the auditor finds PFH RRC substantially compliant with 115.216.

115.217	**Hiring and promotion decisions**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	115.217(a) Pursuant to the PAQ, the Director self reports agency policy prohibits hiring or promoting anyone who may have contact with residents and prohibits enlisting the services of any contractor who may have contact with residents who: Has engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility, or other institution (as defined in 42 U.S.C. 1997); Has been convicted of engaging or attempting to engage in sexual activity in the community facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse; or Has been civilly or administratively adjudicated to have engaged in the activity described above. PHS Policy entitled Prison Rape Elimination Act (PREA) Prevention, Investigation, and Reporting, page 3, section d addresses 115.217(a). The PC and Human Resources (HR) interviewees assert that prior to hire, all applicants are required to complete a Sexual Misconduct Disclosure and Institutional

	Employment/Service Disclosure form. The auditor's onsite review of three of five staff Human Resources (HR) files (staff hired within the last 24 months) reveals that Institutional Employment Service Disclosure forms (the vehicle by which the hiring manager learns about prior institutional employers) were completed either on the date of selection or within two days of selection. The auditor's review of corresponding 2022, 2023, and 2024 Sexual Misconduct Disclosure forms that the same staff signed and dated the same, checking the appropriate boxes in relationship to 115.217(a) and (b) questions, within the same parameters. The auditor notes that Institutional Employment Disclosure Reference Check forms [forms that would be submitted to or addressed telephonically with prior institutional employers pursuant to 115.217(c)] were not required as the random staff were not prior institutional employees. Of note, two additional random staff hired during 2022 and 2023 signed and dated Sexual Misconduct Disclosure form(s) within three to five weeks of the entry on duty (EOD) date. The PC asserts zero contractors are on board at PFH RRC. The auditor's review of two of three HR files (included in the randomly selected staff files) pertaining to promotions reveals the requisite Sexual Misconduct Disclosure form was completed within close proximity to the promotion date. In view of the above, the auditor finds PFH RRC substantially compliant with 115.217(a). 115.217(b) Pursuant to the PAQ, the Director self reports agency policy requires the consideration of any incidents of sexual harassment in determining whether to hire or promote anyone, or to enlist the services of any contractor, who may have contact with residents. PHS Policy entitled Prison Rape Elimination Act (PREA) Prevention, Investigation, and Reporting, page 3, section e addresses 115.217(b). The auditor notes a provision regarding sexual harassment is included within the Sexual Misconduct Disclosure form. As sexual harassment is not captured in the criminal background record check nor is it captured in the Institutional Employment Disclosure Reference Check form submitted to prior institutional employers, the auditor strongly recommends addition of a sexual harassment question to the latter form. This would provide further validation of the employee's/contractor's statement. The auditor's review of the five aforementioned applicable random staff HR files reveals the requisite sexual harassment question was asked with no affirmative responses given by respondents. The auditor's review of two of three HR files pertaining to promotions reveals the requisite Sexual Misconduct Disclosure form

	was completed within close proximity to the promotion date. The Institutional Employment Disclosure Reference Check form provides some validation to one or more of the 115.217(a) requirements. However, as mentioned in the preceding paragraph, the form, in its current state, is absent a sexual harassment question. The AD is the primary official at PFH RRC who facilitates HR functions. The HR interviewee states the facility considers prior incident(s) of sexual harassment when determining whether to hire or promote anyone, or to enlist the services of any contractor, who may have contact with residents. The interviewee states sexual harassment is noted on the Sexual Misconduct Disclosure form. This form is completed and signed by the applicant. In view of the above, the auditor finds PFH RRC substantially compliant with 115.217(b). 115.217(c) Pursuant to the PAQ, the Director self reports agency policy requires that before it hires any new employees who may have contact with residents, it (a) conducts criminal background record checks, and (b) consistent with federal, state, and local law, makes its best efforts to contact all prior institutional employers for information on substantiated allegations of sexual abuse or any resignation during a pending investigation of an allegation of sexual abuse. In the last 12 months, criminal background record checks were facilitated regarding four employees who were hired and who may have contact with residents. The Director further self reports this constitutes 100 percent of such hires. PHS Policy entitled Prison Rape Elimination Act (PREA) Prevention, Investigation, and Reporting, page 3, section f addresses 115.217(c). Additionally, pages 14 and 15 of the FBOP Statement of Work addresses FBOP conduct of criminal background record checks and approval of employment. The HR interviewee states the FBOP performs criminal record background checks or considers pertinent civil or administrative adjudications for all newly hired employees who may have contact with residents and all employees who may have contact with residents who are considered for promotions. Additionally, the same process is completed with respect to any contractor who may have contact with residents. The interviewee further states the FBOP approves all hires, promotions, and selection of contractors. The auditor's random review of three applicable (staff who were hired during the last 12 months) staff HR files reveals NCIC criminal background record checks were concluded prior to or in close proximity to the EOD date in all three cases. With respect to the three promotion cases, criminal background record checks were completed in a timely manner.

	Evidence provided to the auditor reveals that Institutional Employment Disclosure Reference Check forms were not forwarded to or telephonically discussed with any of the prior institutional confinement employers pertaining to three randomly selected employees as none of the applicants presented with prior institutional employment. All of these employees were selected for hire within the last 12 months. Accordingly, the auditor finds PFH RRC compliant with 115.217(c) as such checks were not required. In view of the above, the auditor finds PFH RRC substantially compliant with 115.217(c). 115.217(d) Pursuant to the PAQ, the Director self reports agency policy requires that a criminal background record check be completed before enlisting the services of any contractor who may have contact with residents. The Director further self reports zero contracts for services where criminal background record checks were conducted on all staff covered in the contract (applies to contract staff who might have contact with residents) were completed during the last 12 months. PHS Policy entitled Prison Rape Elimination Act (PREA) Prevention, Investigation, and Reporting, page 3, section f addresses 115.217(d). The HR interviewee states there are no contractors at PFH RRC. The same criminal background record check procedure would apply to contractors, as compared to staff applicants. If an applicant passes the PHS background and urinalysis test, the interviewee requests an FBOP background check. The interview has already occurred at this point and the interviewee is awaiting FBOP approval. Fingerprint request(s), Request for Federal Background Check, and requests for criminal history are forwarded to the FBOP. Those documents trigger the NCIC and the FBOP approves the initial hire. With respect to promotions, the same information as identified in the preceding paragraph is submitted. The FBOP runs a new NCIC and they approve the promotion. As previously referenced, zero contractors provide services at PFH RRC. In view of the above, the auditor finds PFH RRC substantially compliant with 115.217(d). 115.217(e) Pursuant to the PAQ, the Director self reports agency policy requires that either

criminal background record checks be conducted at least every five years for current employees and contractors who may have contact with residents or that a system is in place for otherwise capturing such information for current employees.

PHS Policy entitled Prison Rape Elimination Act (PREA) Prevention, Investigation, and Reporting, page 3, section h addresses 115.217(e). As previously noted, pages 14 and 15 of the FBOP Statement of Work provide specific detail regarding the conduct and processing of criminal background record checks for PFH RRC staff and contractors.

The HR interviewee states the FBOP performs criminal record background checks or considers pertinent civil or administrative adjudications for all newly hired employees who may have contact with residents and all employees, who may have contact with residents, who are considered for promotions. Additionally, the same process is completed with respect to any contractor who may have contact with residents. The interviewee further states the FBOP approves all hires and promotions. The FBOP criminal background record check follows completion of the PHS preliminary check.

Fingerprint request(s), Request for Federal Background Check, and requests for criminal history are forwarded to the FBOP. Those documents trigger the NCIC and the FBOP approves the initial hire.

The FBOP contract is renewed every five years and all current staff receive a new five year review at that time. Personal services contractors complete the same process.

The interviewee notes the FBOP does not facilitate five-year reinvestigations for vendors. Vendors are generally closely monitored by PFH RRC staff.

The auditor's review of five applicable random staff HR files (files pertaining to staff hired prior to or during 2018/2019) reveals all criminal background record checks were concluded within the last five years.

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

115.217(f)

Pursuant to the PAQ, the Director self reports the agency shall also ask all applicants and employees, who may have direct contact with residents, about previous misconduct described in paragraph (a) of this section, in written applications or interviews for hiring or promotions, and in any interviews or written self-evaluations conducted as part of reviews of current employees. The agency shall also impose upon employees a continuing affirmative duty to disclose any such misconduct.

The HR staff interviewee states the facility asks all applicants and employees who may have contact with residents about previous misconduct described above during

	the application stage or promotions. Compliance is accomplished via the Sexual Misconduct Disclosure Form. Completion of the form is required for any promotion above Monitor II. Self-evaluations are not completed by PFH RRC staff. The interviewee also states the facility imposes upon employees a continuing affirmative duty to disclose any such previous misconduct. The provision is addressed in the Standards of Conduct and each employee receives a copy of the same. The auditor finds no evidence that interviews or written self-evaluations are facilitated as part of any reviews of current employees. Accordingly, the auditor finds PFH RRC substantially compliant with 115.217(f). 115.217(g) Pursuant to the PAQ, the Director self reports agency policy states that material omissions regarding such misconduct, or the provision of materially false information, shall be grounds for termination. PHS Policy entitled Prison Rape Elimination Act (PREA) Prevention, Investigation, and Reporting, page 3, section i addresses 115.217(g). The auditor's review of the Sexual Misconduct Disclosure Form reveals there is a caveat regarding the 115.217(g) requirement within the same. The applicant, promotion candidate, contractor, etc. signs and dates this form and as such, they are aware of their obligation. In view of the above, the auditor finds PFH RRC substantially compliant with 115.217(g). 115.217(h) Pursuant to the PAQ, the Director self reports unless prohibited by law, the agency shall provide information on substantiated allegations of sexual abuse or sexual harassment involving a former employee upon receiving a request from an institutional employer for whom such employee has applied to work. PHS Policy entitled Prison Rape Elimination Act (PREA) Prevention, Investigation, and Reporting, page 3, section j addresses 115.217(h). The HR interviewee states such inquiries as described above are handled by Corporate HR staff. The auditor has not discovered any evidence of such requests. In view of the above, the auditor finds PFH RRC substantially compliant with 115.217(h).

	In view of the evidence presented above, the auditor finds PFH RRC substantially compliant with 115.217.

115.218	Upgrades to facilities and technology
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	115.218(a and b) Pursuant to the PAQ, the Director self reports the facility has not acquired a new facility or made a substantial expansion or modification to existing facilities since the last PREA audit. Similarly, the facility has not installed or updated a video monitoring system, electronic surveillance system, or other monitoring technology since the last PREA audit. Accordingly, the auditor finds 115.218 not applicable to PFH RRC. PHS Policy entitled Prison Rape Elimination Act (PREA) Prevention, Investigation, and Reporting, page 5, second paragraph (a-c) addresses 115.218. The Agency Head interviewee asserts facility design changes are based on annual vulnerability assessments. Blind spots, areas of congregation, entry and egress from rooms, and video monitoring are factors considered in such assessments. The same also applies to video monitoring. If either process is warranted, the above factors are considered in the corporate consideration process. Video monitoring is not applicable to resident rooms or bathrooms. As there is no evidence of deviation from standard, the auditor finds PFH RRC substantially compliant with 115.218.

115.221	Evidence protocol and forensic medical examinations
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	115.221(a) Pursuant to the PAQ, the Director self reports PHS is responsible for conducting administrative sexual abuse investigations (including resident-on-resident sexual abuse or staff sexual misconduct). The facility is not responsible for conducting criminal sexual abuse investigations (including resident-on-resident sexual abuse or staff sexual misconduct) as Seattle Police Department (SPD) investigators and

	Federal Bureau of Prisons (FBOP) investigators are responsible for facilitation of the same. FBOP investigators address staff-on-resident allegations in addition to the SPD investigators. Additionally, the Director self reports when conducting a sexual abuse investigation, agency investigator(s) follow a uniform evidence protocol. The auditor's review of 1st Responder Duties reveals substantial compliance with 115.221(a). PHS Policy entitled Prison Rape Elimination Act (PREA) Prevention, Investigation, and Reporting, page 6, section Policies to ensure referrals for investigations (a-c) addresses 115.221(a). All nine random staff interviewees state they know and understand the agency's protocol for obtaining usable physical evidence if a resident alleges sexual abuse. Since PFH RRC staff do not collect physical evidence however, they are responsible for preservation of the same, 1st Responder Duties constitute the administrative protocol for obtaining usable physical evidence. Seven of nine random staff interviewees were able to properly cite 1st Responder Duties as articulated at 115.264(a). Additionally, two interviewees state that the PC facilitates administrative sexual abuse/harassment investigations while seven of nine interviewees state SPD investigators facilitate criminal sexual abuse/harassment investigations. In view of the above, the auditor finds PFH RRC substantially compliant with 115.221(a). 115.221(b) Pursuant to the PAQ, the Director self reports that a developmentally appropriate protocol for youth is not applicable to PFH RRC as youth are not housed at the facility. The Director self reports the evidence preservation protocol was adapted from or is otherwise based on the most recent edition of the DOJ’s Office on Violence Against Women publication, “A National Protocol for Sexual Assault Medical Forensic Examinations, Adults/Adolescents,” or similarly comprehensive and authoritative protocols developed after 2011. PHS Policy entitled Prison Rape Elimination Act (PREA) Prevention, Investigation, and Reporting, page 5, section II(b) addresses 115.221(b). In view of the above, the auditor finds PFH RRC substantially compliant with 115.221(b). 115.221(c) Pursuant to the PAQ, the Director self reports the facility offers all residents who experience sexual abuse access to forensic medical examinations. Forensic medical examinations are offered without financial cost to the victim. Where possible,

	examinations are conducted by Sexual Assault Forensic Examiners (SAFEs) or Sexual Assault Nurse Examiners (SANEs). Additionally, when SANEs or SAFEs are not available, a qualified medical practitioner performs forensic medical examinations. The facility documents efforts to provide SANEs or SAFEs. According to the Director, zero forensic medical examinations in response to incidents of sexual abuse at PFH RCC were conducted during the last 12 months. PHS Policy entitled Prison Rape Elimination Act (PREA) Prevention, Investigation, and Reporting, page 5, section II(c) addresses 115.221(c). Pursuant to the PFH RRC PREA Coordinated Response Plan, a local hospital is used for the facilitation of a forensic examination. The SANE interviewee asserts that her organization contracts with seven local hospitals and if a sexually abused PFH RRC resident was transported to one of the affected hospitals, she or one of the other nearly 30 SANEs would respond to facilitate a forensic examination. The on-call SANEs are available on a 24/7 basis at one hospital. The interviewee asserts that a SANE is always available however, in the unlikely or very remote case there is no availability, the victim would be transported to the hospital wherein 24/7 services are available. In terms of SANE training, all SANEs complete a training curriculum which parallels that of the International Association of Forensic Nurses (IAFN) curriculum. This is a 40-hour didactic course which is followed by both clinical and non-clinical training. Training includes the conduct of eight to ten forensic examinations in conjunction with a tenured SANE. Currently there are four IAFN trained SANEs on staff. The SANE interviewee states that a pregnancy test is either facilitated in the Emergency Room (ER) or pursuant to the forensic examination process for female residents and following consultation with the ER physician. Additionally, Sexually Transmitted Infections (STI) prophylaxis medications are generally administered as part of the forensic examination process (28-days) and if additional medications are required, a prescription for prophylaxis medications is written by the ER physician and subsequently filled by facility staff. In view of the above, the auditor finds PFH RRC substantially compliant with 115.221(c). 115.221(d) Pursuant to the PAQ, the Director self reports the facility attempts to make available to the victim a victim advocate from a rape crisis center, either in person or by other means. These efforts are documented. If and when a rape crisis center is not available to provide victim advocate services, the facility provides a qualified staff member from a community-based organization or a qualified agency staff member. PHS Policy entitled Prison Rape Elimination Act (PREA) Prevention, Investigation, and Reporting, pages 5 and 6, section II(d and e) addresses 115.221(d).

	VA services are available through Harborview Abuse & Treatment Center (HATC). The auditor's review of the Memorandum of Agreement (MOA) between PHS and HATC reveals substantial compliance with 115.221(d). The PC asserts HATC victim advocates (VAs) provide advocacy services to the PFH RRC population, if needed. The MOA implies that victim advocates are qualified pursuant to Washington standards. As zero incidents of sexual abuse/harassment were reported, minimally, during the last 12 months, zero victims could be interviewed. In view of the above, the auditor finds PFH RRC substantially compliant with 115.221(d). 115.221(e) Pursuant to the PAQ, the Director self reports if requested by the victim, a victim advocate, qualified agency staff member, or qualified community-based organization staff member accompanies and supports the victim through the forensic medical examination process and investigatory interviews and provides emotional support, crisis intervention, information, and referrals. PHS Policy entitled Prison Rape Elimination Act (PREA) Prevention, Investigation, and Reporting, pages 5 and 6, section II(d and e) addresses 115.221(e). The PC asserts that if requested by the victim, a victim advocate, qualified agency staff member, or qualified community-based organization staff member accompanies and provides emotional support, crisis intervention, information, and referrals during the forensic medical examination and investigatory interview processes. Such emotional support services are provided pursuant to an MOA with HATC. The auditor notes that the aforementioned MOA is silent regarding provision of VA services during investigatory interviews. However, the same clearly addresses provision of VA services to PFH RRC residents who are referred for sexual assault. Accordingly, in an effort to determine if services would be provided during investigatory interviews, the auditor interviewed the HATC Assistant Director who clearly indicated that HATC would provide VA services to requesting victims during investigatory interviews. The auditor does strongly recommend that the PC and/or PFH RRC Director collaborate with HATC officials to add the above to the MOA. Accordingly, it is clear that PFH RRC is substantially compliant with 115.221(e). 115.221(f) PHS Policy entitled Prison Rape Elimination Act (PREA) Prevention, Investigation, and Reporting, page 6, section II(f) addresses 115.221(f). SPD facilitates criminal sexual

	abuse investigations pursuant to state standards. In view of the above, the auditor finds PFH RRC substantially compliant with 115.221(f). 115.221(h) As reflected in the narrative for 115.221(d), PHS is engaged in a Memorandum of Agreement (MOA) with HATC (a rape crisis center) to provide VA services at the facility. Accordingly, 115.221(h) is not applicable to PFH RRC. In view of the above, the auditor finds PFH RRC substantially compliant with 115.221(h). In view of the evidence provided above, the auditor finds PFH RRC substantially compliant with 115.221.

115.222	**Policies to ensure referrals of allegations for investigations**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	115.222(a) Pursuant to the PAQ, the Director self reports the agency ensures that an administrative or criminal investigation is completed for all allegations of sexual abuse and sexual harassment (including resident-on-resident sexual abuse or staff sexual misconduct). The Director further self reports that in the last 12 months, zero allegations of sexual abuse/harassment at PFH RRC, were received. PHS Policy entitled Prison Rape Elimination Act (PREA) Prevention, Investigation, and Reporting, page 6, section Policies to ensure referrals of allegations for investigations (a) addresses 115.222(a). The Agency Head interviewee asserts the agency ensures that an administrative or criminal investigation is completed for all allegations of sexual abuse/harassment. The PHS PC, the Director of Tacoma Residential Reentry Center (TRRC), and the interviewee are trained investigators with the PHS PC serving as the primary administrative investigator. He assigns administrative investigations to the aforementioned trained administrative investigators.

	SPD investigators facilitate criminal sexual abuse investigations and collect physical evidence relative to PFH RRC resident allegations. PFH RRC staff and administrative investigators preserve physical evidence of sexual abuse/harassment. In view of the above, the auditor finds PFH RRC substantially compliant with 115.222(a). 115.222(b) Pursuant to the PAQ, the Director self reports that the agency has a policy that requires allegations of sexual abuse or sexual harassment be referred for investigation to an agency with the legal authority to conduct criminal investigations, including the agency, if it conducts its own investigations, unless the allegation does not involve potentially criminal behavior. The agency's policy regarding the referral of allegations of sexual abuse or sexual harassment for criminal investigation is published on the agency website or made publicly available via other means. Additionally, the agency documents all referrals of allegations of sexual abuse or sexual harassment for criminal investigation. PHS Policy entitled Prison Rape Elimination Act (PREA) Prevention, Investigation, and Reporting, pages 6 and 16, 17 sections Policies to ensure referrals of allegations for investigations (b) and Investigations a(1) address 115.222(b). The aforementioned policies stipulate, in standard narrative, agency responsibilities in terms of assistance to criminal investigative agencies. The administrative investigative staff interviewee states that SPD investigators facilitate criminal investigations. The auditor's review of the PHS/PFH RRC website reveals substantial compliance with 115.222(b). In view of the above, the auditor finds PFH RRC substantially compliant with 115.222(b). 115.222(c) Pursuant to the PAQ, the Director asserts that if a separate entity is responsible for conducting criminal investigations, such publication shall describe the responsibilities of both the agency and the investigating entity. PHS Policy entitled Prison Rape Elimination Act (PREA) Prevention, Investigation, and Reporting, pages 6 and 16, 17 sections Policies to ensure referrals of allegations for investigations (b) and Investigations a(1) address 115.222(c) in standard narrative terms. The auditor notes that the above policy is uploaded to the agency website.

	In view of the above, the auditor finds PFH RRC substantially compliant with 115.222(c). The auditor's review of all evidence mentioned throughout this narrative reveals substantial compliance with 115.222.

115.231	**Employee training**
	Auditor Overall Determination: Exceeds Standard
	Auditor Discussion
	115.231(a) Pursuant to the PAQ, the Director self reports the agency trains all employees who may have contact with residents on: The agency's zero-tolerance policy for sexual abuse and sexual harassment; How to fulfill their responsibilities under agency sexual abuse and sexual harassment prevention, detection, reporting, and response policies and procedures; The right of residents to be free from sexual abuse and sexual harassment; The right of residents and employees to be free from retaliation for reporting sexual abuse and sexual harassment; The dynamics of sexual abuse and sexual harassment in confinement; The common reactions of sexual abuse and sexual harassment victims; How to detect and respond to signs of threatened and actual sexual abuse; How to avoid inappropriate relationships with residents; How to communicate effectively and professionally with residents, including lesbian, gay, bisexual, transgender, intersex, or gender-nonconforming residents; and How to comply with relevant laws related to mandatory reporting of sexual abuse to outside authorities. PHS Policy entitled Prison Rape Elimination Act (PREA) Prevention, Investigation, and Reporting, pages 6 and 7, sections III(a)(1-14) addresses 115.231(a). The auditor's review of the PHS A Chance for Change PREA Training for RRC Staff curriculum reveals substantial compliance with 115.231(a). The auditor's review of the PHS PREA Acknowledgment Prior to Training, PHS PREA Training Acknowledgment, and PHS Professional Communication in Reentry documents also

	reveals substantial compliance with 115.231. All nine random staff interviewees state they received training regarding the above PREA topics during either PREA New Employee Orientation or 2024 PREA ART. All interviewees state they received this training during 2024 either in-person or pursuant to on-line Relias training. The auditor's review of two random staff training files (pertaining to staff hired during the last 12 months) reveals that PREA New Employee Orientation training was provided prior to resident contact. The training was provided in close proximity to the date of hire. Additionally, in one case wherein the employee was hired during August, 2021, PREA training was provided one day following the date of hire and prior to contact with residents. In view of the above, the auditor finds PFH RRC substantially compliant with 115.231(a) 115.231(b) Pursuant to the PAQ, the Director self reports training is tailored to the male and female genders of the residents at the facility. Additionally, employees who are reassigned from facilities housing the opposite gender are given additional training. PHS Policy entitled Prison Rape Elimination Act (PREA) Prevention, Investigation, and Reporting, page 7, section III(b) addresses 115.231(b). The auditor's review of the training curriculum mentioned in the narrative for 115.231(a) reveals substantial compliance with 115.231(b). As previously mentioned, both male and female residents are housed at PFH RRC. In view of the above, the auditor finds PFH RRC substantially compliant with 115.231(b). 115.231(c) Pursuant to the PAQ, the Director self reports that between trainings, the agency provides employees who may have contact with residents refresher information about current policies regarding sexual abuse and harassment. The Director further self reports refresher training is facilitated on an annual basis. PHS Policy entitled Prison Rape Elimination Act (PREA) Prevention, Investigation, and Reporting, page 6, section III Staff Training addresses 115.231(c). The auditor's review of seven of 10 additional random staff training files reveals the staff were hired during previous audit periods and accordingly, PREA ART was conducted in each case. All PREA ART training regarding random staff file reviews was facilitated during 2024.

	Given the facts that 115.231(c) requires PREA training every two years and PFH RRC provides such training on an annual basis, the auditor finds that PFH RRC exceeds requirements. 115.231(d) Pursuant to the PAQ, the Director self reports the agency documents that employees who may have contact with residents understand the training they have received through employee signature or electronic verification. PHS Policy entitled Prison Rape Elimination Act (PREA) Prevention, Investigation, and Reporting, page 7, section III(d) addresses 115.231(d). The auditor's review of completed PFH Staff Training Acknowledgment forms pertaining to eight staff hired between 2021 and 2024 reveals much of the information provided in the aforementioned policy citations. The employee signs and dates the same, acknowledging understanding of relevant information, and the Director/AD/ or Trainer also signs and dates the same. In view of the above, the auditor finds PFH RRC substantially compliant with 115.231(d). In view of the evidence cited above and especially in the narrative for 115.231(c), the auditor finds PFH RRC exceeds expectations with respect to 115.231.

115.232	**Volunteer and contractor training**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	115.232(a) Pursuant to the PAQ, the Director self reports all volunteers and contractors who have contact with residents have been trained on their responsibilities under the agency’s policies and procedures regarding sexual abuse and sexual harassment prevention, detection, and response. According to the Director, zero contractors and/or volunteers are utilized at PFH RRC. PHS Policy entitled Prison Rape Elimination Act (PREA) Prevention, Investigation, and Reporting, page 1, section Applicability addresses 115.232(a). Additionally, the auditor's review of the PHS Sexual Harassment, Abuse & Assault Zero Tolerance Policy for Staff, Contractors, and Volunteers brochure addresses 115.232(b). In view of the above, the auditor finds PFH RRC substantially compliant with

	115.232(a). 115.232(b) Pursuant to the PAQ, the Director self reports the level and type of training provided to volunteers and contractors is based on the services they provide and level of contact they have with residents. As previously mentioned, zero contractors or volunteers provide services at PFH RRC and accordingly, zero documentary evidence is available. PHS Policy entitled Prison Rape Elimination Act (PREA) Prevention, Investigation, and Reporting, page 1, section Applicability addresses 115.232(b). The auditor's review of the PHS Sexual Harassment, Abuse & Assault Zero Tolerance Policy for Staff, Contractors, and Volunteers brochure address 115.232(b). Given the fact that zero contractors and volunteers are utilized at PFH RRC, validating evidence is not available. However, blank copies of applicable 115.232(c) validation documents are uploaded into OAS. In view of the above, the auditor finds PFH RRC substantially compliant with 115.232(b). 115.232(c) Pursuant to the PAQ, the agency maintains documentation confirming that volunteers and contractors who have contact with residents understand the training they have received. PHS Policy entitled Prison Rape Elimination Act (PREA) Prevention, Investigation, and Reporting, page 7, section III(d) addresses 115.232(c). Given the fact that zero contractors and volunteers are utilized at PFH RRC, validating evidence is not available. However, blank copies of applicable 115.232(c) validation documents are included in OAS. The document clearly reflects the "I understand" caveat and includes signature blocks for both the contractor/volunteer, as well as, a witness. In view of the above, the auditor finds PFH RRC substantially compliant with 115.232(c). In view of the above, the auditor finds PFH RRC substantially compliant with 115.232.

115.233	**Resident education**

	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	115.233(a) Pursuant to the PAQ, the Director self reports residents receive information at time of intake about the zero-tolerance policy, how to report incidents or suspicions of sexual abuse or harassment, their rights to be free from sexual abuse and sexual harassment and to be free from retaliation for reporting such incidents, and regarding agency policies and procedures for responding to such incidents. Seventy-one residents admitted during the last 12 months were given this information at intake. PHS Policy entitled Prison Rape Elimination Act (PREA) Prevention, Investigation, and Reporting, page 7, section Resident education (a) addresses 115.233(a). The auditor's review of the PHS Sexual Harassment, Abuse, and Assault Zero Tolerance Policy trifold brochure also reveals substantial compliance with 115.233(a) with the exception that the internal PREA reporting Hotline telephone number is inaccurate. During the post-audit phase, the trifold brochure was corrected and the same is uploaded into OAS. The auditor notes that case managers facilitate intake and 115.241 screening functions at PFH RRC. The intake staff interviewee states she provides residents with information about the zero-tolerance policy and how to report incidents or suspicions of sexual abuse or sexual harassment. The same is provided in the Sexual Harassment, Abuse & Assault Zero Tolerance Policy Information for Residents tri-fold brochure which is generally forwarded to incoming residents while they are still confined at the sending institution. If not provided while confined at the sending institution, she provides the same during the intake process. The PFH RRC Resident Handbook and PREA video are also provided to each incoming resident during intake. Residents sign for the PFH RRC Resident Handbook received at intake or prior to arrival at the facility. The auditor's review of the Dynamic Language Center (DLC) Limited contract reveals the same encompasses 300 languages, as well as, sign language. The PC asserts the DLC contract is based on fee for services. All Directors are trained and made aware of the DLC contract. The PC and Director asset that all PFH RRC residents must be able to meet a minimal level of self care. With this said, PFH RRC does not accept residents who cannot perform basic self care functions or who present with acute special needs. The intake staff interviewee states that all PFH RRC residents are provided one-on-one PREA training and education during their initial intake (facilitated by their case manager), inclusive of an initial victimization/aggressor screening or risk assessment. She does read and explain the zero tolerance policy regarding sexual abuse/harassment and she generally explains PREA procedures to the incoming resident. A PREA brochure is provided to each resident during intake and if a PFH

	RRC Handbook has not been mailed to the resident while confined in prison, the same is provided at intake. The PC asserts that all information addressed during intake is likewise covered during a follow-up educational session facilitated following intake. The follow-up session is intended to provide residents the opportunity to review the tri-fold brochure issued during intake or prior to arrival at the facility and ask any questions. Given the fact that all requisite information is provided to the resident during intake, the auditor finds PFH RRC substantially compliant with 115.233(a). The standard does not require the conduct of a comprehensive education follow-up subsequent to the intake education, especially since requisite information is provided at intake. While the auditor recommends that the second education session practice be eliminated, he applauds facility staff for their efforts to ensure residents fully understand PREA rights. All six random resident interviewees report they received information about the facility's rules against sexual abuse/harassment either at the sending institution or within 48 hours of arrival at PFH RRC. Each interviewee states they received the PHS Sexual Harassment, Abuse, and Assault Zero Tolerance Policy trifold brochure and/or the PFH RRC Resident Handbook for Residents and signed/dated a document entitled PREA wherein definitions of sexual abuse/harassment, and certifications of review and understanding of the PREA Information for Residents and Zero Tolerance Policy, My Right to be Free from Sexual Abuse/Harassment, How to Report. All six interviewees state they were told about the following at intake up to 48 hours from arrival at the facility. This information included the following: Your right not to be sexually abused/harassed; How to report sexual abuse/harassment; and Your right not to be punished for reporting sexual abuse/harassment. The auditor's review of three of four interviewee's files who either reported receiving the above information within 24 to 48 hours of arrival or they didn't recall when the information was provided reveals they received relevant information on the date of arrival at PFH RRC. Additionally, all of these interviewees articulated that they received at least the tri-fold brochure or PFH RRC Resident Handbook while confined at the sending institution. The auditor's review of 11 of 13 random resident files reveals timely provision of requisite PREA education information on the date of arrival or prior to arrival at PFH RRC. In view of the above, the auditor finds PFH RRC substantially compliant with 115.233(a). 115.233(b)

	Pursuant to the PAQ, the Director self reports the facility provides residents who are transferred from a different community confinement facility with refresher information referenced in the narrative for 115.233(a). The Director further self reports zero residents were transferred from a different community confinement facility during the last 12 months. PHS Policy entitled Prison Rape Elimination Act (PREA) Prevention, Investigation, and Reporting, page 7, section Resident education (b) addresses 115.233(b). The intake staff interviewee asserts that 115.233(a) information is generally mailed to incoming residents at the sending facility prior to arrival at PFH RRC. If not mailed to the resident prior to arrival at PFH RRC, the PFH RRC Resident Handbook, the aforementioned tri-fold brochure, and PREA video are provided at the facility within 24 hours of arrival. Five of six random resident interviewees validated the same. None of the random resident interviewees state they transferred from another community confinement facility. Clearly, all arriving residents receive PREA training at PFH RRC. In view of the above, the auditor finds PFH RRC substantially compliant with 115.233(b). 115.233(c) Pursuant to the PAQ, the Director self reports resident PREA education is available in formats accessible to all residents, including those who are limited English proficient, deaf, visually impaired, otherwise disabled, and those with limited reading skills. PHS Policy entitled Prison Rape Elimination Act (PREA) Prevention, Investigation, and Reporting, page 7, section Resident education (c) addresses 115.233(c). The intake staff interviewee states that all PFH RRC residents are provided one-on-one PREA training and education during their initial intake (facilitated by their case manager), inclusive of an initial victimization/aggressor screening or risk assessment. A PREA brochure is provided to each resident during intake if the same has not been mailed to the resident while confined in prison. The auditor notes that sufficient tools are available to low vision residents as staff provide verbal training to them and low hearing residents can read PREA documentation and/or have sign language available to them. In regard to non-English speaking residents, the auditor's review of the Dynamic Language Center (DLC) Limited contract reveals the same encompasses 300 languages, as well as, sign language. The PC asserts the DLC contract is based on fee for services. All Directors are trained and made aware of the DLC contract. If required to communicate relevant PREA information to non-English speaking

residents, intake staff can invoke DLC services.

The auditor notes a Spanish PREA reporting poster is included in the PAQ materials. The Director advises that zero LEP residents were housed at PFH RRC at the time of the on-site review and this is consistent with the auditor's observations. Accordingly, the same interview questionnaire could not be administered.

As previously mentioned, the auditor's review of the PHS Sexual Harassment, Abuse, and Assault Zero Tolerance Policy trifold brochure reveals substantial compliance with 115.233(a) with the exception that the internal PREA reporting Hotline telephone number is inaccurate. During the post-audit phase, the trifold brochure was corrected and the same is uploaded into OAS.

Generally, acute mental illness or medical cases are not received at PFH RRC as the FBOP screens cases to ensure residents can function. The four disabled residents (two low vision, one physically disabled, and one Attention Deficit Disorder) state the facility provides information about sexual abuse and sexual harassment that they are able to understand.

In view of the above, the auditor finds PFH RRC substantially compliant with 115.233(c).

115.233(d)

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

All six random resident interviewees report they received information about the facility's rules against sexual abuse/harassment either at the sending institution or within 48 hours of arrival at PFH RRC. Each interviewee states they received the PHS Sexual Harassment, Abuse, and Assault Zero Tolerance Policy trifold brochure and/or the PFH RRC Resident Handbook and signed/dated a document entitled PREA wherein definitions of sexual abuse/harassment, and certifications of review and understanding of the PREA Information for Residents and Zero Tolerance Policy, My Right to be Free from Sexual Abuse/Harassment, How to Report.

The auditor's review of three of four specialized interviewee's files who either reported receiving the above information within 24 to 48 hours of arrival or they didn't recall when the information was provided reveals they received relevant information on the date of arrival at PFH RRC. Additionally, all of these interviewees articulated that they received at least the tri-fold brochure or PFH RRC Resident Handbook while confined at the sending institution.

The auditor's review of 11 of 13 random resident files reveals timely provision of requisite PREA education information on the date of arrival or prior to arrival at PFH RRC.

In view of the above, the auditor finds PFH RRC substantially compliant with

	115.233(d). 115.233(e) Pursuant to the PAQ, the Director self reports the agency ensures that key information about the agency's PREA policies is continuously and readily available or visible through posters, resident handbooks, or other written formats. During the facility tour, the auditor noted the aforementioned documents, as well as, posters were available for resident consumption regarding the PREA program at PFH RRC. A PHS toll-free hotline number is provided on the PREA Hotline posters (855-800-4305) and the Sexual Harassment, Abuse & Assault Zero Tolerance Policy Information for Residents tri-fold brochure while a different PHS PREA Hotline telephone number is reflected in the PFH RRC Resident Handbook (844-810-6901). Accordingly, the auditor finds PFH RRC non-compliant with 115.251(a) and 115.233(e). The conflict between the poster and the PFH RRC Resident Handbook is confusing for the auditor and most likely the residents. Accordingly, the auditor places PFH RRC in a 180-day corrective action period wherein the disparity between the poster and the PFH RRC Resident Handbook will be corrected. The corrective action due date is February 3, 2025. To demonstrate compliance with 115.251(a) and 115.233(e), the PC will update both the poster and the PFH RRC Resident Handbook to coincide with one another. Upon completion of the same, the PC will upload the same for the auditor's review and subsequently post a memorandum in all housing units to all residents, advising of the updates. A copy of the memorandum will likewise be uploaded into OAS. September 27, 2024 Update: The auditor's review of both the tri-fold brochure, as well as, the sexual abuse/ harassment reporting poster reveals the above amendments were completed during the post-audit phase. The amended poster replaces the inaccurate poster previously mentioned and is mounted on the PREA Bulletin Board located in the entrance hallway. The brochure is now being provided to incoming residents. In view of the above, the auditor finds PFH RRC substantially compliant with this component of the 115.233(e) finding. In addition to the above, while testing the third-party reporting Hotline (Northwest Regional Reentry Center), the auditor found that the test failed [115.253(a)]. Accordingly, corrective action has been imposed to address the failure and the same may require revision of the reporting procedure, requiring updating of the PHS

	Sexual Harassment, Abuse, and Assault Zero Tolerance Policy Information for Residents trifold brochure/the PFH RRC Resident Handbook and relevant poster(s). If so, the PC and the auditor will collaborate to identify corrective action strategies. The corrective action due date will be February 3, 2025. February 26, 2025 Update: At 11:35AM on the above date, the auditor tested the Northwest Regional Reentry Center Sexual Abuse Reporting Hotline by dialing (502)546-8178 from his office telephone. As he was unable to speak to anyone in person, he left a voice mail message. On February 26, 2025, the PHS PC advised the auditor that the test call had been reported to him. Accordingly, the auditor finds that PFH RRC is now substantially compliant with 115.233(e). In view of the above, the auditor finds PFH RRC substantially compliant with 115.233(e). In view of the 115.233(e) findings, the auditor finds PFH RRC substantially compliant with 115.233.

115.234	**Specialized training: Investigations**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	115.234(a) Pursuant to the PAQ, the Director self reports agency policy requires that investigators are trained in conducting sexual abuse investigations in confinement settings. PHS Policy entitled Prison Rape Elimination Act (PREA) Prevention, Investigation, and Reporting, page 8, section Specialized Training: Investigations (a and b) addresses 115.234(a). The administrative investigative staff interviewee states he completed training specific to conducting sexual abuse investigations in a confinement setting. The same consisted of a six hour Moss Group ZOOM training entitled PREA Specialized Investigations Training. The training included a power point presentation and scenario training. Additionally, a testing component was incorporated at the conclusion of the training. The criminal investigative interviewee states that he did not complete training

	regarding the conduct of sexual abuse investigations in a confinement setting. Rather, his training and that of his subordinates addresses the conduct of sexual abuse investigations within the community and in general. Of note, detectives assigned to his section have facilitated sexual abuse investigations at the King County Jail. Additionally, the auditor's review of two Relias Training Systems certificates dated March 15, 2023 and January 21, 2024 regarding a course entitled Dynamics of Sexual Abuse in Correctional Systems reveals substantial compliance with 115.234(a). The PC/administrative investigative interviewee asserts that this course serves as the PREA ART training for executives. In view of the above, the auditor finds PFH RRC substantially compliant with 115.234(a). 115.234(b) Pursuant to the PAQ, the Director self reports specialized training includes the following: Techniques for interviewing sexual abuse victims; Proper use of Miranda and Garrity warnings; Sexual abuse evidence collection in confinement settings; and The criteria and evidence required to substantiate a case for administrative action or prosecution referral. The administrative investigative interviewee and his certificate of completion validate that his training addressed the above topics. Additionally, the auditor's previous review of the syllabus for the National Institute of Corrections (NIC) course reveals substantial compliance with 115.234(b). The criminal investigative interviewee states that his academy and specialized subject-matter training addressed the following: Techniques for interviewing sexual abuse victims; Proper use of Miranda and Garrity warnings; Sexual abuse evidence collection in confinement settings; and The criteria and evidence required to substantiate a case for administrative action or prosecution referral. In view of the above, the auditor finds PFH RRC substantially compliant with 115.234(b).

	115.234(c) Pursuant to the PAQ, the Director self reports the agency maintains documentation showing that four investigators have completed requisite specialty investigative training. The auditor's review of two Relias Training Systems certificates dated March 15, 2023 and January 21, 2024 regarding a course entitled Dynamics of Sexual Abuse in Correctional Systems reveals substantial compliance with 115.234(a). The PC asserts that this course serves as the PREA ART training for executives. The auditor's review of four Certificates (two awarded by PHS for completion of the Moss Group PREA Specialized Investigations Training and two Certificates of Completion awarded by the Moss Group for Specialized Investigations Training reveals substantial compliance with 115.234(c). The auditor's review of the lesson plan regarding the aforementioned courses reveals substantial compliance with 115.234(b). Of note, the Moss Group lesson plan parallels the National Institute of Corrections plan regarding the same topics. In view of the above, the auditor finds PFH RRC substantially compliant with 115.234(c). In view of the above, the auditor finds PFH RRC substantially compliant with 115.234.

115.235	**Specialized training: Medical and mental health care**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	115.235(a-d) Pursuant to the PAQ, the Director self reports the agency has a policy related to the training of medical and mental health practitioners who work regularly in its facilities. The Director further self reports zero medical and mental health care practitioners are employed at PFH RRC. The auditor notes that the same is validated pursuant to onsite observation. PHS Policy entitled Prison Rape Elimination Act (PREA) Prevention, Investigation, and Reporting, page 8, section Specialized Training: Medical and mental health care c(1-7) addresses 115.235(a-d). Accordingly, the auditor finds 115.235(a-d) are not applicable to PFH RRC. In view of the above, neither the medical nor mental health staff interviews were facilitated. Additionally, training files, certifications, etc. could not be reviewed.

	Since there are no deviations from policy or standard, the auditor finds PFH RRC substantially compliant with 115.235.

115.241	Screening for risk of victimization and abusiveness
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	115.241(a) Pursuant to the PAQ, the Director self reports the agency has a policy that requires screening (upon admission to a facility or transfer to another facility) for risk of sexual abuse victimization or sexual abusiveness toward other residents. PHS Policy entitled Prison Rape Elimination Act (PREA) Prevention, Investigation, and Reporting, page 8, section IV(a) addresses 115.241(a). The staff responsible for risk screening interviewee states she does screen residents upon admission to PFH RCC or transfer from another facility for risk of sexual abuse victimization or sexual abusiveness toward other residents. Such risk screenings are completed within 24 hours of arrival. Five of six random resident interviewees state when they first arrived, either on the date of arrival (one), within 24 hours of arrival (three), or within 48 hours of arrival (one), they were asked questions like: Whether they had been in jail or prison before; Whether they have have ever been sexually abused; Whether they identify as being gay, lesbian, or bisexual; and Whether they think they might be in danger of sexual abuse at PFH RRC. The auditor's review of two PAQ victimization/aggressor screenings reveals that the initial assessment relative to one resident was completed on the day following arrival and another initial screening (different resident) was completed within 48 hours of arrival. One random resident interviewee states that he was not asked any of the above questions upon arrival at PFH RRC. The auditor's review of his victimization/ aggressor screening reveals he was asked the aforementioned questions on the day of arrival at PFH RRC. The auditor's review of 10 of 13 random resident files, inclusive of the one pertaining to the resident who states he was not asked any of the above questions,

	reveals the above questions were asked within 24 hours of arrival at PFH RRC. In the three cases wherein the questions were not asked within a 24 hours of arrival, only one case reveals that questions were asked outside the standard requisite 72 hours of arrival. While policy and the standard require that the initial screening be completed within 72 hours of arrival at the facility, the staff responsible for risk screening interviewee states she completes initial assessments within 24 hours of arrival at PFH RRC. Given the fact that residents are not separated from one another by secured doors (two to four residents assigned to each room) and an orientation unit concept is not utilized at PFH RRC, the auditor strongly recommends that initial screenings be completed within 24 hours of arrival at the facility. Implementation of the same in policy and practice could enhance resident sexual safety. Based on staff interviews, the auditor has learned that case manager(s) facilitate initial victimization/aggressor and reassessments at PFH RRC. In view of the above, the auditor finds PFH RRC substantially compliant with 115.241(a). 115.241(b) Pursuant to the PAQ, the Director self reports the policy requires that residents be screened for risk of sexual victimization or risk of sexually abusing other residents within 72 hours of their intake. The Director further self reports that during the last 12 months, 71 residents (whose length of stay in the facility was for 72 hours or more) were screened for risk of sexual victimization or risk of sexually abusing other residents within 72 hours of their entry into the facility. This equates to 100 percent of those residents who remained at PFH RRC for 72 hours or more from intake. PHS Policy entitled Prison Rape Elimination Act (PREA) Prevention, Investigation, and Reporting, page 8, section IV(b) addresses 115.241(b). Five of six random resident interviewees state when they first arrived, either on the date of arrival (one), within 24 hours of arrival (three), or within 48 hours of arrival (one), they were asked questions like: Whether they had been in jail or prison before; Whether they have have ever been sexually abused; Whether they identify as being gay, lesbian, or bisexual; and Whether they think they might be in danger of sexual abuse at PFH RRC. One random resident interviewee states that he was not asked any of the above questions upon arrival at PFH RRC. The auditor's review of his victimization/ aggressor screening reveals he was asked the aforementioned questions on the day of arrival at PFH RRC.

	The auditor's review of 10 of 13 random resident files, inclusive of the one pertaining to the resident who states he was not asked any of the above questions, reveals the above questions were asked within 24 hours of arrival at PFH RRC. In the three cases wherein the questions were not asked within a 24 hours of arrival, only one case reveals that questions were asked outside the standard requisite 72 hours of arrival. While policy and the standard require that the initial screening be completed within 72 hours of arrival at the facility, the staff responsible for risk screening interviewee states she completes initial assessments within 24 hours of arrival at PFH RRC. Given the fact that residents are not separated from one another by secured doors (two to four residents assigned to each room) and an orientation unit concept is not utilized at PFH RRC, the auditor strongly recommends that initial screenings be completed within 24 hours of arrival at the facility. Implementation of the same in policy and practice could enhance resident sexual safety. In view of the above, the auditor finds PFH RRC substantially compliant with 115.241(b). 115.241(c) Pursuant to the PAQ, the Director self reports risk assessment is conducted using an objective screening instrument. PHS Policy entitled Prison Rape Elimination Act (PREA) Prevention, Investigation, and Reporting, page 9, section IV(c) addresses 115.241(c). The auditor's review of the PHS victimization/aggressor risk assessment instrument reveals substantial compliance with 115.241(c) as the same is objective. All required assessment issues [as identified in 115.241(d)] associated with point values and thresholds for identification, are reflected in the risk assessment instrument. In view of the above, the auditor finds PFH RRC substantially compliant with 115.241(c). 115.241(d) Pursuant to the PAQ, the Director self reports the intake screening instrument shall consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: Whether the resident has a mental, physical, or developmental disability; The age of the resident; The physical build of the resident;

	Whether the resident has previously been incarcerated; Whether the resident's criminal history is exclusively nonviolent; Whether the resident has prior convictions for sex offenses against an adult or child; Whether the resident is or is perceived to be gay, lesbian, bisexual, transgender, intersex, or gender nonconforming; Whether the resident has previously experienced sexual victimization; and The resident's own perception of vulnerability. PHS Policy entitled Prison Rape Elimination Act (PREA) Prevention, Investigation, and Reporting, page 9, section IV(d) addresses 115.241(d). The staff responsible for risk screening interviewee states that issues captured in the initial risk screening include the following: History of sexual victimization in prison; History of sexual victimization; History of confinement; History of violence; and Vulnerability. The interviewee states that she facilitates both initial and 30-day reassessments in the case manager's office (one-on-one) with the door open as there are no windows in the same. Zero other residents are located in the screening area at the time of the screening. She reads all of the questions to the residents and documents response(s) on the screening tool. The interviewee reviews the FBOP pending arrival packet prior to the screening and accordingly, she is equipped to ask probing questions during the screening. The Pre-Sentence Report and the Judgment and Commitment Order are the source documents reviewed, as well as, progress reports and disciplinary synopses. In view of the above, the auditor finds PFH RRC substantially compliant with 115.241(d). 115.241(e) Pursuant to the PAQ, the Director self reports the intake screening shall consider prior acts of sexual abuse, prior convictions for violent offenses, and history of prior institutional violence or sexual abuse, as known to the agency, in assessing residents for risk of being sexually abusive. PHS Policy entitled Prison Rape Elimination Act (PREA) Prevention, Investigation, and

	Reporting, page 9, section IV(e) addresses 115.241(e). The auditor's review of the screening instrument reveals substantial compliance with 115.241(e). Additionally, the staff responsible for risk screening interviewee states that history of sexual victimization in prison and history of violence are asked as part of the victimization/aggressor screening. In view of the above, the auditor finds PFH RRC substantially compliant with 115.241(e). 115.241(f) Pursuant to the PAQ, the Director self reports the policy requires that the facility reassess each resident's risk of victimization or abusiveness within a set time period, not to exceed 30 days after the resident's arrival at the facility, based upon any additional, relevant information received by the facility since the intake screening. The Director further self reports that 71 residents entering the facility (either through intake or transfer) within the last 12 months whose length of stay in the facility was for 30 days or more, were reassessed for their risk of sexual victimization or of being sexually abusive within 30 days after their arrival at the facility based upon any additional, relevant information received since intake. PHS Policy entitled Prison Rape Elimination Act (PREA) Prevention, Investigation, and Reporting, page 9, section IV(f) addresses 115.241(f). The staff responsible for risk screening interviewee states resident risk levels are reassessed within 30 days of arrival at the facility. A spreadsheet is used to track due dates. Five of the six random resident interviewees state they were asked the same type of questions again while at PFH RRC. In view of the date of arrival with respect to the last random resident interviewee, he was not yet due for reassessment. The auditor's onsite review of three of the five files relative to the random resident interviewees reveals that 30-day reassessments were completed in a timely manner. In the last two cases, reassessments were completed one day outside the 30-day window. With respect to the two PAQ assessments and reassessments addressed in the narrative for 115.241(a), the auditor notes that both reassessments were completed within 30 days of the initial assessment completion date, as opposed to 30 days from the date of arrival at PFH RRC. The auditor's onsite review of five of 11 random resident files reveals 30-day reassessments were completed within 30 days of arrival. In two additional cases, the 30-day reassessment was not yet due based on the date of arrival at PFH RRC. The appearance of a trend reveals that the 30-day reassessments are completed within 30-days of the initial assessment, as opposed to, 30-days of the date of

arrival at the facility. This was the case with respect to three reassessments.

In view of the above, the auditor finds PFH RRC non-compliant with 115.241(f), imposing a 180-day corrective action period wherein the PC and Director will demonstrate compliance with and institutionalization of 115.241(f). The corrective action due date is February 3, 2025.

To demonstrate compliance with and institutionalization of the 115.241(f) requirement, the PC and/or the Director will facilitate a training session for all staff who conduct requisite 30-day reassessment screenings. The PC and/or the Director will upload a training syllabus regarding content provided to all staff who facilitate sexual victimization and abusiveness screenings. The syllabus must clearly reflect that the 30-day reassessment will be completed within 21-27 days of the resident's arrival date at PFH RRC. Additionally, the PC and/or the Director will upload training certifications regarding the training, validating all stakeholders have received the requisite training.

In addition to the above, on or before February 3, 2025, the PC or Director will provide to the auditor a roster of current PFH RRC residents who arrived at the facility subsequent to the date of the interim report. The auditor will randomly select names from that roster, forward the same to the PC, and the PC or Director will upload evidence validating timely completion of the 30 day reassessment in each case. The PC or Director will provide to the auditor the resident's date of arrival at PFH RRC, the initial assessment, and the 30-day reassessment. Upon the auditor's review of the evidence presented, he will determine the status of compliance with respect to 115.241(f).

In view of the findings reflected above, the auditor finds PFH RRC non-compliant with 115.241(f).

March 26, 2025 Update:

The auditor's review of the training syllabus addressing timely completion of reassessments reveals that reassessments are completed within 21-27 days of arrival at PFH RRC. Three training stakeholders signed an attestation that they understand this requirement. The subject-matter of the syllabus is commensurate with 115.241(f).

April 8, 2025 Update:

The auditor's review of 23 of 24 randomly selected initial assessments and reassessments reveals that reassessments were completed within 30 days of arrival at PFH RRC. Accordingly, 95 percent of the randomly selected files regarding residents that arrived at PFH RRC since the completion date of this interim report were found to be substantially compliant with 115.241(f).

	In view of the above, the auditor finds PFH RRC substantially compliant with 115.241(f). 115.241(g) Pursuant to the PAQ, the Director self reports the policy requires that a resident's risk level be reassessed when warranted due to a referral, request, incident of sexual abuse, or receipt of additional information that bears on the resident's risk of sexual victimization or abusiveness. PHS Policy entitled Prison Rape Elimination Act (PREA) Prevention, Investigation, and Reporting, page 9, section IV(g) addresses 115.241(g). As reflected throughout this report, zero sexual abuse/harassment investigations were facilitated at PFH RRC during the last 12 months. Additionally, the auditor has not been provided any evidence from PFH RRC staff regarding circumstances wherein 115.241(g) reassessment(s) were warranted. Finally, the PC asserts that zero 115.241(g) reassessments were completed during the last 12 months. The staff responsible for risk screening interviewee states she would reassess a resident's risk level as needed due to a referral, request, incident of sexual abuse, or receipt of additional information that bears on the resident's risk of sexual victimization or abusiveness. The interviewee further states that the Director would alert her regarding any reassessment needs. In view of the above, the auditor finds PFH RRC substantially compliant with 115.241(g). 115.241(h) Pursuant to the PAQ, the Director self reports policy prohibits disciplining residents for refusing to answer (or for not disclosing complete information related to) the questions regarding: Whether or not the resident has a mental, physical, or developmental disability; Whether or not the resident is or is perceived to be gay, lesbian, bisexual, transgender, intersex, or gender non-conforming; Whether or not the resident has previously experienced sexual victimization; and The resident's own perception of vulnerability. PHS Policy entitled Prison Rape Elimination Act (PREA) Prevention, Investigation, and Reporting, page 9, section IV(h) addresses 115.241(h). The staff responsible for risk screening interviewee states that residents are not

	disciplined in any way for refusing to respond to (or for not disclosing complete information related to the topics mentioned above. The auditor has not discovered any instances (during the last 12 months) wherein discipline was meted out to residents in violation of 115.241(h) requirements. In view of the above, the auditor finds PFH RRC substantially compliant with 115.241(h). 115.241(i) Pursuant to the PAQ, the Director self reports the agency shall implement appropriate controls on the dissemination within the facility of responses to questions asked pursuant to this standard in order to ensure that sensitive information is not exploited to the resident's detriment by staff or other residents. PHS Policy entitled Prison Rape Elimination Act (PREA) Prevention, Investigation, and Reporting, page 9, section IV(i) addresses 115.241(i). The PC asserts the agency has outlined who should have access to a resident's risk assessment within the facility in order to protect sensitive information from exploitation. Hard copies of assessments are maintained in case managers' offices under lock and key. Case managers and above (with resident care responsibilities) can access assessments. Specifically, the CMs, DD, Director, and social services coordinator (SSC) have access to risk assessments. The staff responsible for risk screening interviewee validates the PC's assertion and the auditor observed the same during the facility tour. While hard copies of assessments and reassessments are maintained in the CMs' offices in locked cabinets, electronic copies are retained in a password-protected system. In view of the above, the auditor finds PFH RRC substantially compliant with 115.241(i). Based on the completed corrective action as articulated in the narrative for 115.241(f), as well as, the findings throughout the 115.241 narrative, the auditor now finds PFH RRC substantially compliant with 115.241.

115.242	**Use of screening information**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion

	115.242(a) Pursuant to the PAQ, the Director self reports the facility uses information from the risk screening required by §115.241 to inform housing, bed, work, education, and program assignments with the goal of keeping separate those residents at high risk of being sexually victimized from those at high risk of being sexually abusive. PHS Policy entitled Prison Rape Elimination Act (PREA) Prevention, Investigation, and Reporting, page 9, Use of screening information (a) addresses 115.242(a). The PC asserts that the 115.241(d) assessment tool scores victims and aggressors. If the score(s) represent neither, the resident can be housed with either classification or a resident similarly situated. Victims and aggressors are not housed in the same room. The staff responsible for risk screening interviewee further states that numerical values are assigned to each question and the screener (CM) manually tallies the points on a hard copy to assign a classification. Subsequently, when points are added electronically, the system generates an assignment and the case manage forwards an email to the Resident Monitor II (RM II) (advising of the classification). The RM II subsequently makes housing assignments. In view of the above, the auditor finds PFH RRC substantially compliant with 115.242(a). 115.242(b) Pursuant to the PAQ, the Director self reports the facility makes individualized determinations about how to ensure the safety of each resident. PHS Policy entitled Prison Rape Elimination Act (PREA) Prevention, Investigation, and Reporting, page 10, Use of screening information (b) addresses 115.242(b). The PC asserts that the 115.241(d) assessment tool scores victims (V) and aggressors (A). If the score(s) represent neither, the resident can be housed with either classification or a resident similarly situated. Victims and aggressors are not housed in the same room. The staff responsible for risk screening interviewee further states that numerical values are assigned to each question and the screener (CM) manually tallies the points on a hard copy to assign a classification. Subsequently, when points are added electronically, the system generates an assignment. The RM II actually makes the room assignment(s) and the same are reviewed by the Director and assistant director (ad). Program activities are supervised by staff. The RM II states that a spreadsheet is not used to identify Vs, As, and Unrestricted. A victim may be placed in a single room or in a room with another victim or unrestricted classification.

	The auditor does recommend that a simple spreadsheet be developed and implemented wherein resident victimization/aggressor classifications are noted. This spread sheet would be updated each time a resident is admitted to PFH RRC. Documentation of classifications would be a benefit to sexual safety in any facility. Such a visual aid will assist in the housing assignment process. In view of the above, the auditor finds PFH RRC substantially compliant with 115.242(b). 115.242(c) Pursuant to the PAQ, the Director self reports the facility makes housing and program assignments for transgender or intersex residents in the facility on a case-by-case basis. PHS Policy entitled Prison Rape Elimination Act (PREA) Prevention, Investigation, and Reporting, page 10, Use of screening information (c) addresses 115.242(c). The PC asserts that resident gender is determined by the customer (in this case, the FBOP) and housing assignments are effected in accordance with the customer's assessment. Current practice dictates that resident gender specific services (e.g. housing, pat search, UA procedures) are dictated by the resident's identified gender as provided to PHS pursuant to the FBOP referral. All disagreements with FBOP decisions must be addressed through a formal mediation process between the FBOP and the PHS authorized mediator. As an agency, PHS has never needed to dispute FBOP gender classifications. Residents are not placed in specific wings or units based on sexual preference status. Security, resident health and safety, and security/management concerns are considered when placing transgender/intersex residents. The Director states that zero transgender/intersex residents were housed at PFH RRC during the on-site audit. Accordingly, that interview could not be conducted. In view of the above, the auditor finds PFH RRC substantially compliant with 115.242(c). 115.242(d) Pursuant to the PAQ, the Director self reports that a transgender or intersex resident's own views with respect to his or her own safety shall be given serious consideration. PHS Policy entitled Prison Rape Elimination Act (PREA) Prevention, Investigation, and Reporting, page 10, Use of screening information (d) addresses 115.242(d).

	The PC asserts that a transgender or intersex resident's own views of his or her own safety are given serious consideration in placement and programming assignments. The staff responsible for risk screening interviewee validates the PC's statement. As reflected throughout this narrative, zero transgender/intersex residents were housed at PFH RRC during the onsite visit and accordingly, such interviews could not be facilitated. In view of the above, the auditor finds PFH RRC substantially compliant with 115.242(d). 115.242(e) Pursuant to the PAQ, the Director self reports transgender and intersex residents shall be given the opportunity to shower separately from other residents. PHS Policy entitled Prison Rape Elimination Act (PREA) Prevention, Investigation, and Reporting, page 10, Use of screening information (e) addresses 115.242(e). The PC asserts that transgender/intersex residents are given the opportunity to shower separately from other residents. If separate showers are requested through the Director, the shower area is closed and the transgender/intersex resident showers at a designated time. Cameras and live supervision effectively monitor shower entrance and egress areas during such shower times. The staff responsible for risk screening interviewee adds that residents can lock the individual bathroom door so they can shower alone. In view of the above, the auditor finds PFH RRC substantially compliant with 115.242(e). 115.242(f) Pursuant to the PAQ, the Director self reports the agency shall not place lesbian, gay, bisexual, transgender, or intersex residents in dedicated facilities, units, or wings solely on the basis of such identification or status, unless such placement is in a dedicated facility, unit, or wing established in connection with a consent decree, legal settlement, or legal judgment for the purpose of protecting such residents. PHS Policy entitled Prison Rape Elimination Act (PREA) Prevention, Investigation, and Reporting, page 10, Use of screening information (f) addresses 115.242(f). The PC asserts the facility is not subject to a consent decree, legal settlement, or legal judgment requiring that it establish a dedicated facility, unit, wing for LGBTI residents. Housing assignments regarding residents with a history or propensity for predation are keyed electronically into their case notes and these residents are closely monitored.

	The only bisexual resident interviewee states he has not been placed in a housing area only for LGBTI residents. In view of the above, the auditor finds PFH RRC substantially compliant with 115.242(f). In view of the above, the auditor finds PFH RRC substantially compliant with 115.242.

115.251	**Resident reporting**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	115.251(a) Pursuant to the PAQ, the Director self reports the agency has established procedures allowing for multiple internal ways for residents to report privately to agency officials about: Sexual abuse or sexual harassment; Retaliation by other residents or staff for reporting sexual abuse and sexual harassment; and Staff neglect or violation of responsibilities that may have contributed to such incidents. PHS Policy entitled Prison Rape Elimination Act (PREA) Prevention, Investigation, and Reporting, pages 10 and 11, section V (a and b) addresses 115.251(a). The PHS Sexual Harassment, Abuse, and Assault Zero Tolerance Policy Information for Residents trifold brochure also addresses 115.251(a). All nine random staff interviewees were able to provide two or more options for reporting sexual abuse/harassment. Options included the following: PHS Hotline; Third-party Hotline (Northwest Regional Reentry Center in Oregon; Verbal report to staff; and Written report. Five of six random resident interviewees were able to provide at least two options for reporting sexual abuse/harassment. Options included the following:

	Verbal to staff; PHS Hotline; Written report; Third-party report; and Third-party Hotline (Northwest Regional Reentry Center in Oregon). During the process of resident interviews, none of the interviewees identified any issues with the mail system. Additionally, none of the interviewees identified any concerns regarding emails. A PHS toll-free hotline number is provided on the PREA Hotline posters (855-800-4305) and the Sexual Harassment, Abuse & Assault Zero Tolerance Policy Information for Residents tri-fold pamphlet while a different PHS PREA Hotline telephone number is reflected in the PFH RRC Resident Handbook (844-810-6901). Accordingly, the auditor finds PFH RRC non-compliant with 115.251(a) and 115.233(e). The conflict between the poster, pamphlet, and the PFH RRC Resident Handbook is confusing for the auditor and most likely, the residents. Accordingly, the auditor places PFH RRC in a 180-day corrective action period wherein the disparity between the poster, pamphlet, and the PFH RRC Resident Handbook will be corrected. The corrective action due date is February 3, 2025. To demonstrate compliance with 115.251(a) and 115.233(e), the PC will update the poster, pamphlet, and the PFH RRC Resident Handbook to coincide with one another. Upon completion of the same, the PC will upload the same for the auditor's review and subsequently post a memorandum in all housing units to all residents, advising of the updates. A copy of the memorandum will likewise be uploaded into OAS, with photographs of the postings. In view of the above, the auditor finds PFH RRC non-compliant with 115.251(a). August 27, 2024 Update: The auditor's review of an amended poster, tri-fold brochure, and PFH RRC Resident Handbook reveals that the telephone numbers have been amended with the correct telephone number, and the poster has been placed on the PREA Bulletin Board in the main lobby of the facility. Likewise, the PFH RRC Hotline number has been amended in the PFH RRC Resident Handbook. In view of the above, all 115.251(a) corrective action is complete with the exception of posting a memorandum in housing areas explaining the changes. Once completed, the auditor will again assess compliance. March 28, 2025 Update:

	The auditor's review of a memorandum dated January 6, 2024 reveals that the updated documents as reflected above, are available on bulletin boards throughout the facility and a computer terminal accessible to residents. Residents are encouraged to review the amended documents to remain informed of the most current information. In view of the above, the auditor now finds PFH RRC substantially compliant with 115.251(a). 115.251(b) Pursuant to the PAQ, the Director self reports the agency provides at least one way for residents to report sexual abuse/harassment to a public or private entity or office that is not part of the agency. PHS Policy entitled Prison Rape Elimination Act (PREA) Prevention, Investigation, and Reporting, pages 10 and 11, section V(b)(1 and 4) addresses 115.251(b). The PC asserts that the facility provides the Northwest Regional Reentry Center PREA Hotline as one way for residents to report sexual abuse/harassment to a public or private entity or office that is not part of the agency. The PC asserts that Northwest Regional Reentry Center (located in Oregon) has engaged in a Memorandum of Agreement (MOA) with PHS to provide these third-party 115.251(b) reporting source services. Northwest Regional Reentry Center is another non-profit community confinement facility and accordingly, they meet muster with respect to 115.251(b) requirements. According to the MOA, reports of sexual abuse/harassment are forwarded to the PC within two days of receipt of the report. Of note, anonymity is addressed in the MOA. Three of six random resident interviewees state they are allowed to make a report without giving their name. On June 13, 2024, the auditor did test the third-party 115.251(b) reporting line with respect to functionality. The telephone call was made on a telephone dedicated for resident use. The telephone was operable, no charges were assessed to any resident register number, and the call was unmonitored. The auditor contacted the telephone number reflected on the poster and tri-fold brochure (Northwest Regional Reentry Center) (503-546-8178) and the auditor did leave a message as he did not reach a human. Of note, the auditor clearly articulated that he was testing the third-party 115.251(b) reporting procedure. As of the final day of the onsite visit (June 14, 2024), the PC had not advised of receipt of notification regarding the test call. Similarly, since conclusion of the onsite visit, the auditor has not been advised of receipt of any communication from

	Northwest Regional Reentry Center regarding the test call. In view of the above, the auditor finds that the test failed and accordingly, PFH RRC is not compliant with 115.251(b). In view of the above, the auditor imposes a 180-day corrective action period wherein the PC will demonstrate compliance with and institutionalization of 115.251(b) requirements. The due date for corrective action is established as February 3, 2025. To demonstrate compliance with and institutionalization of 115.251(b) requirements, the PC will address the auditor's findings and correct the failure. The results of the PC's finding(s) will be discussed with the auditor and corrective action strategies will be implemented. All corrective action strategy documents will be uploaded into OAS. Once addressed, the auditor will facilitate another test call. In view of the above, the auditor finds PFH RRC non-compliant with 115.251(b). February 26, 2025 Update: At 11:35AM on the above date, the auditor tested the Northwest Regional Reentry Center Sexual Abuse Reporting Hotline by dialing (502)546-8178 from his office telephone. As he was unable to speak to anyone in person, he left a voice mail message. On February 26, 2025, the PHS PC advised the auditor that the test call had been reported to him. Accordingly, the auditor finds that PFH RRC is now substantially compliant with 115.233(e). In view of the above, the auditor now finds PFH RRC substantially compliant with 115.251(b). 115.251(c) Pursuant to the PAQ, the Director self reports the agency has a policy mandating that staff accept reports of sexual abuse and sexual harassment made verbally, in writing, anonymously, and from third parties. The Director further self reports staff are required to promptly document verbal reports. PHS Policy entitled Prison Rape Elimination Act (PREA) Prevention, Investigation, and Reporting, page 11, section Reporting for Residential Reentry Facilities b(2) addresses 115.251(c). Seven of nine random staff interviewees state that staff must accept reports of sexual abuse and sexual harassment made verbally, in writing, anonymously, and from third parties and document the same immediately. All six random resident interviewees state they can make sexual abuse/harassment

	reports both in-person or in writing. Four of six interviewees state that someone else can make the report so that he/she (resident victim) does not have to be named. In view of the above, the auditor finds PFH RRC substantially compliant with 115.251(c). 115.251(d) Pursuant to the PAQ, the Director self reports the agency has established procedures for staff to privately report sexual abuse and sexual harassment of residents. The Director further self reports staff are informed of these procedures during new hire training. PHS Policy entitled Prison Rape Elimination Act (PREA) Prevention, Investigation, and Reporting, page 11, section V(f) addresses 115.251(d). 115.251(d) subject-matter is also addressed as reflected in the PREA Staff Training brochure. A PHS toll-free hotline number is provided on the PREA Hotline posters (855-800-4305) and the Sexual Harassment, Abuse & Assault Zero Tolerance Policy Information for Residents tri-fold brochure while a different PHS PREA Hotline telephone number is reflected in the Sexual Harassment, Abuse & Assault Zero Tolerance Policy Information for Staff, Contractors, and Volunteers (844-810-6901) document. Accordingly, the auditor finds PFH RRC non-compliant with 115.251(d). The conflict between the poster and the afore-mentioned tri-fold brochure is confusing for the auditor and most likely staff. Accordingly, the auditor places PFH RRC in a 180-day corrective action period wherein the disparity between the poster and the tri-fold brochure will be corrected. The corrective action due date is February 3, 2025. To demonstrate compliance with and institutionalization of 115.251(d) requirements, the PC and/or Director will amend the tri-fold pamphlet and/or the poster to reflect the correct information. Upon completion, the PC and/or Director will upload the corrected documents for the auditor's review. Additionally, the PC and/or Director will exchange the amended tri-fold pamphlet(s) with the old documents. The PC and/or the Director will subsequently train all staff regarding the affected change(s) and evidence of the training will subsequently be uploaded. All nine random staff interviewees were able to articulate at least one method of private reporting of sexual abuse/harassment of a resident. The following options were provided by interviewees: Verbal report to the Director, AD, or supervisor behind closed doors; Email; Telephone call;

	Call the PHS Hotline; Call the Northwest Regional Reentry Center Hotline; or Written report. In view of the above, the auditor finds PFH RRC non-compliant with 115.251(d). August 27, 2024 Update: The auditor's review of an amended poster, tri-fold brochure, and PFH RRC Resident Handbook reveals that the telephone numbers have been amended with the correct telephone number, and the poster has been placed on the PREA Bulletin Board in the main lobby of the facility. Likewise, the PFH RRC Hotline number has been amended in the PFH RRC Resident Handbook. In view of the above, all 115.251(d) corrective action is complete with the exception of posting a memorandum in housing areas explaining the changes. Once completed, the auditor will again assess compliance. March 28, 2025 Update: The auditor's review of a memorandum dated January 6, 2024 reveals that the updated documents as reflected above, are available on bulletin boards throughout the facility and a computer terminal accessible to residents. Residents are encouraged to review the amended documents to remain informed of the most current information. In view of the above, the auditor now finds PFH RRC substantially compliant with 115.251(d). Based on the corrective action articulated in 115.251(a), (b), and (d), the auditor now finds PFH RRC non-compliant with 115.251.

115.252	**Exhaustion of administrative remedies**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	115.252(a) Pursuant to the PAQ, the Director self reports the agency has an administrative

	procedure for dealing with resident grievances regarding sexual abuse. PHS Policy entitled Prison Rape Elimination Act (PREA) Prevention, Investigation, and Reporting, page 11, section Exhaustion of administrative remedies (a) addresses 115.252(a). In view of the above, the auditor finds PFH RRC substantially compliant with 115.252(a). 115.252(b) Pursuant to the PAQ, the Director self reports agency policy or procedure allows a resident to submit a grievance regarding an allegation of sexual abuse at any time, regardless of when the incident is alleged to have occurred. The Director further self reports that residents are not required to use an informal grievance process, or otherwise attempt to resolve with staff, an alleged incident of sexual abuse. PHS Policy entitled Prison Rape Elimination Act (PREA) Prevention, Investigation, and Reporting, page 11, section Exhaustion of administrative remedies (a)(1 and 3) addresses 115.252. The auditor has also learned that PHS Policy entitled Client Grievance and Compliant Policy and Procedure, pages 1-9 also applies to 115.252. This policy clearly reflects that clients or residents will be informed of the grievance procedures should they avail themselves of the program. Although the auditor has been advised that program users are verbally informed of procedures, he has been provided no evidence validating that 115.252 information is provided to residents. Pursuant to research of written materials provided to the resident at intake, the auditor finds no reference to any provision(s) of 115.252. Accordingly, the auditor finds PFH RRC non-compliant with 115.252 and imposes a 180-day corrective action period wherein the PC and facility Director will demonstrate compliance with and institutionalization of 115.252 requirements. The corrective action due date is February 3, 2025. To demonstrate compliance with and institutionalization of 115.252 requirements, the auditor recommends that the PC and/or Director add all tenets of 115.252 into the PFH RRC Resident Handbook. This recommendation is based on the fact that each resident receives a copy of the PFH RRC Handbook and therefore, requisite information would be available for consumption. Of note, the auditor and the PC discussed this recommendation prior to publishing this interim report. If the above option is implemented, the PC will upload the amended PFH RRC Resident Handbook into OAS. Additionally, the PC will post a memorandum to all residents regarding the updated handbook and subject-matter. A copy of that memorandum will likewise be uploaded into OAS, along with photograph(s) of the posting at various locations throughout the facility. The Director asserts that zero 115.252 grievances have been filed during the last 12 months.

	In view of the above, the auditor finds PFH RRC non-compliant with 115.252(b). February 2, 2025 Update: The auditor's review of the PFH RRC Resident Handbook, inclusive of Attachment E, reveals that a time limit is not imposed for filing a 115.252(b) grievance regarding a sexual abuse incident and there is no requirement that the grievant utilize an informal resolution process. Accordingly, the auditor now finds PFH RRC substantially compliant with 115.252(b) as education is now provided to residents. In addition to the above, the auditor's review of the requisite informational memorandum dated January 6, 2025 reveals completion of the requisite corrective action. Accordingly, the auditor now finds PFH RRC substantially compliant with 115.252(b). 115.252(c) Pursuant to the PAQ, the Director self reports the agency's policy and procedure allows a resident to submit a grievance alleging sexual abuse without submitting it to the staff member who is the subject of the complaint. The Director further self reports the agency's policy and procedure requires that a resident grievance alleging sexual abuse not be referred to the staff member who is the subject of the complaint. PHS Policy entitled Prison Rape Elimination Act (PREA) Prevention, Investigation, and Reporting, page 11, section Exhaustion of administrative remedies (b) addresses 115.252(c). The auditor has also learned that PHS Policy entitled Client Grievance and Compliant Policy and Procedure, pages 1-9 also applies to 115.252. This policy clearly reflects that clients or residents will be informed of the grievance procedures should they avail themselves of the program. Although the auditor has been advised that program users are verbally informed of procedures, he has been provided no evidence validating that 115.252 information is provided to residents. Pursuant to research of written materials provided to the resident at intake, the auditor finds no reference to any provision(s) of 115.252. Accordingly, the auditor finds PFH RRC non-compliant with 115.252 and imposes a 180-day corrective action period wherein the PC and facility Director will demonstrate compliance with and institutionalization of 115.252 requirements. The corrective action due date is February 3, 2025. To demonstrate compliance with and institutionalization of 115.252(b) requirements, the auditor recommends that the PC and/or Director add all tenets of 115.252 into the PFH RRC Resident Handbook. This recommendation is based on the fact that each resident receives a copy of the PFH RRC Handbook and therefore, requisite

information would be available for consumption. Of note, the auditor and the PC discussed this recommendation prior to publishing this interim report.

If the above option is implemented, the PC will upload the amended PFH RRC Resident Handbook into OAS. Additionally, the PC will post a memorandum to all residents regarding the updated handbook and subject-matter. A copy of that memorandum will likewise be uploaded into OAS, along with photograph(s) of the posting at various locations throughout the facility.

As zero PREA grievances regarding a sexual abuse incident have been filed at PFH RRC during the last 12 months, there is no documentary evidence review.

In view of the above, the auditor finds PFH RRC non-compliant with 115.252(c).

February 2, 2025 Update:

The auditor's review of the PFH RRC Resident Handbook, inclusive of Attachment E, reveals there is no requirement that the grievant submit his/her grievance to the perpetrator, if he/she is a staff member. Furthermore, policy precludes assignment of the grievance to the perpetrator for investigation. Accordingly, the auditor now finds PFH RRC substantially compliant with 115.252(c) as education is now provided to residents.

In addition to the above, the auditor's review of the requisite informational memorandum dated January 6, 2025 reveals completion of the requisite corrective action.

Accordingly, the auditor now finds PFH RRC substantially compliant with 115.252(c).

115.252(d)

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

PHS Policy entitled Prison Rape Elimination Act (PREA) Prevention, Investigation, and Reporting, page 12, section Exhaustion of administrative remedies (c)(3) and (4) addresses 115.252(d). The auditor has also learned that PHS Policy entitled Client Grievance and Compliant Policy and Procedure, pages 1-9 also applies to 115.252. This policy clearly reflects that clients or residents will be informed of the grievance procedures should they avail themselves of the program.

Although the auditor has been advised that program users are verbally informed of

	procedures, he has been provided no evidence validating that 115.252 information is provided to residents. Pursuant to research of written materials provided to the resident at intake, the auditor finds no reference to any provision(s) of 115.252. Accordingly, the auditor finds PFH RRC non-compliant with 115.252 and imposes a 180-day corrective action period wherein the PC and facility Director will demonstrate compliance with and institutionalization of 115.252 requirements. The corrective action due date is February 3, 2025. To demonstrate compliance with and institutionalization of 115.252(b) requirements, the auditor recommends that the PC and/or Director add all tenets of 115.252 into the PFH RRC Resident Handbook. This recommendation is based on the fact that each resident receives a copy of the PFH RRC Handbook and therefore, requisite information would be available for consumption. Of note, the auditor and the PC discussed this recommendation prior to publishing this interim report. If the above option is implemented, the PC will upload the amended PFH RRC Resident Handbook into OAS. Additionally, the PC will post a memorandum to all residents regarding the updated handbook and subject-matter. A copy of that memorandum will likewise be uploaded into OAS, along with photograph(s) of the posting at various locations throughout the facility. The Director advises that zero residents who reported a sexual abuse at PFH RRC were housed at the facility during the on-site visit as zero allegations of sexual abuse occurred during the last 12 months. The same is consistent with the fact that zero investigations of sexual abuse were facilitated at PFH RRC during the last 12 months. Accordingly, the same interview(s) could not be conducted. In view of the above, the auditor finds PFH RRC non-compliant with 115.252(d). February 2, 2025 Update: The auditor's review of the PFH RRC Resident Handbook, inclusive of Attachment E, reveals that the agency response time due date when responding to a grievance regarding a sexual abuse incident is 90 days. An extension can be granted however, the agency must advise of the new due date. Policy reflects that a 70-day extension time limit may be granted. Accordingly, the auditor now finds PFH RRC substantially compliant with 115.252(d) as education is now provided to residents. In addition to the above, the auditor's review of the requisite informational memorandum dated January 6, 2025 reveals completion of the requisite corrective action. Accordingly, the auditor finds PFH RRC substantially compliant with 115.252(d). 115.242(e)

	Pursuant to the PAQ, the Director self reports agency policy and procedure permits third parties, including fellow residents, staff members, family members, attorneys, and outside advocates to assist residents in filing requests for administrative remedies relating to allegations of sexual abuse and to file such requests on behalf of residents. The Director further self reports agency policy and procedure requires that if a resident declines to have third-party assistance in filing a grievance alleging sexual abuse, the agency documents the resident's decision to decline. Zero grievances were filed during the last 12 months wherein sexual abuse was alleged and the resident declined third-party assistance. Accordingly, there is no documentary evidence of the resident's decision to decline. PHS Policy entitled Prison Rape Elimination Act (PREA) Prevention, Investigation, and Reporting, page 12, section Exhaustion of administrative remedies (d)(1 and 3) addresses 115.252(e). The auditor has also learned that PHS Policy entitled Client Grievance and Compliant Policy and Procedure, pages 1-9 also applies to 115.252. This policy clearly reflects that clients or residents will be informed of the grievance procedures should they avail themselves of the program. Although the auditor has been advised that program users are verbally informed of procedures, he has been provided no evidence validating that 115.252 information is provided to residents. Pursuant to research of written materials provided to the resident at intake, the auditor finds no reference to any provision(s) of 115.252. Accordingly, the auditor finds PFH RRC non-compliant with 115.252 and imposes a 180-day corrective action period wherein the PC and facility Director will demonstrate compliance with and institutionalization of 115.252 requirements. The corrective action due date is February 3, 2025. To demonstrate compliance with and institutionalization of 115.252(b) requirements, the auditor recommends that the PC and/or Director add all tenets of 115.252 into the PFH RRC Resident Handbook. This recommendation is based on the fact that each resident receives a copy of the PFH RRC Handbook and therefore, requisite information would be available for consumption. Of note, the auditor and the PC discussed this recommendation prior to publishing this interim report. If the above option is implemented, the PC will upload the amended PFH RRC Resident Handbook into OAS. Additionally, the PC will post a memorandum to all residents regarding the updated handbook and subject-matter. A copy of that memorandum will likewise be uploaded into OAS, along with photograph(s) of the posting at various locations throughout the facility. As zero PREA grievances regarding a sexual abuse incident have been filed at PFH RRC during the last 12 months, there is no documentary evidence review. In view of the above, the auditor finds PFH RRC non-compliant with 115.252(e). February 2, 2025 Update:

	The auditor's review of the PFH RRC Resident Handbook, inclusive of Attachment E, reveals that (e.g. family members, attorney, advocate, a PHS grievance advocate) can assist the resident in filing a grievance regarding a sexual abuse incident. Accordingly, the auditor now finds PFH RRC substantially compliant with 115.252(e) as education is now provided to residents. In addition to the above, the auditor's review of the requisite informational memorandum dated January 6, 2025 reveals completion of the requisite corrective action. In view of the corrective action articulated above, the auditor now finds PFH RRC substantially compliant with 115.252(e). 115.242(f) Pursuant to the PAQ, the Director self reports the agency has a policy and established procedures for filing an emergency grievance alleging that a resident is subject to a substantial risk of imminent sexual abuse. Agency policy and procedure for emergency grievances alleging substantial risk of imminent sexual abuse requires an initial response within 48 hours. Zero emergency grievances alleging substantial risk of imminent sexual abuse were filed in the last 12 months. Agency policy and procedure for emergency grievances alleging substantial risk of imminent sexual abuse requires that a final agency decision be issued within 5 days. PHS Policy entitled Prison Rape Elimination Act (PREA) Prevention, Investigation, and Reporting, pages 12 and 13, section Exhaustion of administrative remedies (e)(1 and 2) addresses 115.252(f). The auditor has also learned that PHS Policy entitled Client Grievance and Compliant Policy and Procedure, pages 1-9 also applies to 115.252. This policy clearly reflects that clients or residents will be informed of the grievance procedures should they avail themselves of the program. Although the auditor has been advised that program users are verbally informed of procedures, he has been provided no evidence validating that 115.252 information is provided to residents. Pursuant to research of written materials provided to the resident at intake, the auditor finds no reference to any provision(s) of 115.252. Accordingly, the auditor finds PFH RRC non-compliant with 115.252 and imposes a 180-day corrective action period wherein the PC and facility Director will demonstrate compliance with and institutionalization of 115.252 requirements. The corrective action due date is February 3, 2025. To demonstrate compliance with and institutionalization of 115.252(b) requirements, the auditor recommends that the PC and/or Director add all tenets of 115.252 into the PFH RRC Resident Handbook. This recommendation is based on the fact that each resident receives a copy of the PFH RRC Handbook and therefore, requisite information would be available for consumption. Of note, the auditor and the PC discussed this recommendation prior to publishing this interim report.

If the above option is implemented, the PC will upload the amended PFH RRC Resident Handbook into OAS. Additionally, the PC will post a memorandum to all residents regarding the updated handbook and subject-matter. A copy of that memorandum will likewise be uploaded into OAS, along with photograph(s) of the posting at various locations throughout the facility.

In view of the above, the auditor finds PFH RRC non-compliant with 115.252(f).

February 4, 2025 Update:

The auditor's review of the PFH RRC Resident Handbook, inclusive of Attachment E, reveals the requisite standard language regarding the filing of emergency grievances. Accordingly, the auditor now finds PFH RRC substantially compliant with 115.252(e) as education is now provided to residents.

In addition to the above, the auditor's review of the requisite informational memorandum dated January 6, 2025 reveals completion of the requisite corrective action.

In view of the corrective action articulated above, the auditor now finds PFH RRC substantially compliant with 115.252(f).

115.252(g)

Pursuant to the PAQ, the Director self reports the agency has a written policy that limits its ability to discipline a resident for filing a grievance alleging sexual abuse to occasions where the agency demonstrates that the resident filed the grievance in bad faith. In the last 12 months, zero resident grievances alleging sexual abuse resulted in disciplinary action by the agency against the resident for having filed the grievance in bad faith. As previously mentioned, zero grievances regarding sexual abuse incident(s) have been filed during the last 12 months.

PHS Policy entitled Prison Rape Elimination Act (PREA) Prevention, Investigation, and Reporting, page 13, section Exhaustion of administrative remedies (f) addresses 115.252(g). The auditor has also learned that PHS Policy entitled Client Grievance and Compliant Policy and Procedure, pages 1-9 also applies to 115.252. This policy clearly reflects that clients or residents will be informed of the grievance procedures should they avail themselves of the program.

Although the auditor has been advised that program users are verbally informed of procedures, he has been provided no evidence validating that 115.252 information is provided to residents. Pursuant to research of written materials provided to the resident at intake, the auditor finds no reference to any provision(s) of 115.252. Accordingly, the auditor finds PFH RRC non-compliant with 115.252 and imposes a 180-day corrective action period wherein the PC and facility Director will demonstrate compliance with and institutionalization of 115.252 requirements. The

	corrective action due date is February 3, 2025. To demonstrate compliance with and institutionalization of 115.252(b) requirements, the auditor recommends that the PC and/or Director add all tenets of 115.252 into the PFH RRC Resident Handbook. This recommendation is based on the fact that each resident receives a copy of the PFH RRC Handbook and therefore, requisite information would be available for consumption. Of note, the auditor and the PC discussed this recommendation prior to publishing this interim report. If the above option is implemented, the PC will upload the amended PFH RRC Resident Handbook into OAS. Additionally, the PC will post a memorandum to all residents regarding the updated handbook and subject-matter. A copy of that memorandum will likewise be uploaded into OAS, along with photograph(s) of the posting at various locations throughout the facility. In view of the above, the auditor finds PFH RRC non-compliant with 115.252(g). February 4, 2025 Update: The auditor's review of the PFH RRC Resident Handbook, inclusive of Attachment E, reveals the requisite standard language regarding bad faith filing of grievances being the basis for disciplinary action. Accordingly, the auditor now finds PFH RRC substantially compliant with 115.252(g) as education is now provided to residents. In addition to the above, the auditor's review of the requisite informational memorandum dated January 6, 2025 reveals completion of the requisite corrective action. In view of the corrective action articulated above, the auditor finds now PFH RRC substantially compliant with 115.252(g). In view of the corrective action noted above for 115.252(b-g), the auditor now finds PFH RRC substantially compliant with 115.252. .

115.253	**Resident access to outside confidential support services**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	115.253(a) Pursuant to the PAQ, the Director self reports the facility provides residents with

	access to outside victim advocates for emotional support services related to sexual abuse. The facility provides residents with access to such services by giving them mailing addresses and telephone numbers (including toll-free hotline numbers where available) for local, state, or national victim advocacy or rape crisis organizations. Additionally, the facility provides residents with access to such services by enabling reasonable communication between residents and these organizations in as confidential a manner as possible. PHS Policy entitled Prison Rape Elimination Act (PREA) Prevention, Investigation, and Reporting, page 13, section Resident access to outside confidential support services (a) addresses 115.253(a). Page 3 of the PFH RRC Resident Handbook, section entitled Support Services also addresses 115.253(a). Five of six random resident interviewees state there are service(s) available outside the facility for dealing with sexual abuse, if needed. Five of the six random resident interviewees could not identify such service(s). Four of the six interviewees state that the information regarding the service(s) is/are available pursuant to review of the PFH RRC Resident Handbook, tri-fold pamphlet issued at intake, or on poster(s). Four of the random resident interviewees state the numbers are free to call and all six interviewees state they can communicate with staff from those services anytime as all are in possession of cell phones. Telephone calls can be made from personal cell phones and the facility telephone available to residents who do not yet have a cell phone. The Director self reports that zero residents who reported a sexual abuse at PFH RRC were housed in the facility at the time of the onsite visit. Accordingly, the auditor was unable to conduct such interviews. The auditor notes that the PHS Sexual Harassment, Abuse & Assault Zero Tolerance Policy Information for Residents tri-fold pamphlet reflects a contact number of (206-744-1600) while the PFH RRC Resident Handbook reflects that telephone number as (206-744-1660). Accordingly, the auditor finds PFH RRC non-compliant with 115.253(a). Additionally, the address for the victim advocacy provider [Harborview Center for Abuse & Traumatic Stress (HATC)] is not reflected in either document. The conflict(s) and omissions reflected in the above documents are confusing for the auditor and, most likely, the residents, as well. Accordingly, the auditor places PFH RRC in a 180-day corrective action period wherein the disparity between the above documents will be corrected. The corrective action due date is February 3, 2025. To demonstrate compliance with 115.253(a), the PC will update both of the above documents to coincide with one another, including the address for HATC. Upon completion of the same, the PC will upload those documents for the auditor's review and subsequently post a memorandum in all housing units to all residents, advising of the updates. A copy of the memorandum and photographs of the postings will likewise be uploaded into OAS.

	At 2:57 PM on June 13, 2024, the auditor tested the HATC Hotline. The call was placed from the institution telephone that residents can access and the same was operable. As the telephone was an institutional telephone, the call was toll-free. Additionally, the auditor did not have to key any identifying data and the call was not monitored. During the test, the auditor spoke with a VA who validated the process for resident contact with a VA. The auditor determined that the Hotline was operational and the same was administered in accordance with the MOU. In view of the above, the auditor finds PFH RRC non-compliant with 115.253(a). September 27, 2024 Update: The auditor's review of both the tri-fold brochure, as well as, the PFH RRC Resident Handbook reveals that the appropriate telephone number for HATC is (206)744-1600 and the address has been added to the tri-fold brochure. The brochure and Handbook are now being provided to incoming residents. Additionally, the auditor's review of the requisite informational memorandum dated January 6, 2025 reveals completion of the requisite educational corrective action. In view of the corrective action noted above, the auditor now finds PFH RRC substantially compliant with 115.253(a). 115.253(b) Pursuant to the PAQ, the Director self reports the facility informs residents, prior to giving them access to outside support services, of the extent to which such communications will be monitored. Specifically, the facility informs residents, prior to giving them access to outside support services, of the mandatory reporting rules governing privacy, confidentiality, and/or privilege that apply to disclosures of sexual abuse made to outside victim advocates, including any limits to confidentiality under relevant federal, state, or local law. PHS Policy entitled Prison Rape Elimination Act (PREA) Prevention, Investigation, and Reporting, page 13, section Resident access to outside confidential support services (b) addresses 115.253(b). All six random resident interviewees state that what they say to people from these services remains private. Two interviewees state their conversations could be told to or shared with someone else. Interviewees state communication regarding a criminal act being perpetrated at the facility warrants such sharing. The aforementioned PFH RRC tri-fold pamphlet clearly provides information

	regarding Mandatory Reporting, at a minimum. As this document is provided to residents at intake or prior to arrival at the facility, the auditor finds that residents have ample opportunity to be apprised of confidentiality limitations. In view of the above, the auditor finds PFH RRC is substantially compliant with 115.253(b). 115.253(c) Pursuant to the PAQ, the Director self reports the facility maintains memorandums of agreement (MOAs) or other agreements with community service providers that are able to provide residents with emotional support services related to sexual abuse. The Director further self reports the facility maintains copies of such agreements. PHS Policy entitled Prison Rape Elimination Act (PREA) Prevention, Investigation, and Reporting, page 13, section Resident access to outside confidential support services (c) addresses 115.253(c). The auditor's review of the MOA between PHS and HATC reveals substantial compliance with 115.253(c). In view of the above, the auditor finds PFH RRC substantially compliant with 115.253(c). In view of the above and corrective action completion as noted in the narrative for 115.253(a), the auditor finds PFH RRC substantially compliant with 115.253.

115.254	**Third party reporting**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	115.254(a) Pursuant to the PAQ, the Director self reports the facility provides a method to receive third-party reports of resident sexual abuse or sexual harassment. The Director further self reports the facility publicly distributes information on how to report resident sexual abuse or sexual harassment on behalf of residents. PHS Policy entitled Prison Rape Elimination Act (PREA) Prevention, Investigation, and Reporting, page 13, Third Party Reporting (a) addresses 115.254(a). The auditor's review of the Sexual Abuse, Harassment & Assault Zero Tolerance

	Policy Information for Family and Friends pamphlet is available for consumption by resident family and friends. The same reflects the toll-free telephone number for the PHS PREA Hotline, as well as, the Northwest Regional Reentry Center [115.251(b)] telephone number and email address. The PC asserts that the same is provided to family and friends upon request. According to the PC, the agency operates a public web page that provides multiple avenues of reporting, including third party reporting. The auditor's review of the PHS website validates the same. The auditor's test of the PHS PREA Hotline (1-855-800-4305) was facilitated on September 10, 2024. The Hotline is managed live by staff from an answering service (live) between the hours of 9:00AM-5:00PM, Monday through Friday. Calls outside these hours may be handled via, voicemail, email, or text. During this 12:15PM test, the auditor spoke with a person who asked if the auditor desired this call to be anonymous. Additionally, she asked relevant questions regarding the alleged incident. Finally, she advised that the report would be forwarded to the PHS PC. Accordingly, the auditor determined that the test was successful. In view of the above, the auditor finds PFH RRC substantially compliant with 115.254(a). Based on the evidence cited above, the auditor finds PFH RRC substantially compliant with 115.254.

115.261	**Staff and agency reporting duties**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	115.261(a) Pursuant to the PAQ, the Director self reports the agency: Requires all staff to report immediately and according to agency policy any knowledge, suspicion, or information they receive regarding an incident of sexual abuse or sexual harassment that occurred in a facility, whether or not it is part of the agency; Requires all staff to report immediately and according to agency policy retaliation against residents or staff who reported such an incident; and Requires all staff to report immediately and according to agency policy any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation.

	PHS Policy entitled Prison Rape Elimination Act (PREA) Prevention, Investigation, and Reporting, page 13, section VI(a) addresses 115.261(a). Eight of nine random staff interviewees state the agency requires all staff to immediately report to the AD and/or Director and one of the eight interviewees also states the report is also directed to the PC. One interviewee states the following must be forwarded within 24 hours to the Director and/or AD: Any knowledge, suspicion, or information regarding an incident of sexual abuse/ harassment that occurred in a facility; Retaliation against residents or staff who reported such an incident; and Any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation. In view of the above, the auditor finds PFH RRC substantially compliant with 115.261(a). 115.261(b) Pursuant to the PAQ, the Director self reports that apart from reporting to designated supervisors or officials and designated state or local services agencies, agency policy prohibits staff from revealing any information related to a sexual abuse report to anyone other than to the extent necessary to make treatment, investigation, and other security and management decisions. PHS Policy entitled Prison Rape Elimination Act (PREA) Prevention, Investigation, and Reporting, page 14, section VI(e) addresses 115.261(b). Eight of nine random staff interviewees state the agency requires all staff to immediately report to the AD and/or Director and one of the eight interviewees also states the report is also directed to the PC. One interviewee states the following must be forwarded within 24 hours to the Director and/or AD Any knowledge, suspicion, or information regarding an incident of sexual abuse/ harassment that occurred in a facility; Retaliation against residents or staff who reported such an incident; and Any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation. The PC asserts the agency has outlined who should have access to a resident's risk assessment within the facility in order to protect sensitive information from exploitation. Hard copies of assessments and reassessments are maintained in case managers' offices under lock and key. Case managers and above (with resident care responsibilities) can access assessments. Specifically, the CMs, DD, Director, and SSC have access to risk assessments. The interviewee validates the

	PC's assertion and the auditor observed the same during the facility tour. In view of the above, the auditor finds PFH RRC substantially compliant with 115.261(b). 115.261(c) Pursuant to the PAQ, the Director self reports that unless otherwise precluded by Federal, State, or local law, medical and mental health practitioners shall be required to report sexual abuse pursuant to paragraph (a) of this section and to inform residents of the practitioner's duty to report, and the limitations of confidentiality, at the initiation of services. As previously mentioned, medical and mental health staff are not employed at PFH RRC. Accordingly, the medical/mental health staff interviews were not facilitated. PHS Policy entitled Prison Rape Elimination Act (PREA) Prevention, Investigation, and Reporting, page 14, section VI(f) addresses 115.261(c). In view of the above, the auditor finds PFH RRC substantially compliant with 115.261(c). 115.261(d) Pursuant to the PAQ, the Director self reports If the alleged victim is under the age of 18 or considered a vulnerable adult under a state or local vulnerable persons statute, the agency shall report the allegation to the designated state or local services agency pursuant to applicable mandatory reporting laws. PHS Policy entitled Prison Rape Elimination Act (PREA) Prevention, Investigation, and Reporting, page 14, section VI(d and g) addresses 115.251(d). The Director asserts that zero residents under the age of 18 and/or vulnerable adults are housed at PFH RRC. If a vulnerable adult was victimized at PFH RRC, the PC would coordinate notifications to FBOP officials. The PC corroborates the assertion of the Director with the exception of coordinating notification(s) to FBOP officials and State of Washington Adult Protective Services (APS) or equivalent agency. In view of the above, the auditor finds PFH RRC substantially compliant with 115.261(d). 115.261(e) Pursuant to the PAQ, the Director self reports that the facility shall report all allegations of sexual abuse and sexual harassment, including third-party and

	anonymous reports, to the facility's designated investigators. PHS Policy entitled Prison Rape Elimination Act (PREA) Prevention, Investigation, and Reporting, page 14, section VI(h) addresses 115.261(e). The Director asserts that all allegations of sexual abuse/harassment (including those from third-party and anonymous sources) are reported directly to designated investigators. The initial report is forwarded to the Director and she reports the same to the PC. The PC then assigns the investigation to an investigator. As reflected throughout this report, zero allegations of sexual abuse/harassment have been received during the last 12 months. Accordingly, validation pursuant to document review cannot be completed. In view of the above, the auditor finds PFH RRC substantially compliant with 115.261(e). In view of the evidence presented above, the auditor finds PFH RRC substantially compliant with 115.261.

115.262	**Agency protection duties**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	115.262(a) Pursuant to the PAQ, the Director self reports when the agency or facility learns that a resident is subject to a substantial risk of imminent sexual abuse, it takes immediate action to protect the resident (i.e., it takes some action to assess and implement appropriate protective measures without unreasonable delay). In the last 12 months, facility staff determined, on zero occasions, that a resident was subject to a substantial risk of imminent sexual abuse. PHS Policy entitled Prison Rape Elimination Act (PREA) Prevention, Investigation, and Reporting, page 14, section Agency Protection Duties (a) addresses 115.262(a). The Agency Head interviewee asserts staff immediately remove the affected resident from the danger zone. The potential victim may be moved to another PHS facility or the alleged perpetrator may be moved to the Federal Detention Center (FDC) Seatac, WA subject to approval by FBOP staff. The Director asserts that the potential victim would immediately be removed from the danger zone and supervision and monitoring would be enhanced. If the situation warranted, the Director would contact FBOP officials to move the potential

	victim to Tacoma Residential Reentry Center (TRRC) in Tacoma, the FDC Seatac, or placement on Home Confinement. All nine random staff interviewees state that if they learn a resident is at risk of imminent sexual abuse, they immediately remove the affected resident from the danger zone, placing them in a safe place. In view of the above, the auditor finds PFH RRC substantially compliant with 115.262(a). In view of the above, the auditor finds PFH RRC substantially compliant with 115.262.

115.263	**Reporting to other confinement facilities**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	115.263(a) Pursuant to the PAQ, the Director self reports the agency has a policy requiring that, upon receiving an allegation that a resident was sexually abused while confined at another facility, the head of the facility must notify the head of the facility or appropriate office of the agency or facility where sexual abuse is alleged to have occurred. The Director further asserts that during the last 12 months, zero allegations were received by the facility indicating that a resident was sexually abused while confined at another facility. The auditor confirmed the same pursuant to review of 13 random resident victimization/aggressor screenings and four PAQ victimization/aggressor screenings wherein zero residents were subjected to sexual abuse while incarcerated. PHS Policy entitled Prison Rape Elimination Act (PREA) Prevention, Investigation, and Reporting, page 14, section Reporting to other confinement facilities (a) addresses 115.263(a). This policy clearly reflects that the PC will notify FBOP RRC and the affected agency point of contact of such information within 72 hours of staff learning the same and the notification shall be memorialized in writing, The auditor notes that within the PHS hierarchy and pursuant to the PHS Organizational Chart, the current PC's role and title are recognized as higher in responsibility and authority in comparison to the PFH RRC Director. For this reason, the auditor finds PFH RRC substantially compliant with the intent of 115.263(a) as the PC is charged with generating 115.263(a) notifications. In view of the above, the auditor finds PFH RRC substantially compliant with 115.263(a).

115.263(b)

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

PHS Policy entitled Prison Rape Elimination Act (PREA) Prevention, Investigation, and Reporting, page 14, section Reporting to other confinement facilities (b) addresses 115.263(b).

The Director asserts that during the last 12 months, zero allegations were received by the facility indicating that a resident was sexually abused while confined at another facility. The auditor confirmed the same pursuant to review of 13 random resident victimization/aggressor screenings and four PAQ victimization/aggressor screenings wherein zero residents were subjected to sexual abuse while incarcerated.

In view of the above, the auditor finds PFH RRC substantially compliant with 115.263(b).

115.263(c)

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

PHS Policy entitled Prison Rape Elimination Act (PREA) Prevention, Investigation, and Reporting, page 14, section Reporting to other confinement facilities (c) addresses 115.263(c).

The Director asserts that during the last 12 months, zero allegations were received by the facility indicating that a resident was sexually abused while confined at another facility. The auditor confirmed the same pursuant to review of 13 random resident victimization/aggressor screenings and four PAQ victimization/aggressor screenings wherein zero residents were subjected to sexual abuse while incarcerated.

In view of the above, the auditor finds PFH RRC substantially compliant with 115.263(c).

115.263(d)

Pursuant to the PAQ, the Director self reports the facility policy requires that allegations received from other facilities and agencies are investigated in

	accordance with the PREA standards. In the last 12 months, zero allegations of sexual abuse originating at PFH RRC, were received from other facilities. PHS Policy entitled Prison Rape Elimination Act (PREA) Prevention, Investigation, and Reporting, page 15, section Reporting to other confinement facilities (d) addresses 115.263(d). The Agency Head interviewee asserts that If a report is received from the chief executive at another facility regarding an alleged sexual abuse incident that occurred at PFH RRC, immediate action is initiated to complete a full investigation. Upon completion of the investigation, PHS PC generally reports back to the reporter. This investigation includes review of the crime scene, victim/witness/and perpetrator interviews, and file and video reviews, minimally. Additionally, resident cell phones may be searched. The Director asserts that a complete sexual abuse investigation is initiated and completed when an allegation of sexual abuse, alleged to have originated at PFH RRC, is received from another facility. There are no examples of receipt of such allegations during this audit period. In view of the above, the auditor finds PFH RRC substantially compliant with 115.263(d). In view of the lack of findings in response to 115.263(a-d), the auditor finds PFH RRC substantially compliant with 115.263.

115.264	**Staff first responder duties**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	115.264(a) Pursuant to the PAQ, the Director self reports the agency has a first responder policy for allegations of sexual abuse and the policy requires that: Upon learning of an allegation that a resident was sexually abused, the first security staff member to respond to the report shall be required to separate the alleged victim and abuser; Upon learning of an allegation that a resident was sexually abused, the first security staff member to respond to the report shall be required to preserve and protect any crime scene until appropriate steps can be taken to collect any evidence; Upon learning of an allegation that a resident was sexually abused and the abuse

occurred within a time period that still allows for the collection of physical evidence, the first security staff member to respond to the report shall be required to request that the alleged victim not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating; and

Upon learning of an allegation that a resident was sexually abused and the abuse occurred within a time period that still allows for the collection of physical evidence, the first security staff member to respond to the report shall be required to ensure that the alleged abuser not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating. During the last 12 months, zero allegations of sexual abuse were received at PFH RRC and accordingly, identified resident interviews could not be facilitated.

PHS Policy entitled Prison Rape Elimination Act (PREA) Prevention, Investigation, and Reporting, pages 14 and 15, section Staff first responder duties a(1-4) addresses 115.264(a). The auditor also notes 115.264(a) requirements are clearly articulated in the TRRC PREA Coordinated Response Plan.

Seven of nine random staff interviewees were able to properly recite 1st Responder duties as articulated above. Both the random security staff and the non-security staff interviewees accurately cited their 115.264(a) responsibilities.

The auditor strongly recommends that a laminated First Responder Duties informational card be provided to each staff member with the intent they carry the same while on duty. The card will serve as an informational tool and a quick access resource, if needed.

In view of the above, the auditor finds SPF RRC substantially compliant with 115.264(a).

115.264(b)

Pursuant to the PAQ, the Director self reports agency policy requires that if the first staff responder is not a security staff member, that responder shall be required to request that the alleged victim not take any actions that could destroy physical evidence. Additionally, agency policy requires that if the first staff responder is not a security staff member, that responder shall be required to notify security staff. Zero allegations of sexual abuse were received during the last 12 months.

PHS Policy entitled Prison Rape Elimination Act (PREA) Prevention, Investigation, and Reporting, page 15, section Staff first responder duties (b) addresses 115.264(b). The auditor has learned that all PFH RRC staff receive the same first responder duties training.

The random non-security staff interviewee accurately cited his 115.264(a) responsibilities.

	In view of the above, the auditor finds PFH RRC substantially compliant with 115.264(b). In view of the above, the auditor finds PFH RRC substantially compliant with 115.264.

115.265	Coordinated response
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	115.265(a) Pursuant to the PAQ, the Director self reports the facility has developed a written institutional plan to coordinate actions taken in response to an incident of sexual abuse among staff first responders, medical, and mental health practitioners, investigator(s), and facility leadership. PHS Policy entitled Prison Rape Elimination Act (PREA) Prevention, Investigation, and Reporting, page15, section Coordinated response a(1) addresses 115.265(a). The auditor's review of the PFH RRC PREA Coordinated Response Plan reveals substantial compliance with 115.265(a). The Director asserts the facility does have a plan to coordinate actions among staff first responders, medical and mental health practitioners, investigators, and facility leadership in response to an incident of sexual abuse. The same is articulated in a memorandum entitled the PFH RRC PREA Coordinated Response Plan. The auditor's review of the same reveals a user-friendly document wherein sexual abuse incident resolution steps are clearly defined. This living document serves as a guideline for staff. In view of the above, the auditor finds PFH RRC substantially compliant with 115.265(a). In view of the above, the auditor finds PFH RRC substantially compliant with 115.265.

115.266	Preservation of ability to protect residents from contact with abusers
	Auditor Overall Determination: Meets Standard

	Auditor Discussion
	115.266(a) Pursuant to the PAQ, the Director self reports the agency, facility, or any other governmental entity responsible for collective bargaining on the agency's behalf has not entered into or renewed any collective bargaining agreement(s) or other agreement(s) since the last PREA audit. The Director and Agency Head interviewees further self report that the facility is not engaged in any collective bargaining agreement(s). Since there are no deviations from standard, the auditor finds PFH RRC substantially compliant with 115.266.

115.267	**Agency protection against retaliation**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	115.267(a) Pursuant to the PAQ, the Director self reports the agency has a policy to protect all residents and staff who report sexual abuse or sexual harassment or cooperate with sexual abuse or sexual harassment investigations from retaliation by other residents or staff. The agency designates staff member(s) or charges department(s) with monitoring for possible retaliation. Dependent upon the situation, the designation can be the PC, Director, or the assigned client case manger. PHS Policy entitled Prison Rape Elimination Act (PREA) Prevention, Investigation, and Reporting, pages 15 and 16, section Agency protection against retaliation b(2)(i) addresses 115.267(a). The auditor notes that zero sexual abuse/harassment allegations were realized during the last 12 months at PFH RRC. In view of the above, the auditor finds PFH RRC substantially compliant with 115.267(a). 115.267(b) Pursuant to the PAQ, the Director self reports the agency shall employ multiple protection measures, such as housing changes or transfers for resident victims or abusers, removal of alleged staff or resident abusers from contact with victims, and

	implementation or offer of emotional support services for residents or staff who fear retaliation for reporting sexual abuse or sexual harassment or for cooperating with investigations. PHS Policy entitled Prison Rape Elimination Act (PREA) Prevention, Investigation, and Reporting, page 16, section Agency protection against retaliation (b)(1)(i-iv) addresses 115.267(b). The Agency Head interviewee asserts PHS employs a zero tolerance policy regarding sexual abuse/harassment of residents. Retaliation for reporting sexual abuse/harassment is, minimally, a punishable administrative offense. The victim's case manager is designated as the retaliation monitor at PFH RRC. As retaliation monitor, she coordinates with the Director of AD to remove the perpetrator of the sexual abuse incident or retaliation from PFH RRC. The sexual abuse or potential/actual retaliation victim may be moved to another room. Security rounds may be increased to ensure closer monitoring of the potential/ actual sexual abuse/retaliation victim. Additionally, she may recommend mental health intervention for the affected resident victim and the Employee Assistance Program (EAP) for potential staff victim(s). With respect to potential or actual staff victims of retaliation, work schedule(s) may be adjusted. Affected staff may also be reassigned to work at TRRC. The interviewee further asserts she would initiate contact with affected resident(s) or staff upon notification of the incident or potential retaliation. She would meet with the victim or potential victim on a weekly basis for the first month. As previously noted throughout this report narrative, zero residents reported a sexual abuse incident at PFH RRC during the last 12 months and accordingly, an interview could not be conducted with any victims and zero documentation is available for review. In view of the above, the auditor finds PFH RRC substantially compliant with 115.267(b). 115.267(c) Pursuant to the PAQ, the Director self reports the facility monitors the conduct or treatment of residents or staff who reported sexual abuse and of residents who were reported to have suffered sexual abuse to see if there are any changes that may suggest possible retaliation by residents or staff. Monitoring continues for a minimum period of 90 days. The facility acts promptly to remedy any such retaliation and the facility continues such monitoring beyond 90 days if the initial monitoring indicates a continuing need. Zero occasions of retaliation occurred during the last 12 months. PHS Policy entitled Prison Rape Elimination Act (PREA) Prevention, Investigation, and Reporting, page 16, section Agency protection against retaliation (b)(1)(i-iv) and

	(b)(4) addresses 115.267(c). The retaliation monitor interviewee asserts she looks for the following with respect to resident victims of retaliation: Any deviation(s) from the baseline; Resident Isolation; More aggressive behavior; Change(s) in eating habits; Hygiene decompensation; Avoidance; Less talkative; Changes in associations; Increased sick calls; Depreciation in programming; and Poor work performance. The retaliation monitor interviewee asserts the following factors may be indicative of retaliation with respect to staff: Many of the same behaviors listed in the preceding paragraph; Changes in staff and resident association patterns; Increased sick call-offs; Multiple shift change requests or requests for reassignment to TRCC; Poor work performance; and/or Accrual of greater number of misconduct reports. The retaliation monitor interviewee states she monitors retaliation victims for at least 90 days plus periodic status checks. Periodic status checks are documented in emails or case notes. If it is determined there is a continuing need, retaliation monitoring could be extended throughout the entire stay. Such extensions may be directed by the PC. In view of the above, the auditor finds PFH RRC substantially compliant with 115.267(c).

	115.267(d) Pursuant to the PAQ, the Director self reports that in the case of residents, such monitoring shall also include periodic status checks. PHS Policy entitled Prison Rape Elimination Act (PREA) Prevention, Investigation, and Reporting, page 16, section Agency protection against retaliation b(5) addresses 115.267(d). The retaliation monitor interviewee states she monitors retaliation victims for at least 90 days plus periodic status checks. Periodic status checks are documented in emails or case notes. If it is determined there is a continuing need, retaliation monitoring could be extended throughout the victim's entire stay. Such extensions may be directed by the PC. In view of the above, the auditor finds PFH RRC substantially compliant with 115.267(d). 115.267(e) Pursuant to the PAQ, the Director self reports if any other individual who cooperates with an investigation expresses a fear of retaliation, the agency shall take appropriate measures to protect that individual against retaliation. PHS Policy entitled Prison Rape Elimination Act (PREA) Prevention, Investigation, and Reporting, page 16, section Agency protection against retaliation (b)(6) addresses 115.267(e). The Agency Head and Director assert that if an individual who cooperates with an investigation expresses a fear of retaliation, retaliation monitoring, as articulated above, is initiated. Development and implementation of a plan to ensure safety is the primary strategy. In view of the above, the auditor finds PFH RRC substantially compliant with 115.267(e). In view of the evidence presented above, the auditor finds PFH RRC substantially compliant with 115.267.

115.271	**Criminal and administrative agency investigations**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion

	115.271(a) Pursuant to the PAQ, the Director self reports the facility has a policy related to criminal and administrative agency investigations. PHS Policy entitled Prison Rape Elimination Act (PREA) Prevention, Investigation, and Reporting, pages 16 and 17, section VII(a)(1-3) addresses 115.271(a). The PC/investigative staff interviewee asserts he would generally receive sexual abuse allegation(s) from either the Hotline or the facility Director. He subsequently assigns the same to an investigator within 24 hours of receipt of the report. Currently, there are four trained investigators and additional investigators are pending completion of training. If onsite and he self-assigned the investigation, he would commence the investigation immediately (both for sexual abuse/harassment allegations). If during non-regular business hours, he would report to the facility to initiate the investigation. The administrative and criminal investigative staff interviewees state that anonymous and third-party reports of sexual abuse/harassment are handled in the same manner as any others. In view of the above, the auditor finds PFH RRC substantially compliant with 115.271(a). 115.271(b) Pursuant to the PAQ, the Director self reports where sexual abuse is alleged, the agency shall use investigators who have received specialized training in sexual abuse investigations pursuant to § 115.234. PHS Policy entitled Prison Rape Elimination Act (PREA) Prevention, Investigation, and Reporting, page 17, section VII(c) addresses 115.271(b). The administrative investigative staff interviewee states that he completed a six hour ZOOM meeting (training) facilitated by Moss Group, Associates trainers. The training was entitled PREA Specialized Investigations Training and included a power point presentation and scenario training with a testing component at the conclusion of the course. The criminal investigative interviewee states that he did not complete training regarding the conduct of sexual abuse investigations in a confinement setting. Rather, his training and that of his subordinates addresses the conduct of sexual abuse investigations within the community and in general. Of note, detectives assigned to his section have facilitated sexual abuse investigations at the King County Jail. In view of the above, the auditor finds PFH RRC substantially compliant with

	115.271(b). 115.271(c) Pursuant to the PAQ, the Director self reports investigators shall gather and preserve direct and circumstantial evidence, including any available physical and DNA evidence and any available electronic monitoring data; shall interview alleged victims, suspected perpetrator(s), and witnesses; and shall review prior complaints and reports of sexual abuse involving the suspected perpetrator. PHS Policy entitled Prison Rape Elimination Act (PREA) Prevention, Investigation, and Reporting, page 17, section VII(d) addresses 115.271(c). The administrative investigative staff interviewee states that the following steps are employed in any administrative sexual abuse/harassment investigation: Assess effectiveness of 1st Responder responsibilities (30 minutes); Contact SPD relative to any sexual abuse allegation(s). SPD investigator(s) make the call regarding conduct of a forensic examination (10 minutes); Investigator facilitates threshold questioning of the victim to identify potential witnesses and establish a timeline (two hours); Interview witnesses (two hours per interviewee); Video and file reviews (one hour to five days); Interview perpetrator if SPD has released case for administrative processing (0 to four hours); Re-interivew victim (two hours per interviewee); and Write report (five hours). The administrative investigative staff interviewee states he secures video, staff and resident statements, staff/investigative/resident files, interview notes, cell phone data (texts and emails), evidence notes, and any prior complaints. The criminal investigative staff interviewee states that the following steps are employed in any administrative sexual abuse/harassment investigation: Patrolman is dispatched to PFH RRC to facilitate and initial investigation; If warranted, assign a detective; Physical evidence- Generally, a patrolman collects physical evidence. Dependent upon the complexity of the crime scene, Crim Scene Investigative Unit officers or the assigned detective may collect physical evidence;

	Review video and staff and resident files; Facilitate threshold questioning of victim; If necessary, facilitate video review and develop an interview plan; Commence video reviews and file reviews; Conduct interviews; After consideration of evidence discovered, facilitate re-interviews, if necessary; and Write report. With respect to anonymous or third party reports of sexual abuse, both the administrative and criminal investigative interviewees state the investigation(s) would be handled the same as any sexual abuse investigation. In view of the above, the auditor finds PFH RRC substantially compliant with 115.271(c). 115.271(d) Pursuant to the PAQ, the Director self reports when the quality of evidence appears to support criminal prosecution, the agency shall conduct compelled interviews only after consulting with prosecutors as to whether compelled interviews may be an obstacle for subsequent criminal prosecution. PHS Policy entitled Prison Rape Elimination Act (PREA) Prevention, Investigation, and Reporting, page 17, section VII(e) addresses 115.271(d). The administrative investigative staff interviewee states that SPD would be responsible for the conduct of compelled interviews if authorized pursuant to department regulations. The criminal investigative interviewee states that compelled interviews are not facilitated by SPD investigators. In view of the above, the auditor finds PFH RRC substantially compliant with 115.271(d). 115.271(e) Pursuant to the PAQ, the Director self reports the credibility of an alleged victim, suspect, or witness shall be assessed on an individual basis and shall not be determined by the person's status as resident or staff. No agency staff shall require a resident who alleges sexual abuse to submit to a polygraph examination or other truth-telling device as a condition for proceeding with the investigation of such an allegation.

	PHS Policy entitled Prison Rape Elimination Act (PREA) Prevention, Investigation, and Reporting, page 17, section VII(f) addresses 115.271(e). Both the administrative and criminal investigative staff interviewees state that credibility of an alleged victim, suspect, or witness is judged on an individual basis and is not based on status as resident or staff. Specifically, they assess how the victim's/witnesses' statement aligns with the evidence gathered during the investigative process and the degree of fact pattern substantiation. Personal history is also considered. Both the administrative and criminal investigative interviewees further state that under no circumstances would an interviewee be required to submit to a polygraph examination or truth-telling device as a condition for proceeding with an investigation. In view of the above, the auditor finds PFH RRC substantially compliant with 115.271(e). 115.271(f) Pursuant to the PAQ, the Director self reports administrative investigations shall include an effort to determine whether staff actions or failures to act contributed to the abuse and shall be documented in written reports that include a description of the physical and testimonial evidence, the reasoning behind credibility assessments, and investigative facts and findings. PHS Policy entitled Prison Rape Elimination Act (PREA) Prevention, Investigation, and Reporting, page 17, section VII(g) addresses 115.271(f). The administrative investigative staff interviewee states that he facilitates an analysis of the code of conduct, training, and policy/procedure vs. the fact pattern to determine whether staff actions or failures to act contributed to the sexual abuse. Additionally, he documents administrative investigations in written formats bearing the following information: Recitation of allegations; Synopsis of investigative steps, inclusive of establishment of an investigation timeline; Policy adherence; Interview Findings; Evidence Findings; and Conclusion. The criminal investigative interviewee also states that the following physical

	evidence is collected by SPD sworn officers and civilians: Sheets; Clothing; Mail; Documents; Any item of clothing or non-clothing wherein bodily fluids are present; Anything linked to the allegations; and Weapons. In view of the above, the auditor finds PFH RRC substantially compliant with 115.271(f). 115.271(g) Pursuant to the PAQ, the Director self reports criminal investigations shall be documented in a written report that contains a thorough description of physical, testimonial, and documentary evidence and attaches copies of all documentary evidence where feasible. PHS Policy entitled Prison Rape Elimination Act (PREA) Prevention, Investigation, and Reporting, page 17, section VII(h) addresses 115.271(g). The administrative investigative staff interviewee states that criminal investigators do compile their findings in a written report. While he has not received any criminal reports at PFH RRC during the last 12 months, the criminal report would capture much of the same information as compared to the administrative report, plus a physical evidence recapitulation and credibility analysis of the same. The criminal investigative interviewee states that the criminal investigative report addresses the following: Investigative steps taken during the investigative process; Interview findings; Physical evidence recovered; Interview notes; Summary; and Disposition. In view of the above, the auditor finds PFH RRC substantially compliant with

	115.271(g). 115.271(h) Pursuant to the PAQ, the Director self reports substantiated allegations of conduct that appear to be criminal are referred for prosecution. Zero substantiated allegations of conduct that appear to be criminal were referred for prosecution since the last PREA audit. PHS Policy entitled Prison Rape Elimination Act (PREA) Prevention, Investigation, and Reporting, page 17, section VII(i) addresses 115.271(h). The administrative investigative staff interviewee states that SPD is responsible for referring cases for prosecution. The criminal investigative interviewee states that a statutory violation must be present, identified victim and perpetrator, as well as, probable cause. In view of the above, the auditor finds PFH RRC substantially compliant with 115.271(h). 115.271(i) Pursuant to the PAQ, the Director self reports the agency retains all written reports pertaining to the administrative or criminal investigation of alleged sexual abuse or sexual harassment for as long as the alleged abuser is incarcerated or employed by the agency, plus five years. PHS Policy entitled Prison Rape Elimination Act (PREA) Prevention, Investigation, and Reporting, page 17, section VII(j) addresses 115.271(i). The auditor has found no deviation(s) from policy. Investigations and investigative findings are electronically forwarded to the PC who maintains the same in a password protected system. Hard copies of investigations completed by the PC are maintained in a locked file cabinet in his off-site locked office. The auditor did validate the same during the onsite visit pursuant to discussion with the PC. In view of the above, the auditor finds PFH RRC substantially compliant with 115.271(i). 115.271(j) Pursuant to the PAQ, the Director self reports the departure of the alleged abuser or victim from the employment or control of the facility or agency shall not provide a basis for terminating an investigation.

	PHS Policy entitled Prison Rape Elimination Act (PREA) Prevention, Investigation, and Reporting, page 17, section VII(k) addresses 115.271(j). The administrative and criminal investigative interviewees state that the investigation continue when a staff member alleged to have committed sexual abuse terminates employment prior to a completed investigation into his/her conduct. Similarly, the investigation continues when a victim who alleges sexual abuse/harassment or an abuser leaves the facility prior to a completed investigation into the incident. In view of the above, the auditor finds PFH RRC substantially compliant with 115.271(j). 115.271(l) Pursuant to the PAQ, the Director self reports when outside agencies investigate sexual abuse, the facility shall cooperate with outside investigators and shall endeavor to remain informed about the progress of the investigation. PHS Policy entitled Prison Rape Elimination Act (PREA) Prevention, Investigation, and Reporting, page 17, section VII(l) addresses 115.271(l). The PC asserts that communication between the facility and outside agency facilitating the investigation is accomplished by the PC on a bi-weekly basis. Generally, such contact is facilitated via email. The investigative staff interviewee asserts he acts as a facilitator or liaison between PFH RRC and SPD when an outside criminal investigation is completed. He assists with interview scheduling, evidence identification, amongst other request(s) from the criminal investigator. In view of the above, the auditor finds PFH RRC substantially compliant with 115.271(l). In view of the evidence presented above, the auditor finds PFH RRC substantially compliant with 115.271.

115.272	**Evidentiary standard for administrative investigations**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	115.272(a) Pursuant to the PAQ, the Director self reports the agency imposes a standard of a preponderance of evidence or a lower standard of proof when determining whether

	allegations of sexual abuse or sexual harassment can be substantiated. PHS Policy entitled Prison Rape Elimination Act (PREA) Prevention, Investigation, and Reporting, page 18, section Reporting to residents (c) addresses 115.272(a). The administrative investigative staff interviewee asserts that a preponderance of evidence is used to substantiate allegations of sexual abuse or sexual harassment within the administrative investigative context. In other words, there is more evidence that the incident occurred as reported, than not. The criminal investigative interviewee states that the minimum standard of evidence generally required for prosecution referral is probable cause. As previously mentioned throughout this report, zero sexual abuse/harassment allegations were reported during the last 12 months. In view of the above, the auditor finds PFH RRC substantially compliant with 115.272.

115.273	**Reporting to residents**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	115.273(a) Pursuant to the PAQ, the Director self reports the agency has a policy requiring that any resident who makes an allegation he or she suffered sexual abuse in an agency facility is informed verbally, or in writing, as to whether the allegation has been determined to be substantiated, unsubstantiated, or unfounded following an investigation by the agency. Zero criminal and/or administrative investigations of alleged resident sexual abuse were completed by the facility during the last 12 months. PHS Policy entitled Prison Rape Elimination Act (PREA) Prevention, Investigation, and Reporting, page 18, section Reporting to residents (a)(1-3) addresses 115.273(a). The Director asserts the facility does notify a resident who makes an allegation of sexual abuse when the allegation has been determined to be substantiated, unsubstantiated, or unfounded following an investigation. The PC makes such notification(s) as confirmed by the Director and investigative staff interviewee. In view of the above, the auditor finds PFH RRC substantially compliant with 115.273(a).

115.273(b)

Pursuant to the PAQ, the Director self reports if an outside entity conducts such investigations, the agency requests the relevant information from the investigative entity in order to inform the resident of the outcome of the investigation. Zero investigations of alleged resident sexual abuse in the facility were completed by an outside agency during the last 12 months.

PHS Policy entitled Prison Rape Elimination Act (PREA) Prevention, Investigation, and Reporting, page 18, section Reporting to residents (b) addresses 115.273(b).

The Director and PC assert that communication between the facility and outside agency facilitating the investigation is accomplished by the PC on a bi-weekly basis. Generally, such contact is facilitated via email.

In view of the above, the auditor finds PFH RRC substantially compliant with 115.273(b).

115.273(c)

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

The staff member is no longer posted within the resident's unit;

The staff member is no longer employed at the facility;

The agency learns that the staff member has been indicted on a charge related to sexual abuse within the facility; or

The agency learns that the staff member has been convicted on a charge related to sexual abuse within the facility.

There has not been a substantiated or unsubstantiated complaint (i.e., not unfounded) of sexual abuse committed by a staff member against a resident in an agency facility during the last 12 months.

PHS Policy entitled Prison Rape Elimination Act (PREA) Prevention, Investigation, and Reporting, page 18, section Reporting to residents (d) addresses 115.273(c).

At the time of the on-site audit, the PC and the Director advised the auditor that zero residents who reported a sexual abuse incident at PFH RRC were housed at the facility. This coincides with the fact that zero sexual abuse investigations were facilitated at PFH RRC during the last 12 months.

In view of the above, the auditor finds PFH RRC substantially compliant with 115.271(c).

	115.273(d) Pursuant to the PAQ, the Director self reports following a resident's allegation that he or she has been sexually abused by another resident in an agency facility, the agency subsequently informs the alleged victim whenever: The agency learns that the alleged abuser has been indicted on a charge related to sexual abuse within the facility; or The agency learns that the alleged abuser has been convicted on a charge related to sexual abuse within the facility. PHS Policy entitled Prison Rape Elimination Act (PREA) Prevention, Investigation, and Reporting, page 18, section Reporting to residents (e)(1 and 2) addresses 115.273(d). At the time of the on-site audit, the PC and the Director advised the auditor that zero residents who reported a sexual abuse incident at PFH RRC were housed at the facility as zero allegations of sexual abuse were reported at the facility during the last 12 months In view of the above, the auditor finds PFH RRC substantially compliant with 115.273(d).. 115.273(e) Pursuant to the PAQ, the Director self reports the agency has a policy that all notifications to residents described under this standard are documented. In the last 12 months, zero notifications to residents were provided pursuant to this standard provision. PHS Policy entitled Prison Rape Elimination Act (PREA) Prevention, Investigation, and Reporting, page 18, section Reporting to residents (f) addresses 115.273(e). In view of the above and the evidence provided throughout this standard narrative, the auditor finds PFH RRC substantially compliant with 115.273(e). Based on the evidence reflected in the above narratives, the auditor finds PFH RRC substantially compliant with 115.273.

115.276	**Disciplinary sanctions for staff**
	Auditor Overall Determination: Meets Standard

	Auditor Discussion
	115.276(a) Pursuant to the PAQ, the Director self reports staff is subject to disciplinary sanctions up to and including termination for violating agency sexual abuse or sexual harassment policies. PHS Policy entitled Prison Rape Elimination Act (PREA) Prevention, Investigation, and Reporting, page 18, section VIII(a) addresses 115.276(a). The Director further self reports in the last 12 months, zero PFH RRC staff have violated agency sexual abuse or sexual harassment policies. This is validated by the absence of sexual abuse/harassment investigations during the last 12 months. In view of the above, the auditor finds PFH RRC substantially compliant with 115.276(a). 115.276(b) Pursuant to the PAQ, the Director self reports that termination shall be the presumptive disciplinary sanction for staff who have engaged in sexual abuse. The Director further self reports that during the last 12 months, zero PFH RRC staff have violated agency sexual abuse or sexual harassment. policies. PHS Policy entitled Prison Rape Elimination Act (PREA) Prevention, Investigation, and Reporting, page 18, section VIII(a) addresses 115.276(a). The Director self reports in the last 12 months, zero PFH RRC staff have violated agency sexual abuse or sexual harassment policies. This is validated by the absence of sexual abuse/harassment investigations during the last 12 months. In view of the above, the auditor finds PFH RRC substantially compliant with 115.276(b). 115.276(c) Pursuant to the PAQ, the Director self reports that disciplinary sanctions for violations of agency policies relating to sexual abuse or sexual harassment (other than actually engaging in sexual abuse) are commensurate with the nature and circumstances of the acts committed, the staff member’s disciplinary history, and the sanctions imposed for comparable offenses by other staff with similar histories. In the last 12 months, zero PFH RRC staff have been disciplined, short of termination, for violation of agency sexual abuse or sexual harassment policies (other than actually engaging in sexual abuse). PHS Policy entitled Prison Rape Elimination Act (PREA) Prevention, Investigation, and

	Reporting, page 19, section VIII(c) addresses 115.276(c). The Director self reports in the last 12 months, zero PFH RRC staff have violated agency sexual abuse or sexual harassment policies. This is validated by the absence of sexual abuse/harassment investigations during the last 12 months. In view of the above, the auditor finds PFH RRC substantially compliant with 115.276(c). 115.276(d) Pursuant to the PAQ, the Director self reports all terminations for violations of agency sexual abuse or sexual harassment policies, or resignations by staff who would have been terminated if not for their resignation, are reported to law enforcement agencies (unless the activity was clearly not criminal) and to any relevant licensing bodies. In the last 12 months, zero PFH RRC staff have been reported to law enforcement or licensing boards following their termination (or resignation prior to termination) for violating agency sexual abuse or sexual harassment policies. PHS Policy entitled Prison Rape Elimination Act (PREA) Prevention, Investigation, and Reporting, page 19, section VIII(d) addresses 115.276(d). The Director self reports in the last 12 months, zero PFH RRC staff have violated agency sexual abuse or sexual harassment policies. This is validated by the absence of sexual abuse/harassment investigations during the last 12 months. In view of the above, the auditor finds PFH RRC substantially compliant with 115.276(d). Based on the evidence cited throughout the above narratives, the auditor finds PFH RRC substantially compliant with 115.276.

115.277	**Corrective action for contractors and volunteers**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	115.277(a) Pursuant to the PAQ, the Director self reports agency policy requires that any contractor or volunteer who engages in sexual abuse with a resident is reported to law enforcement agencies (unless the activity was clearly not criminal) and to relevant licensing bodies. Furthermore, agency policy requires that any contractor

	or volunteer who engages in sexual abuse is prohibited from contact with residents. In the last 12 months, zero contractors or volunteers have been reported to law enforcement agencies and relevant licensing bodies for engaging in sexual abuse of residents. Of note, zero contractors or volunteers provide services at PFH RRC. PHS Policy entitled Prison Rape Elimination Act (PREA) Prevention, Investigation, and Reporting, page 18 and 19, section VIII(b)(1) addresses 115.277(a). In view of the above, the auditor finds PFH RRC substantially compliant with 115.277(a). 115.277(b) Pursuant to the PAQ, the Director self reports the facility takes appropriate remedial measures and considers whether to prohibit further contact with residents in the case of any other violation of agency sexual abuse or sexual harassment policies by a contractor or volunteer. PHS Policy entitled Prison Rape Elimination Act (PREA) Prevention, Investigation, and Reporting, page 18, section VIII(b)(1) addresses 115.277(b). The Director asserts that zero contractors provide services at PFH RRC. However, in the case of any violation of agency sexual abuse/harassment policies by a contractor or volunteer, facility access privileges would be suspended pending the results of an investigation. If the investigation is substantiated, access privileges are permanently rescinded. In view of the above, the auditor finds PFH RRC substantially compliant with 115.277(b). In view of the above, the auditor finds PFH RRC substantially compliant with 115.277.

115.278	**Disciplinary sanctions for residents**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	115.278(a) Pursuant to the PAQ, the Director self reports that residents are subject to disciplinary sanctions only pursuant to a formal disciplinary process following an administrative finding that a resident engaged in resident-on-resident sexual abuse or a criminal finding of guilt for resident-on-resident sexual abuse. The Director

	further self reports that in the last 12 months, zero administrative or criminal findings of guilt for resident-on-resident sexual abuse occurred at the facility and the auditor has validated the same as zero sexual abuse/harassment investigations were facilitated during the last 12 months. PHS Policy entitled Prison Rape Elimination Act (PREA) Prevention, Investigation, and Reporting, page 19, section Disciplinary sanctions for residents (a) addresses 115.278(a). In view of the above, the auditor finds PFH RRC substantially compliant with 115.278(a). 115.278(b) Pursuant to the PAQ, the Director self reports sanctions shall be 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. PHS Policy entitled Prison Rape Elimination Act (PREA) Prevention, Investigation, and Reporting, page 19, section Disciplinary sanctions for residents (b) addresses 115.278(b). The Director asserts that PFH RRC staff issue misconduct reports to resident(s) in the case of resident sexual misconduct. The misconduct report, investigation, and Center Discipline Committee (CDC) report(s) are also facilitated by PHS staff. If major sanctions are warranted, the FBOP Discipline Hearing Officer (DHO) facilitates the same. FBOP staff review the CDC report(s) and ratify or modify sanctions. The perpetrator is generally administratively removed from the facility and permanent removal (sanction) is subsequently facilitated by the FBOP DHO. Disallowance of Good Conduct Time (GCT) and a disciplinary transfer can be recommended pursuant to the CDC process and the sanction is then ratified by the FBOP DHO. Sanctions are proportionate to the nature and circumstances of the abuses committed, the resident's disciplinary history, and the sanctions imposed for similar offenses by other residents with similar histories. Additionally, mental disability or mental illness are addressed during the investigation, CDC, and DHO review processes. In view of the above, the auditor finds PFH RRC substantially compliant with 115.278(b). 115.278(c) Pursuant to the PAQ, the Director self reports the disciplinary process shall consider

	whether a resident's mental disabilities or mental illness contributed to his or her behavior when determining what type of sanction, if any, should be imposed. PHS Policy entitled Prison Rape Elimination Act (PREA) Prevention, Investigation, and Reporting, page 19, section Disciplinary sanctions for residents (c) addresses 115.278(c). The Director asserts that mental disability or mental illness are addressed during the investigation, CDC, and DHO review processes. Generally, the DHO will address the same during the DHO process as he/she imposes major sanctions. In view of the above, the auditor finds PFH RRC substantially compliant with 115.278(c). 115.278(d) Pursuant to the PAQ, the Director self reports the facility does not offer therapy, counseling, or other interventions designed to address and correct the underlying reasons or motivations for abuse. PHS Policy entitled Prison Rape Elimination Act (PREA) Prevention, Investigation, and Reporting, page 19, section Disciplinary sanctions for residents (d) addresses 115.278(d). In view of the previously cited fact that medical and mental health staff are not employed at PFH RRC, the auditor finds 115.278(d) not applicable to PFH RRC. The PC asserts that all residents are assessed by FBOP mental health staff prior to admission to PHS RRC programs. If therapy is identified as necessary, the same is communicated to respective program staff (PFH RRC) during the referral process. If therapy is indicated, the resident's assigned case manager connects the resident with community resources as necessary. As there is no evidence of PFH RRC violation of either standard or policy, the auditor finds PFH RRC substantially compliant with 115.278(d). 115.278(e) Pursuant to the PAQ, the Director self reports the agency disciplines residents for sexual conduct with staff only upon finding that the staff member did not consent to such contact. PHS Policy entitled Prison Rape Elimination Act (PREA) Prevention, Investigation, and Reporting, page 19, section Disciplinary sanctions for residents (e) addresses 115.278(e). As mentioned throughout this audit narrative, zero allegations of sexual abuse/

	harassment were received during the last 12 months. In view of the above, the auditor finds PFH RRC substantially compliant with 115.278(e). 115.278(f) Pursuant to the PAQ, the Director self reports the agency prohibits disciplinary action for a report of sexual abuse made in good faith based upon a reasonable belief that the alleged conduct occurred, even if an investigation does not establish evidence sufficient to substantiate the allegation. PHS Policy entitled Prison Rape Elimination Act (PREA) Prevention, Investigation, and Reporting, page 19, section Disciplinary sanctions for residents (f) addresses 115.278(f). As mentioned throughout this audit narrative, zero allegations of sexual abuse were received during the last 12 months. In view of the above, the auditor finds PFH RRC substantially compliant with 115.278(f). 115.278(g) Pursuant to the PAQ, the Director self reports the agency prohibits all sexual activity between residents. If the agency prohibits all sexual activity between residents and disciplines residents for such activity, the agency deems such activity to constitute sexual abuse only if it determines that the activity is coerced. PHS Policy entitled Prison Rape Elimination Act (PREA) Prevention, Investigation, and Reporting, page 19, section Disciplinary sanctions for residents (g) addresses 115.278(g). As mentioned throughout this audit narrative, zero allegations of sexual abuse were received during the last 12 months. In view of the above, the auditor finds PFH RRC substantially compliant with 115.278(g). In view of the above, the auditor finds PFH RRC substantially compliant with 115.278.

115.282	**Access to emergency medical and mental health services**

	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	115.282(a) Pursuant to the PAQ, the Director self reports resident victims of sexual abuse receive timely, unimpeded access to emergency medical treatment and crisis intervention services. The nature and scope of such services are determined by medical and mental health practitioners according to their professional judgment. As previously mentioned in the narrative for 115.235, medical/mental health staff are not employed at PFH RRC. PHS Policy entitled Prison Rape Elimination Act (PREA) Prevention, Investigation, and Reporting, page 20, section Access to emergency medical and mental health services (a) addresses 115.282(a). The auditor has learned that affected residents are treated in community medical facilities and accordingly, the community standard of care requirement is met. According to the PC, case management staff facilitate contact with community providers to address non-emergent medical/mental health issues. As previously indicated, zero sexual abuse allegations have been received at PFH RRC during the last 12 months. Accordingly, the resident(s) who reported a sexual abuse at PFH RRC questionnaire could not be administered. Likewise, the medical/ mental health staff questionnaire could not be administered as zero medical/mental health staff are employed at the facility. In view of the above, the auditor finds PFH RRC substantially compliant with 115.282(a). 115.282(b) Pursuant to the PAQ, the Director self reports if no qualified medical or mental health practitioners are on duty at the time a report of recent sexual abuse is made, security staff first responders shall take preliminary steps to protect the victim pursuant to 115.262 and shall immediately notify the appropriate medical and mental health practitioners. Pursuant to the PAQ, the Director self reports the agency has a first responder policy for allegations of sexual abuse and the policy requires that: Upon learning of an allegation that a resident was sexually abused, the first security staff member to respond to the report shall be required to separate the alleged victim and abuser; Upon learning of an allegation that a resident was sexually abused, the first security staff member to respond to the report shall be required to preserve and protect any

	crime scene until appropriate steps can be taken to collect any evidence; Upon learning of an allegation that a resident was sexually abused and the abuse occurred within a time period that still allows for the collection of physical evidence, the first security staff member to respond to the report shall be required to request that the alleged victim not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating; and Upon learning of an allegation that a resident was sexually abused and the abuse occurred within a time period that still allows for the collection of physical evidence, the first security staff member to respond to the report shall be required to ensure that the alleged abuser not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating. PHS Policy entitled Prison Rape Elimination Act (PREA) Prevention, Investigation, and Reporting, pages 14 and 15, section Staff first responder duties a(1-4) addresses 115.264(a). The auditor also notes 115.264(a) requirements are clearly articulated in the TRRC PREA Coordinated Response Plan. Seven of nine random staff interviewees were able to properly recite 1st Responder duties as articulated above. Both the random security staff and the non-security staff interviewees accurately cited their 115.264(a) responsibilities. Additionally, five of the nine random staff interviewees and the non-security staff 1st responder state that the Director or AD would contact medical/mental health resources. In view of the above, the auditor finds PFH RRC substantially compliant with 115.282(b). 115.282(c) Pursuant to the PAQ, the Director self reports resident victims of sexual abuse while incarcerated are offered timely information about and timely access to emergency contraception and sexually transmitted infections prophylaxis, in accordance with professionally accepted standards of care, where medically appropriate. PHS Policy entitled Prison Rape Elimination Act (PREA) Prevention, Investigation, and Reporting, page 20, section Access to emergency medical and mental health services (b) addresses 115.282(c). The SANE interviewee states that a pregnancy test is either facilitated in the Emergency Room (ER) or pursuant to the forensic examination process for female residents and following consultation with the ER physician. Additionally, prophylaxis medications are generally administered as part of the forensic examination process and if additional medications are required, a prescription for prophylaxis medications is written by the ER physician and subsequently filled by facility staff.

	In view of the above, the auditor finds PFH RRC substantially compliant with 115.282(c). 115.282(d) Pursuant to the PAQ, the Director self reports treatment services are provided to every victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident. PHS Policy entitled Prison Rape Elimination Act (PREA) Prevention, Investigation, and Reporting, page 20, section Access to emergency medical and mental health services (c) addresses 115.282(d). Given the fact that zero allegations of sexual abuse were reported during the last 12 months, the auditor finds PFH RRC substantially compliant with 115.282(d). Given the evidence articulated throughout the above narratives, the auditor finds PFH RRC substantially compliant with 115.282.

115.283	**Ongoing medical and mental health care for sexual abuse victims and abusers**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	115.283(a) Pursuant to the PAQ, the Director self reports the facility offers medical and mental health evaluation and, as appropriate, treatment to all residents who have been victimized by sexual abuse in any prison, jail, lockup, or juvenile facility. PHS Policy entitled Prison Rape Elimination Act (PREA) Prevention, Investigation, and Reporting, page 21, section Ongoing medical and mental health care for sexual abuse victims and abusers (a) addresses 115.283(a). Pursuant to the auditor's review of random resident victimization/aggressor assessment files, he determined that zero residents reported prior sexual abuse victimization in a confinement setting. As medical/mental health providers are not employed at PFH RRC and such services are provided in the community or at another PHS program. PFH RRC staff must refer appropriate cases to the provider. The auditor recommends that the PC and facility Director reduce specific procedures to accomplish 115.283(a) and (b) requirements. According to the PHS PC, such

	arrangements for medical/mental health follow-up under such circumstances are generally facilitated by the resident's case manager following notification by the victimization/aggressor assessment screener. In view of the above, the auditor recommends that specific screener responsibilities for referral for the meeting and subsequent scheduling, inclusive of scheduling the follow-up meeting within 14 days of receipt of the allegation, be included in a procedural memorandum. The PC and/or facility Director should ensure that all PFH RRC stakeholders receive and sign for a copy of this memorandum. Subsequently, a copy of the memorandum should be included in the stakeholder's performance file. If the affected resident declines a follow-up meeting with medical/mental health professionals, the same must be documented. The same may be documented in an email or memorandum and placed in the resident's case file. If not already part of PFH RRC protocols, the auditor recommends that the PC or Director develop a form whereby the resident can either accept the 115.283(a) and (b) meeting or decline the same. Of course, the completed form, email, memorandum must also be filed in the resident's file. In view of the above, the auditor finds PFH RRC substantially compliant with 115.283(a). 115.283(b) Pursuant to the PAQ, the Director self reports the evaluation and treatment of such victims shall include, as appropriate, follow-up services, treatment plans, and, when necessary, referrals for continued care following their transfer to, or placement in, other facilities, or their release from custody. PHS Policy entitled Prison Rape Elimination Act (PREA) Prevention, Investigation, and Reporting, page 20, section Ongoing medical and mental health care for sexual abuse victims and abusers (b) addresses 115.283(b). As mentioned throughout the narrative for this report, medical and mental health staff are not employed at PFH RRC and accordingly, those interview questionnaires could not be administered. Additionally given the fact that zero sexual abuse/ harassment allegations were received during the last 12 months, zero victims of sexual abuse could be interviewed. Pursuant to the auditor's review of random resident victimization/aggressor assessment files, he determined that zero residents reported prior institutional sexual abuse victimization in a confinement setting. As medical/mental health providers are not employed at PFH RRC and such services are provided in the community or at another PHS program, PFH RRC staff must refer appropriate cases to the provider. The auditor recommends that the PC and/or facility Director reduce, to writing, specific procedures to ensure completion of 115.283(a) and (b) requirements.

	According to the PHS PC, such arrangements for medical/mental health follow-up under such circumstances are generally facilitated by the resident's case manager following notification by the victimization/aggressor assessment screener. In view of the above, specific screener responsibilities for referral for the meeting and subsequent scheduling, inclusive of scheduling the follow-up meeting within 14 days of receipt of the allegation, should be included in a procedural memorandum. The PC and/or facility Director should ensure that all PFH RRC stakeholders receive and sign for a copy of this memorandum. Subsequently, a copy of the memorandum should be included in the stakeholder's performance file. If the affected resident declines a follow-up meeting with medical/mental health professionals, the same must be documented. The same may be documented in an email or memorandum and placed in the resident's case file. If not already part of PFH RRC protocols, the auditor recommends that the PC or Director develop a form whereby the resident can either accept the 115.283(a) and (b) meeting or decline the same. Of course, the completed form, email, memorandum must be filed in the resident's file. In view of the above, the auditor finds PFH RRC substantially compliant with 115.283(b). 115.283(c) Pursuant to the PAQ, the Director self reports the facility shall provide such victims with medical and mental health services consistent with the community level of care. PHS Policy entitled Prison Rape Elimination Act (PREA) Prevention, Investigation, and Reporting, page 21, section Ongoing medical and mental health care for sexual abuse victims and abusers (c) addresses 115.283(c) As mentioned throughout the narrative for this report, medical and mental health staff are not employed at PFH RRC and accordingly, those interview questionnaires could not be administered. Additionally given the fact that zero sexual abuse/ harassment allegations were reported during the last 12 months, zero victims of sexual abuse could be interviewed. Finally, since medical/mental health care is provided in the surrounding community, the community standard of care is met. In view of available evidence, the auditor finds PFH RRC substantially compliant with 115.283(c). 115.283(d) Pursuant to the PAQ, the Director self reports female victims of sexually abusive vaginal penetration while incarcerated are offered pregnancy tests.

	PHS Policy entitled Prison Rape Elimination Act (PREA) Prevention, Investigation, and Reporting, page 21, section Ongoing medical and mental health care for sexual abuse victims and abusers (d) addresses 115.283(d). The SANE interviewee states that a pregnancy test is either facilitated in the Emergency Room (ER) or pursuant to the forensic examination process for female residents and following consultation with the ER physician. Pregnancy-related services would be addressed by a community physician following contact with PFH RRC and/or FBOP staff. As noted above, zero sexual abuse allegations were received at PFH RRC during the last 12 months. Accordingly, victim interviews could not be facilitated. In view of the above, the auditor finds PFH RRC substantially compliant with 115.283(d). 115.283(e) Pursuant to the PAQ, the Director self reports if pregnancy results from sexual abuse while incarcerated, victims receive timely and comprehensive information about, and timely access to, all lawful pregnancy-related medical services. PHS Policy entitled Prison Rape Elimination Act (PREA) Prevention, Investigation, and Reporting, page 21, section Ongoing medical and mental health care for sexual abuse victims and abusers (e) addresses 115.283(e). The SANE interviewee states that a pregnancy test is either facilitated in the Emergency Room (ER) or pursuant to the forensic examination process for female residents and following consultation with the ER physician. Pregnancy-related services would be addressed by a community physician following contact with PFH RRC and/or FBOP staff. As noted above, zero sexual abuse allegations were reported at PFH RRC during the last 12 months. Accordingly, victim interviews could not be facilitated. In view of the above, the auditor finds PFH RRC substantially compliant with 115.283(e). 115.283(f) Pursuant to the PAQ, the Director self reports resident victims of sexual abuse while incarcerated are offered tests for sexually transmitted infections as medically appropriate. PHS Policy entitled Prison Rape Elimination Act (PREA) Prevention, Investigation, and Reporting, page 21, section Ongoing medical and mental health care for sexual abuse victims and abusers (f) addresses 115.283(f).

	The SANE interviewee states that STI prophylaxis medications are generally administered as part of the forensic examination process and if additional medications are required, a prescription for prophylaxis medications is written by the ER physician and subsequently filled by facility staff. As noted above, zero sexual abuse allegations were reported at PFH RRC during the last 12 months. Accordingly, victim interviews could not be facilitated. In view of the above, the auditor finds PFH RRC substantially compliant with 115.283(f). 115.283(g) Pursuant to the PAQ, the Director self reports treatment services shall be provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident. PHS Policy entitled Prison Rape Elimination Act (PREA) Prevention, Investigation, and Reporting, page 21, section Ongoing medical and mental health care for sexual abuse victims and abusers (g) addresses 115.283(g). As noted above, zero sexual abuse allegations were reported at PFH RRC during the last 12 months. Accordingly, zero documentation is available for review for purposes of 115.283(g) validation. Additionally, residents who reported sexual abuse could not be interviewed under these circumstances. In view of the above, the auditor finds PFH RRC substantially compliant with 115.283(g). 115.283(h) Pursuant to the PAQ, the Director self reports the facility attempts to conduct a mental health evaluation of all known resident-on-resident abusers within 60 days of learning of such abuse history and offers treatment when deemed appropriate by mental health practitioners. PHS Policy entitled Prison Rape Elimination Act (PREA) Prevention, Investigation, and Reporting, page 21, section Ongoing medical and mental health care for sexual abuse victims and abusers (h) addresses 115.283(h). The auditor has not been provided nor has he identified any resident-on-resident sexual abusers during the course of this audit. The FBOP and PFH RRC pre-screening efforts are designed to preclude placement of such offenders at PFH RRC. As previously indicated throughout this audit narrative, medical and mental health staff are not employed at PFH RRC. Accordingly, such interviews could not be conducted.

	In view of the above, the auditor finds PFH RRC substantially compliant with 115.283(h). Given the evidence articulated in the above 115.283 provisions, the auditor finds PFH RRC substantially compliant with 115.283.

115.286	**Sexual abuse incident reviews**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	115.286(a) Pursuant to the PAQ, the Director self reports the facility conducts a sexual abuse incident review at the conclusion of every criminal or administrative sexual abuse investigation, unless the allegation has been determined to be unfounded. The Director further self reports in the last 12 months, zero criminal and/or administrative investigations of alleged sexual abuse were completed at the facility. PHS Policy entitled Prison Rape Elimination Act (PREA) Prevention, Investigation, and Reporting, page 21, section X(a) addresses 115.286(a). As zero sexual abuse allegations were reported during the last 12 months, validation documents are not available. In view of the above, the auditor finds PFH RRC substantially compliant with 115.286(a). 115.286(b) Pursuant to the PAQ, the Director self reports the facility ordinarily conducts a sexual abuse incident review within 30 days of the conclusion of the criminal or administrative sexual abuse investigation. PHS Policy entitled Prison Rape Elimination Act (PREA) Prevention, Investigation, and Reporting, page 21, section X(b) addresses 115.286(b). As zero sexual abuse allegations were reported during the last 12 months, validation documents are not available. In view of the above, the auditor finds PFH RRC substantially compliant with 115.286(b).

	115.286(c) Pursuant to the PAQ, the Director self reports the sexual abuse incident review team includes upper-level management officials and allows for input from line supervisors, investigators, and medical or mental health practitioners. PHS Policy entitled Prison Rape Elimination Act (PREA) Prevention, Investigation, and Reporting, page 21, section X(c) addresses 115.286(c). The Director asserts that a sexual abuse incident review team (SAIR) is utilized at PFH RRC. The team does include upper-level management officials and allows for input from line supervisors, investigators, and medical or mental health practitioners. As zero sexual abuse allegations reported at PFH RRC during the last 12 months, documentary evidence is not available. In view of the above, the auditor finds PFH RRC substantially compliant with 115.286(c). 115.286(d) Pursuant to the PAQ, the Director self reports the facility prepares a report of its findings from sexual abuse incident reviews including, but not necessarily limited to, determinations made pursuant to paragraphs (d)(1)-(d)(5) of this section and any recommendations for improvement, and submits such report to the facility head and PREA Coordinator. PHS Policy entitled Prison Rape Elimination Act (PREA) Prevention, Investigation, and Reporting, pages 21 and 22, section X(d)(1-6) addresses 115.286(d). The Director asserts the information gleaned from SAIR reviews is used to strengthen "all things PREA" within the facility. Careful analysis of information can provide a roadmap for staff to address any deficiencies and build upon positive policies and practices. Similarly, deficiencies are addressed to ensure positive change. Additionally, the SAIR addresses the following: Considers whether the incident or allegation was motivated by race, ethnicity, gender identity, LGBTI status, gang affiliation, and/or other group dynamics at the facility; Examines the area in the facility where the incident allegedly occurred to assess whether physical barriers in the area may enable abuse; Assesses the adequacy of staffing levels in that area during different shifts; and Assesses whether monitoring technology should be deployed or augmented to

	supplement supervision by staff. The incident review team interviewee validates the statement of the Director as reflected above. The PC asserts SAIR reports are forwarded to him by the Director for review. They are also reviewed by the Facility Director/PCM. If recommendations are noted in the report, follow-through ordinarily occurs and if the same is not prudent, the rationale for non-implementation is documented. In regard to victims under the age of 18 and vulnerable adults, the PC asserts neither category of residents are housed at PFH RRC. In view of the above, the auditor finds PFH RRC substantially compliant with 115.286(d). 115.286(e) Pursuant to the PAQ, the Director self reports the facility implements the recommendations for improvement or documents its reasons for not doing so. PHS Policy entitled Prison Rape Elimination Act (PREA) Prevention, Investigation, and Reporting, page 22, section X(e) addresses 115.286(e). In view of the above, the auditor finds PFH RRC substantially compliant with 115.286(e). Pursuant to the auditor's review of the evidence cited throughout the 115.286 narratives, the auditor finds PFH RRC substantially compliant with 115.286.

115.287	**Data collection**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	115.287(a) Pursuant to the PAQ, the Director self reports the agency collects accurate, uniform data for every allegation of sexual abuse at facilities under its direct control using a standardized instrument and set of definitions. PHS Policy entitled Prison Rape Elimination Act (PREA) Prevention, Investigation, and Reporting, page 22, section Data collection (a) addresses 115.287(a). The auditor's review of a PHS document entitled PHS PREA Definitions and the Data

	Collection Instrument reveals evidence validating that a standardized set of definitions and instrument are used to address 115.287(a). Given the fact that zero sexual abuse allegations were received during the instant audit period, the documents, uploaded into OAS, reflect zero data. In view of the above, the auditor finds PFH RRC substantially compliant with 115.287(a). 115.287(b) Pursuant to the PAQ, the Director self reports the agency aggregates the incident-based sexual abuse data at least annually. PHS Policy entitled Prison Rape Elimination Act (PREA) Prevention, Investigation, and Reporting, page 22, section Data collection (b) addresses 115.287(b). The auditor's review of the 2021, 2022, and 2023 PHS PREA Annual Reports reveals substantial compliance with 115.287(a and b). In view of the above, the auditor finds PFH RRC substantially compliant with 115.287(b). 115.287(c) Pursuant to the PAQ, the Director self reports the standardized instrument includes, at a minimum, the data necessary to answer all questions from the most recent version of the Survey of Sexual Violence (SSV) conducted by the Department of Justice. PHS Policy entitled Prison Rape Elimination Act (PREA) Prevention, Investigation, and Reporting, page 22, section Data collection (b) addresses 115.287(c). The auditor's review of the three aforementioned PHS PREA Annual Reports and the PHS Data Collection Instrument reveals substantial compliance with 115.287(c). In view of the above, the auditor finds PFH RRC substantially compliant with 115.287(c). 115.287(d) Pursuant to the PAQ, the Director self reports the agency maintains, reviews, and collects data as needed from all available incident-based documents, including reports, investigation files, and sexual abuse incident reviews. PHS Policy entitled Prison Rape Elimination Act (PREA) Prevention, Investigation, and Reporting, page 22, section Data collection (b) addresses 115.287(d).

	Based on the evidence presented throughout the 115.287 and 115.288 narratives, the auditor is convinced that relevant documentation is reviewed on a perpetual basis in an effort to assess and enhance PREA programs throughout the company. In view of the above, the auditor finds PFH RRC substantially compliant with 115.287(d). 115.287(e) Pursuant to the PAQ, the Director self reports PHS does not contract with other private facilities for confinement of residents committed to their care. Accordingly, 115.287(e) is not applicable to PFH RRC. As reflected in the narrative for 115.212, the auditor concurs with this assessment based on observation and review of rosters/accompanying data regarding the committing agency(ies). In view of the above, the auditor finds PFH RRC substantially compliant with 115.287(e). 115.287(f) Pursuant to the PAQ, the Director self reports the agency did not provide the U. S. Department of Justice (DOJ) with data from the previous calendar year upon request as the USDOJ did not request such information. Accordingly, 115.287(f) is not applicable to PFH RRC. In view of the above, the auditor finds PFH RRC substantially compliant with 115.287(f). Given the above evidence, the auditor finds PFH RRC substantially compliant with 115.287.

115.288	**Data review for corrective action**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	115.288(a) Pursuant to the PAQ, the Director self reports the agency reviews data collected and aggregated pursuant to §115.287 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, response policies, and training, including:

	Identifying problem areas; Taking corrective action on an ongoing basis; and Preparing an annual report of its findings from its data review and any corrective actions for each facility, as well as, the agency as a whole. PHS Policy entitled Prison Rape Elimination Act (PREA) Prevention, Investigation, and Reporting, page 22, section Data collection (b) addresses 115.288(a). The Agency Head interviewee asserts that incident-based sexual abuse data is used to assess and improve sexual abuse prevention, detection, and response policies, practices, and training. Specifically, all data is reviewed and aggregated to enhance "all things PREA." Corrective action is closely monitored and the same is taken on an ongoing basis. The PC corroborates the assertion of the Agency Head interviewee as reflected above. He further asserts that a report of findings from its data review and any corrective actions for each facility, as well as, the agency as a whole is compiled on an annual basis. The Director generates electronic reports to support the 115.287 requirements. Data is retained in a password protected system and all investigation(s) are generated in an electronic format. The auditor notes that the 2021, 2022, and 2023 PHS Annual Reports have been completed and the auditor has reviewed the same. He finds substantial compliance with 115.288 requirements. In view of the above, the auditor finds PFH RRC substantially compliant with 115.288(a). 115.288(b) Pursuant to the PAQ, the Director self reports the annual report includes a comparison of the current year’s data and corrective actions with those from prior years. The annual report provides an assessment of the agency’s progress in addressing sexual abuse. PHS Policy entitled Prison Rape Elimination Act (PREA) Prevention, Investigation, and Reporting, page 22, section Data collection (b)(3) and (c) addresses 115.288(b). The auditor's review of the 2021, 2022, and 2023 PHS PREA Annual Reports reveals substantial compliance with 115.288(b). Comparisons in terms of data are clearly delineated and as zero substantiated allegations were realized during the last 12 months, recommendations for corrective action were not documented. In view of the above, the auditor finds PFH RRC substantially compliant with 115.288(b).

	115.288(c) Pursuant to the PAQ, the Director self reports the agency makes its annual report readily available to the public at least annually through its website and the reports are approved by the agency head. PHS Policy entitled Prison Rape Elimination Act (PREA) Prevention, Investigation, and Reporting, page 22, section Data collection (d) addresses 115.288(c). The Agency Head interviewee asserts that the PHS PC develops the annual report and he signs and approves the same pursuant to 115.288(c). The annual report includes a compilation of statistics and addresses agency efforts regarding sexual safety of residents. The PC asserts that in years prior to 2020, PHS PREA Annual Reports were completed by the Agency Head. For purposes of the 2020 report, the same was completed by the PC and submitted to the Director of Transition Services for approval however, neither signature on the actual report or an email signifying Agency Head designee review, was completed. The PC asserts that the Agency Head designee has final review authority regarding all PREA Annual Reports. There are no signature and date blocks for either the PC or Agency Head designee. In view of the above, the auditor finds PFH RRC substantially compliant with 115.288(c). 115.288(d) Pursuant to the PAQ, the Director self reports when the agency redacts material from an annual report for publication, the redactions are limited to specific materials where publication would present a clear and specific threat to the safety and security of the facility. Additionally, the agency indicates the nature of material redacted. PHS Policy entitled Prison Rape Elimination Act (PREA) Prevention, Investigation, and Reporting, page 22, section Data collection (d)(1) addresses 115.288(d). The PC asserts that PHI, PPI, and security information are redacted from annual reports. If redacted, the agency indicates the nature of the material redacted. Pursuant to the auditor's aforementioned review of PHS PREA Annual Reports, he finds no evidence of 115.288(d) redactions. In view of the above, the auditor finds PFH RRC substantially compliant with 115.288(d). In view of the evidence presented in the above provision narratives, the auditor

	finds PFH RRC substantially compliant with 115.288.

115.289	Data storage, publication, and destruction
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	115.289(a) Pursuant to the PAQ, the Director self reports the agency ensures that incident based and aggregate data are securely retained. PHS Policy entitled Prison Rape Elimination Act (PREA) Prevention, Investigation, and Reporting, page 22, section Record retention (a) addresses 115.289(a). The PC asserts that agency staff review data collected and aggregated pursuant to 115.287 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies and training. This information is generally captured in annual PREA reports, aggregated and separated by facility. Data is generally maintained at corporate, but may also be maintained at the facility. SAIR reports, retaliation monitoring documents, and sexual abuse/ harassment investigations are generally maintained in electronic format as previously described. Hard copies of investigations completed by the PC are maintained in a locked file cabinet in his off-site locked office. The auditor did validate the same during the onsite visit pursuant to discussion with the PC. The auditor found no deficiencies in terms of standard provision, policy, or practice. In view of the above, the auditor finds PFH RRC substantially compliant with 115.289(a). 115.289(b) Pursuant to the PAQ, the Director self reports agency policy requires that aggregated sexual abuse data from facilities under its direct control and private facilities with which it contracts be made readily available to the public at least annually through its website. PHS Policy entitled Prison Rape Elimination Act (PREA) Prevention, Investigation, and Reporting, page 22, section Data collection (d) addresses 115.289(b). The auditor's review of the PHS/PFH RRC website reveals relevant data is captured in the 2021 and 2022 PREA Annual Reports posted on the same. The data is clearly aggregated. In view of the above, the auditor finds PFH RRC substantially compliant with

	115.289(b). 115.289(c) Pursuant to the PAQ, the Director self reports before making aggregated sexual abuse data publicly available, the agency removes all personal identifiers. The agency maintains sexual abuse data collected pursuant to §115.287 for at least 10 years after the date of initial collection, unless federal, state, or local law requires otherwise. PHS Policy entitled Prison Rape Elimination Act (PREA) Prevention, Investigation, and Reporting, pages 22 and 23, section Data collection (d) and Record retention (c) addresses 115.289(c). The auditor did not identify any 115.289(c) redactions nor did he find any evidence of non-compliant maintenance of PREA data as described at 115.289(c)-2. In view of the above, the auditor finds PFH RRC substantially compliant with 115.289(c). 115.289(d) Pursuant to the PAQ, the Director self reports the agency shall maintain sexual abuse data collected pursuant to § 115.287 for at least 10 years after the date of the initial collection unless Federal, State, or local law requires otherwise. PHS Policy entitled Prison Rape Elimination Act (PREA) Prevention, Investigation, and Reporting, page 23, section Record retention (c) addresses 115.289(d). The auditor has found no violations of 115.289(d) requirements in terms of data maintenance. In view of the above, the auditor finds PFH RRC substantially compliant with 115.289(d). Based on the fact the auditor has not identified any 115.289 deficiencies, he finds PFH RRC substantially compliant with 115.289.

115.401	**Frequency and scope of audits**

	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	115.401(a) As the auditor completed the last PREA PFH RRC PREA Audit with the Final Report submitted in 2022, it is clear that compliance with 115.401(a) has been established. The same is true with respect to PFH RRC. SRRC was completed during 2023. In view of the above, the auditor finds PHS compliant with 115.401(a). 115.401(b) As the auditor completed the last PFH RRC PREA Audit with the Final Report submitted in 2022, it is clear that compliance with 115.401(b) has been established. The same is true with respect to TRRC. SRRC was completed during 2023. In view of the above, the auditor finds PHS compliant with 115.401(b). 115.401(h) Throughout the onsite visit, the auditor was granted access to all areas of the facility inclusive of mop closets, electrical room(s), all staff offices, all living quarters, day rooms, recreation areas, food service, and laundry. In view of the above, the auditor finds PFH RRC substantially compliant with 115.401(h). 115.401(m) All staff and resident interviews were facilitated in private behind a closed door. The interviews were facilitated in a staff office in the administrative area. The auditor's review of the Audit Notices reveals that sufficient information was provided regarding confidentiality. In view of the above, the auditor finds PFH RRC substantially compliant with 115.401(m). 115.401(n) The auditor finds that residents were able to send confidential letters to the auditor had they desired to do so.

	In view of the above, the auditor finds PFH RRC substantially compliant with 115.401(n). In view of the above, the auditor finds PFH RRC substantially compliant with 115.401. 115.401(i) Throughout the audit process inclusive of the pre-audit, onsite visit, and post audit phases, the auditor was granted access to all relevant documents with the same being uploaded into OAS. In view of the above, the auditor finds PFH RRC substantially compliant with 115.401(i).

115.403	**Audit contents and findings**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	115.403(f) The auditor notes that the previous PFH RRC Final PREA Audit Report (Final Report completed in 2022) is posted on the PHS website. As this report is an interim report, the same will not be posted on the website. In view of the above, the auditor finds PFH RRC substantially compliant with 115.403(f). In view of the above, the auditor finds TRRC substantially compliant with 115.403.

Appendix: Provision Findings		
115.211 (a)	**Zero tolerance of sexual abuse and sexual harassment; PREA coordinator**	
	Does the agency have a written policy mandating zero tolerance toward all forms of sexual abuse and sexual harassment?	yes
	Does the written policy outline the agency's approach to preventing, detecting, and responding to sexual abuse and sexual harassment?	yes
115.211 (b)	**Zero tolerance of sexual abuse and sexual harassment; PREA coordinator**	
	Has the agency employed or designated an agency-wide PREA Coordinator?	yes
	Is the PREA Coordinator position in the upper-level of the agency hierarchy?	yes
	Does the PREA Coordinator have sufficient time and authority to develop, implement, and oversee agency efforts to comply with the PREA standards in all of its community confinement facilities?	yes
115.212 (a)	**Contracting with other entities for the confinement of residents**	
	If this agency is public and it contracts for the confinement of its residents with private agencies or other entities, including other government agencies, has the agency included the entity's obligation to adopt and comply with the PREA standards in any new contract or contract renewal signed on or after August 20, 2012? (N/A if the agency does not contract with private agencies or other entities for the confinement of residents.)	na
115.212 (b)	**Contracting with other entities for the confinement of residents**	
	Does any new contract or contract renewal signed on or after August 20, 2012 provide for agency contract monitoring to ensure that the contractor is complying with the PREA standards? (N/A if the agency does not contract with private agencies or other entities for the confinement of residents.)	na
115.212 (c)	**Contracting with other entities for the confinement of residents**	
	If the agency has entered into a contract with an entity that fails to comply with the PREA standards, did the agency do so only in	na

	emergency circumstances after making all reasonable attempts to find a PREA compliant private agency or other entity to confine residents? (N/A if the agency has not entered into a contract with an entity that fails to comply with the PREA standards.)	
	In such a case, does the agency document its unsuccessful attempts to find an entity in compliance with the standards? (N/A if the agency has not entered into a contract with an entity that fails to comply with the PREA standards.)	na
115.213 (a)	**Supervision and monitoring**	
	Does the facility have a documented staffing plan that provides for adequate levels of staffing and, where applicable, video monitoring to protect residents against sexual abuse?	yes
	In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: The physical layout of each facility?	yes
	In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: The composition of the resident population?	yes
	In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: The prevalence of substantiated and unsubstantiated incidents of sexual abuse?	yes
	In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: Any other relevant factors?	yes
115.213 (b)	**Supervision and monitoring**	
	In circumstances where the staffing plan is not complied with, does the facility document and justify all deviations from the plan? (NA if no deviations from staffing plan.)	na
115.213 (c)	**Supervision and monitoring**	
	In the past 12 months, has the facility assessed, determined, and documented whether adjustments are needed to the staffing plan established pursuant to paragraph (a) of this section?	yes
	In the past 12 months, has the facility assessed, determined, and documented whether adjustments are needed to prevailing	yes

	staffing patterns?	
	In the past 12 months, has the facility assessed, determined, and documented whether adjustments are needed to the facility's deployment of video monitoring systems and other monitoring technologies?	yes
	In the past 12 months, has the facility assessed, determined, and documented whether adjustments are needed to the resources the facility has available to commit to ensure adequate staffing levels?	yes
115.215 (a)	**Limits to cross-gender viewing and searches**	
	Does the facility always refrain from conducting any cross-gender strip searches or cross-gender visual body cavity searches, except in exigent circumstances or by medical practitioners?	yes
115.215 (b)	**Limits to cross-gender viewing and searches**	
	Does the facility always refrain from conducting cross-gender pat-down searches of female residents, except in exigent circumstances? (N/A if the facility does not have female inmates.)	yes
	Does the facility always refrain from restricting female residents' access to regularly available programming or other outside opportunities in order to comply with this provision? (N/A if the facility does not have female inmates.)	yes
115.215 (c)	**Limits to cross-gender viewing and searches**	
	Does the facility document all cross-gender strip searches and cross-gender visual body cavity searches?	yes
	Does the facility document all cross-gender pat-down searches of female residents?	yes
115.215 (d)	**Limits to cross-gender viewing and searches**	
	Does the facility have policies that enable residents to shower, perform bodily functions, and change clothing without non-medical staff of the opposite gender viewing their breasts, buttocks, or genitalia, except in exigent circumstances or when such viewing is incidental to routine cell checks?	yes
	Does the facility have procedures that enable residents to shower,	yes

	perform bodily functions, and change clothing without non-medical staff of the opposite gender viewing their breasts, buttocks, or genitalia, except in exigent circumstances or when such viewing is incidental to routine cell checks?	
	Does the facility require staff of the opposite gender to announce their presence when entering an area where residents are likely to be showering, performing bodily functions, or changing clothing?	yes
115.215 (e)	**Limits to cross-gender viewing and searches**	
	Does the facility always refrain from searching or physically examining transgender or intersex residents for the sole purpose of determining the resident's genital status?	yes
	If the resident's genital status is unknown, does the facility determine genital status during conversations with the resident, by reviewing medical records, or, if necessary, by learning that information as part of a broader medical examination conducted in private by a medical practitioner?	yes
115.215 (f)	**Limits to cross-gender viewing and searches**	
	Does the facility/agency train security staff in how to conduct cross-gender pat down searches in a professional and respectful manner, and in the least intrusive manner possible, consistent with security needs?	yes
	Does the facility/agency train security staff in how to conduct searches of transgender and intersex residents in a professional and respectful manner, and in the least intrusive manner possible, consistent with security needs?	yes
115.216 (a)	**Residents with disabilities and residents who are limited English proficient**	
	Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Residents who are deaf or hard of hearing?	yes
	Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Residents who are blind or have low vision?	yes

	Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Residents who have intellectual disabilities?	yes
	Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Residents who have psychiatric disabilities?	yes
	Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Residents who have speech disabilities?	yes
	Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Other (if "other," please explain in overall determination notes.)	yes
	Do such steps include, when necessary, ensuring effective communication with residents who are deaf or hard of hearing?	yes
	Do such steps include, when necessary, providing access to interpreters who can interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary?	yes
	Does the agency ensure that written materials are provided in formats or through methods that ensure effective communication with residents with disabilities including residents who: Have intellectual disabilities?	yes
	Does the agency ensure that written materials are provided in formats or through methods that ensure effective communication with residents with disabilities including residents who: Have limited reading skills?	yes
	Does the agency ensure that written materials are provided in formats or through methods that ensure effective communication with residents with disabilities including residents who: Who are blind or have low vision?	yes
115.216 (b)	**Residents with disabilities and residents who are limited English proficient**	

	Does the agency take reasonable steps to ensure meaningful access to all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment to residents who are limited English proficient?	yes
	Do these steps include providing interpreters who can interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary?	yes
115.216 (c)	**Residents with disabilities and residents who are limited English proficient**	
	Does the agency always refrain from relying on resident interpreters, resident readers, or other types of resident assistants except in limited circumstances where an extended delay in obtaining an effective interpreter could compromise the resident's safety, the performance of first-response duties under §115.264, or the investigation of the resident's allegations?	yes
115.217 (a)	**Hiring and promotion decisions**	
	Does the agency prohibit the hiring or promotion of anyone who may have contact with residents who: Has engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility, or other institution (as defined in 42 U.S.C. 1997)?	yes
	Does the agency prohibit the hiring or promotion of anyone who may have contact with residents who: Has been convicted of engaging or attempting to engage in sexual activity in the community facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse?	yes
	Does the agency prohibit the hiring or promotion of anyone who may have contact with residents who: Has been civilly or administratively adjudicated to have engaged in the activity described in the two questions immediately above ?	yes
	Does the agency prohibit the enlistment of the services of any contractor who may have contact with residents who: Has engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility, or other institution (as defined in 42 U.S.C. 1997)?	yes
	Does the agency prohibit the enlistment of the services of any contractor who may have contact with residents who: Has been convicted of engaging or attempting to engage in sexual activity in the community facilitated by force, overt or implied threats of	yes

	force, or coercion, or if the victim did not consent or was unable to consent or refuse?	
	Does the agency prohibit the enlistment of the services of any contractor who may have contact with residents who: Has been civilly or administratively adjudicated to have engaged in the activity described in the two questions immediately above ?	yes
115.217 (b)	**Hiring and promotion decisions**	
	Does the agency consider any incidents of sexual harassment in determining whether to hire or promote anyone who may have contact with residents?	yes
	Does the agency consider any incidents of sexual harassment in determining to enlist the services of any contractor who may have contact with residents?	yes
115.217 (c)	**Hiring and promotion decisions**	
	Before hiring new employees who may have contact with residents, does the agency: Perform a criminal background records check?	yes
	Before hiring new employees who may have contact with residents, does the agency, consistent with Federal, State, and local law, make its best efforts to contact all prior institutional employers for information on substantiated allegations of sexual abuse or any resignation during a pending investigation of an allegation of sexual abuse?	yes
115.217 (d)	**Hiring and promotion decisions**	
	Does the agency perform a criminal background records check before enlisting the services of any contractor who may have contact with residents?	yes
115.217 (e)	**Hiring and promotion decisions**	
	Does the agency either conduct criminal background records checks at least every five years of current employees and contractors who may have contact with residents or have in place a system for otherwise capturing such information for current employees?	yes
115.217	**Hiring and promotion decisions**	

(f)		
	Does the agency ask all applicants and employees who may have contact with residents directly about previous misconduct described in paragraph (a) of this section in written applications or interviews for hiring or promotions?	yes
	Does the agency ask all applicants and employees who may have contact with residents directly about previous misconduct described in paragraph (a) of this section in any interviews or written self-evaluations conducted as part of reviews of current employees?	yes
	Does the agency impose upon employees a continuing affirmative duty to disclose any such misconduct?	yes
115.217 (g)	**Hiring and promotion decisions**	
	Does the agency consider material omissions regarding such misconduct, or the provision of materially false information, grounds for termination?	yes
115.217 (h)	**Hiring and promotion decisions**	
	Does the agency provide information on substantiated allegations of sexual abuse or sexual harassment involving a former employee upon receiving a request from an institutional employer for whom such employee has applied to work? (N/A if providing information on substantiated allegations of sexual abuse or sexual harassment involving a former employee is prohibited by law.)	yes
115.218 (a)	**Upgrades to facilities and technology**	
	If the agency designed or acquired any new facility or planned any substantial expansion or modification of existing facilities, did the agency consider the effect of the design, acquisition, expansion, or modification upon the agency’s ability to protect residents from sexual abuse? (N/A if agency/facility has not acquired a new facility or made a substantial expansion to existing facilities since August 20, 2012 or since the last PREA audit, whichever is later.)	na
115.218 (b)	**Upgrades to facilities and technology**	
	If the agency installed or updated a video monitoring system, electronic surveillance system, or other monitoring technology, did the agency consider how such technology may enhance the	na

	agency’s ability to protect residents from sexual abuse? (N/A if agency/facility has not installed or updated any video monitoring system, electronic surveillance system, or other monitoring technology since August 20, 2012 or since the last PREA audit, whichever is later.)	
115.221 (a)	**Evidence protocol and forensic medical examinations**	
	If the agency is responsible for investigating allegations of sexual abuse, does the agency follow a uniform evidence protocol that maximizes the potential for obtaining usable physical evidence for administrative proceedings and criminal prosecutions? (N/A if the agency/facility is not responsible for conducting any form of criminal or administrative sexual abuse investigations.)	yes
115.221 (b)	**Evidence protocol and forensic medical examinations**	
	Is this protocol developmentally appropriate for youth where applicable? (NA if the agency/facility is not responsible for conducting any form of criminal or administrative sexual abuse investigations.)	yes
	Is this protocol, as appropriate, adapted from or otherwise based on the most recent edition of the U.S. Department of Justice’s Office on Violence Against Women publication, “A National Protocol for Sexual Assault Medical Forensic Examinations, Adults/ Adolescents,” or similarly comprehensive and authoritative protocols developed after 2011? (NA if the agency/facility is not responsible for conducting any form of criminal or administrative sexual abuse investigations.)	yes
115.221 (c)	**Evidence protocol and forensic medical examinations**	
	Does the agency offer all victims of sexual abuse access to forensic medical examinations, whether on-site or at an outside facility, without financial cost, where evidentiarily or medically appropriate?	yes
	Are such examinations performed by Sexual Assault Forensic Examiners (SAFEs) or Sexual Assault Nurse Examiners (SANEs) where possible?	yes
	If SAFEs or SANEs cannot be made available, is the examination performed by other qualified medical practitioners (they must have been specifically trained to conduct sexual assault forensic exams)?	yes

	Has the agency documented its efforts to provide SAFEs or SANEs?	yes
115.221 (d)	**Evidence protocol and forensic medical examinations**	
	Does the agency attempt to make available to the victim a victim advocate from a rape crisis center?	yes
	If a rape crisis center is not available to provide victim advocate services, does the agency make available to provide these services a qualified staff member from a community-based organization, or a qualified agency staff member?	yes
	Has the agency documented its efforts to secure services from rape crisis centers?	yes
115.221 (e)	**Evidence protocol and forensic medical examinations**	
	As requested by the victim, does the victim advocate, qualified agency staff member, or qualified community-based organization staff member accompany and support the victim through the forensic medical examination process and investigatory interviews?	yes
	As requested by the victim, does this person provide emotional support, crisis intervention, information, and referrals?	yes
115.221 (f)	**Evidence protocol and forensic medical examinations**	
	If the agency itself is not responsible for investigating allegations of sexual abuse, has the agency requested that the investigating agency follow the requirements of paragraphs (a) through (e) of this section? (N/A if the agency/facility is responsible for conducting criminal AND administrative sexual abuse investigations.)	yes
115.221 (h)	**Evidence protocol and forensic medical examinations**	
	If the agency uses a qualified agency staff member or a qualified community-based staff member for the purposes of this section, has the individual been screened for appropriateness to serve in this role and received education concerning sexual assault and forensic examination issues in general? (N/A if agency attempts to make a victim advocate from a rape crisis center available to victims per 115.221(d) above).	na

115.222 (a)	**Policies to ensure referrals of allegations for investigations**	
	Does the agency ensure an administrative or criminal investigation is completed for all allegations of sexual abuse?	yes
	Does the agency ensure an administrative or criminal investigation is completed for all allegations of sexual harassment?	yes
115.222 (b)	**Policies to ensure referrals of allegations for investigations**	
	Does the agency have a policy in place to ensure that allegations of sexual abuse or sexual harassment are referred for investigation to an agency with the legal authority to conduct criminal investigations, unless the allegation does not involve potentially criminal behavior?	yes
	Has the agency published such policy on its website or, if it does not have one, made the policy available through other means?	yes
	Does the agency document all such referrals?	yes
115.222 (c)	**Policies to ensure referrals of allegations for investigations**	
	If a separate entity is responsible for conducting criminal investigations, does the policy describe the responsibilities of both the agency and the investigating entity? (N/A if the agency/facility is responsible for conducting criminal investigations. See 115.221(a).)	yes
115.231 (a)	**Employee training**	
	Does the agency train all employees who may have contact with residents on: Its zero-tolerance policy for sexual abuse and sexual harassment?	yes
	Does the agency train all employees who may have contact with residents on: How to fulfill their responsibilities under agency sexual abuse and sexual harassment prevention, detection, reporting, and response policies and procedures?	yes
	Does the agency train all employees who may have contact with residents on: Residents’ right to be free from sexual abuse and sexual harassment?	yes
	Does the agency train all employees who may have contact with	yes

	residents on: The right of residents and employees to be free from retaliation for reporting sexual abuse and sexual harassment?	
	Does the agency train all employees who may have contact with residents on: The dynamics of sexual abuse and sexual harassment in confinement?	yes
	Does the agency train all employees who may have contact with residents on: The common reactions of sexual abuse and sexual harassment victims?	yes
	Does the agency train all employees who may have contact with residents on: How to detect and respond to signs of threatened and actual sexual abuse?	yes
	Does the agency train all employees who may have contact with residents on: How to avoid inappropriate relationships with residents?	yes
	Does the agency train all employees who may have contact with residents on: How to communicate effectively and professionally with residents, including lesbian, gay, bisexual, transgender, intersex, or gender nonconforming residents?	yes
	Does the agency train all employees who may have contact with residents on: How to comply with relevant laws related to mandatory reporting of sexual abuse to outside authorities?	yes
115.231 (b)	**Employee training**	
	Is such training tailored to the gender of the residents at the employee's facility?	yes
	Have employees received additional training if reassigned from a facility that houses only male residents to a facility that houses only female residents, or vice versa?	yes
115.231 (c)	**Employee training**	
	Have all current employees who may have contact with residents received such training?	yes
	Does the agency provide each employee with refresher training every two years to ensure that all employees know the agency's current sexual abuse and sexual harassment policies and procedures?	yes
	In years in which an employee does not receive refresher training,	yes

	does the agency provide refresher information on current sexual abuse and sexual harassment policies?	
115.231 (d)	**Employee training**	
	Does the agency document, through employee signature or electronic verification, that employees understand the training they have received?	yes
115.232 (a)	**Volunteer and contractor training**	
	Has the agency ensured that all volunteers and contractors who have contact with residents have been trained on their responsibilities under the agency's sexual abuse and sexual harassment prevention, detection, and response policies and procedures?	yes
115.232 (b)	**Volunteer and contractor training**	
	Have all volunteers and contractors who have contact with residents been notified of the agency's zero-tolerance policy regarding sexual abuse and sexual harassment and informed how to report such incidents (the level and type of training provided to volunteers and contractors shall be based on the services they provide and level of contact they have with residents)?	yes
115.232 (c)	**Volunteer and contractor training**	
	Does the agency maintain documentation confirming that volunteers and contractors understand the training they have received?	yes
115.233 (a)	**Resident education**	
	During intake, do residents receive information explaining: The agency's zero-tolerance policy regarding sexual abuse and sexual harassment?	yes
	During intake, do residents receive information explaining: How to report incidents or suspicions of sexual abuse or sexual harassment?	yes
	During intake, do residents receive information explaining: Their rights to be free from sexual abuse and sexual harassment?	yes

	During intake, do residents receive information explaining: Their rights to be free from retaliation for reporting such incidents?	yes
	During intake, do residents receive information regarding agency policies and procedures for responding to such incidents?	yes
115.233 (b)	**Resident education**	
	Does the agency provide refresher information whenever a resident is transferred to a different facility?	yes
115.233 (c)	**Resident education**	
	Does the agency provide resident education in formats accessible to all residents, including those who: Are limited English proficient?	yes
	Does the agency provide resident education in formats accessible to all residents, including those who: Are deaf?	yes
	Does the agency provide resident education in formats accessible to all residents, including those who: Are visually impaired?	yes
	Does the agency provide resident education in formats accessible to all residents, including those who: Are otherwise disabled?	yes
	Does the agency provide resident education in formats accessible to all residents, including those who: Have limited reading skills?	yes
115.233 (d)	**Resident education**	
	Does the agency maintain documentation of resident participation in these education sessions?	yes
115.233 (e)	**Resident education**	
	In addition to providing such education, does the agency ensure that key information is continuously and readily available or visible to residents through posters, resident handbooks, or other written formats?	yes
115.234 (a)	**Specialized training: Investigations**	
	In addition to the general training provided to all employees pursuant to §115.231, does the agency ensure that, to the extent	yes

	the agency itself conducts sexual abuse investigations, its investigators receive training in conducting such investigations in confinement settings? (N/A if the agency does not conduct any form of criminal or administrative sexual abuse investigations. See 115.221(a)).	
115.234 (b)	**Specialized training: Investigations**	
	Does this specialized training include: Techniques for interviewing sexual abuse victims?(N/A if the agency does not conduct any form of criminal or administrative sexual abuse investigations. See 115.221(a)).	yes
	Does this specialized training include: Proper use of Miranda and Garrity warnings?(N/A if the agency does not conduct any form of criminal or administrative sexual abuse investigations. See 115.221(a)).	yes
	Does this specialized training include: Sexual abuse evidence collection in confinement settings?(N/A if the agency does not conduct any form of criminal or administrative sexual abuse investigations. See 115.221(a)).	yes
	Does this specialized training include: The criteria and evidence required to substantiate a case for administrative action or prosecution referral? (N/A if the agency does not conduct any form of criminal or administrative sexual abuse investigations. See 115.221(a)).	yes
115.234 (c)	**Specialized training: Investigations**	
	Does the agency maintain documentation that agency investigators have completed the required specialized training in conducting sexual abuse investigations? (N/A if the agency does not conduct any form of criminal or administrative sexual abuse investigations. See 115.221(a).)	yes
115.235 (a)	**Specialized training: Medical and mental health care**	
	Does the agency ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in: How to detect and assess signs of sexual abuse and sexual harassment? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners who work regularly in its facilities.)	na

	Does the agency ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in: How to preserve physical evidence of sexual abuse? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners who work regularly in its facilities.)	na
	Does the agency ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in: How to respond effectively and professionally to victims of sexual abuse and sexual harassment? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners who work regularly in its facilities.)	na
	Does the agency ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in: How and to whom to report allegations or suspicions of sexual abuse and sexual harassment? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners who work regularly in its facilities.)	na
115.235 (b)	**Specialized training: Medical and mental health care**	
	If medical staff employed by the agency conduct forensic examinations, do such medical staff receive appropriate training to conduct such examinations? (N/A if agency does not employ medical staff or the medical staff employed by the agency do not conduct forensic exams.)	na
115.235 (c)	**Specialized training: Medical and mental health care**	
	Does the agency maintain documentation that medical and mental health practitioners have received the training referenced in this standard either from the agency or elsewhere? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners who work regularly in its facilities.)	na
115.235 (d)	**Specialized training: Medical and mental health care**	
	Do medical and mental health care practitioners employed by the agency also receive training mandated for employees by §115.231? (N/A for circumstances in which a particular status (employee or contractor/volunteer) does not apply.)	na
	Do medical and mental health care practitioners contracted by	na

	and volunteering for the agency also receive training mandated for contractors and volunteers by §115.232? (N/A for circumstances in which a particular status (employee or contractor/volunteer) does not apply.)	
115.241 (a)	**Screening for risk of victimization and abusiveness**	
	Are all residents assessed during an intake screening for their risk of being sexually abused by other residents or sexually abusive toward other residents?	yes
	Are all residents assessed upon transfer to another facility for their risk of being sexually abused by other residents or sexually abusive toward other residents?	yes
115.241 (b)	**Screening for risk of victimization and abusiveness**	
	Do intake screenings ordinarily take place within 72 hours of arrival at the facility?	yes
115.241 (c)	**Screening for risk of victimization and abusiveness**	
	Are all PREA screening assessments conducted using an objective screening instrument?	yes
115.241 (d)	**Screening for risk of victimization and abusiveness**	
	Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: Whether the resident has a mental, physical, or developmental disability?	yes
	Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: The age of the resident?	yes
	Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: The physical build of the resident?	yes
	Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: Whether the resident has previously been incarcerated?	yes
	Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization:	yes

	Whether the resident's criminal history is exclusively nonviolent?	
	Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: Whether the resident has prior convictions for sex offenses against an adult or child?	yes
	Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: Whether the resident is or is perceived to be gay, lesbian, bisexual, transgender, intersex, or gender nonconforming (the facility affirmatively asks the resident about his/her sexual orientation and gender identity AND makes a subjective determination based on the screener's perception whether the resident is gender non-conforming or otherwise may be perceived to be LGBTI)?	yes
	Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: Whether the resident has previously experienced sexual victimization?	yes
	Does the intake screening consider, at a minimum, the following criteria to assess residents for risk of sexual victimization: The resident's own perception of vulnerability?	yes
115.241 (e)	**Screening for risk of victimization and abusiveness**	
	In assessing residents for risk of being sexually abusive, does the initial PREA risk screening consider, when known to the agency: prior acts of sexual abuse?	yes
	In assessing residents for risk of being sexually abusive, does the initial PREA risk screening consider, when known to the agency: prior convictions for violent offenses?	yes
	In assessing residents for risk of being sexually abusive, does the initial PREA risk screening consider, when known to the agency: history of prior institutional violence or sexual abuse?	yes
115.241 (f)	**Screening for risk of victimization and abusiveness**	
	Within a set time period not more than 30 days from the resident's arrival at the facility, does the facility reassess the resident's risk of victimization or abusiveness based upon any additional, relevant information received by the facility since the intake screening?	yes

115.241 (g)	**Screening for risk of victimization and abusiveness**	
	Does the facility reassess a resident’s risk level when warranted due to a: Referral?	yes
	Does the facility reassess a resident’s risk level when warranted due to a: Request?	yes
	Does the facility reassess a resident’s risk level when warranted due to a: Incident of sexual abuse?	yes
	Does the facility reassess a resident’s risk level when warranted due to a: Receipt of additional information that bears on the resident’s risk of sexual victimization or abusiveness?	yes
115.241 (h)	**Screening for risk of victimization and abusiveness**	
	Is it the case that residents are not ever disciplined for refusing to answer, or for not disclosing complete information in response to, questions asked pursuant to paragraphs (d)(1), (d)(7), (d)(8), or (d)(9) of this section?	yes
115.241 (i)	**Screening for risk of victimization and abusiveness**	
	Has the agency implemented appropriate controls on the dissemination within the facility of responses to questions asked pursuant to this standard in order to ensure that sensitive information is not exploited to the resident’s detriment by staff or other residents?	yes
115.242 (a)	**Use of screening information**	
	Does the agency use information from the risk screening required by § 115.241, with the goal of keeping separate those residents at high risk of being sexually victimized from those at high risk of being sexually abusive, to inform: Housing Assignments?	yes
	Does the agency use information from the risk screening required by § 115.241, with the goal of keeping separate those residents at high risk of being sexually victimized from those at high risk of being sexually abusive, to inform: Bed assignments?	yes
	Does the agency use information from the risk screening required by § 115.241, with the goal of keeping separate those residents at high risk of being sexually victimized from those at high risk of being sexually abusive, to inform: Work Assignments?	yes

	Does the agency use information from the risk screening required by § 115.241, with the goal of keeping separate those residents at high risk of being sexually victimized from those at high risk of being sexually abusive, to inform: Education Assignments?	yes
	Does the agency use information from the risk screening required by § 115.241, with the goal of keeping separate those residents at high risk of being sexually victimized from those at high risk of being sexually abusive, to inform: Program Assignments?	yes
115.242 (b)	**Use of screening information**	
	Does the agency make individualized determinations about how to ensure the safety of each resident?	yes
115.242 (c)	**Use of screening information**	
	When deciding whether to assign a transgender or intersex resident to a facility for male or female residents, does the agency consider on a case-by-case basis whether a placement would ensure the resident’s health and safety, and whether a placement would present management or security problems (NOTE: if an agency by policy or practice assigns residents to a male or female facility on the basis of anatomy alone, that agency is not in compliance with this standard)?	yes
	When making housing or other program assignments for transgender or intersex residents, does the agency consider on a case-by-case basis whether a placement would ensure the resident’s health and safety, and whether a placement would present management or security problems?	yes
115.242 (d)	**Use of screening information**	
	Are each transgender or intersex resident’s own views with respect to his or her own safety given serious consideration when making facility and housing placement decisions and programming assignments?	yes
115.242 (e)	**Use of screening information**	
	Are transgender and intersex residents given the opportunity to shower separately from other residents?	yes
115.242	**Use of screening information**	

(f)		
	Unless placement is in a dedicated facility, unit, or wing established in connection with a consent decree, legal settlement, or legal judgment for the purpose of protecting lesbian, gay, bisexual, transgender, or intersex residents, does the agency always refrain from placing: lesbian, gay, and bisexual residents in dedicated facilities, units, or wings solely on the basis of such identification or status? (N/A if the agency has a dedicated facility, unit, or wing solely for the placement of LGBT or I residents pursuant to a consent decree, legal settlement, or legal judgement.)	yes
	Unless placement is in a dedicated facility, unit, or wing established in connection with a consent decree, legal settlement, or legal judgment for the purpose of protecting lesbian, gay, bisexual, transgender, or intersex residents, does the agency always refrain from placing: transgender residents in dedicated facilities, units, or wings solely on the basis of such identification or status? (N/A if the agency has a dedicated facility, unit, or wing solely for the placement of LGBT or I residents pursuant to a consent decree, legal settlement, or legal judgement.)	yes
	Unless placement is in a dedicated facility, unit, or wing established in connection with a consent decree, legal settlement, or legal judgment for the purpose of protecting lesbian, gay, bisexual, transgender, or intersex residents, does the agency always refrain from placing: intersex residents in dedicated facilities, units, or wings solely on the basis of such identification or status? (N/A if the agency has a dedicated facility, unit, or wing solely for the placement of LGBT or I residents pursuant to a consent decree, legal settlement, or legal judgement.)	yes
115.251 (a)	**Resident reporting**	
	Does the agency provide multiple internal ways for residents to privately report: Sexual abuse and sexual harassment?	yes
	Does the agency provide multiple internal ways for residents to privately report: Retaliation by other residents or staff for reporting sexual abuse and sexual harassment?	yes
	Does the agency provide multiple internal ways for residents to privately report: Staff neglect or violation of responsibilities that may have contributed to such incidents?	yes
115.251 (b)	**Resident reporting**	

	Does the agency also provide at least one way for residents to report sexual abuse or sexual harassment to a public or private entity or office that is not part of the agency?	yes
	Is that private entity or office able to receive and immediately forward resident reports of sexual abuse and sexual harassment to agency officials?	yes
	Does that private entity or office allow the resident to remain anonymous upon request?	yes
115.251 (c)	**Resident reporting**	
	Do staff members accept reports of sexual abuse and sexual harassment made verbally, in writing, anonymously, and from third parties?	yes
	Do staff members promptly document any verbal reports of sexual abuse and sexual harassment?	yes
115.251 (d)	**Resident reporting**	
	Does the agency provide a method for staff to privately report sexual abuse and sexual harassment of residents?	yes
115.252 (a)	**Exhaustion of administrative remedies**	
	Is the agency exempt from this standard? NOTE: The agency is exempt ONLY if it does not have administrative procedures to address resident grievances regarding sexual abuse. This does not mean the agency is exempt simply because a resident does not have to or is not ordinarily expected to submit a grievance to report sexual abuse. This means that as a matter of explicit policy, the agency does not have an administrative remedies process to address sexual abuse.	yes
115.252 (b)	**Exhaustion of administrative remedies**	
	Does the agency permit residents to submit a grievance regarding an allegation of sexual abuse without any type of time limits? (The agency may apply otherwise-applicable time limits to any portion of a grievance that does not allege an incident of sexual abuse.) (N/A if agency is exempt from this standard.)	yes
	Does the agency always refrain from requiring a resident to use any informal grievance process, or to otherwise attempt to resolve	yes

	with staff, an alleged incident of sexual abuse? (N/A if agency is exempt from this standard.)	
115.252 (c)	**Exhaustion of administrative remedies**	
	Does the agency ensure that: a resident who alleges sexual abuse may submit a grievance without submitting it to a staff member who is the subject of the complaint? (N/A if agency is exempt from this standard.)	yes
	Does the agency ensure that: such grievance is not referred to a staff member who is the subject of the complaint? (N/A if agency is exempt from this standard.)	yes
115.252 (d)	**Exhaustion of administrative remedies**	
	Does the agency issue a final agency decision on the merits of any portion of a grievance alleging sexual abuse within 90 days of the initial filing of the grievance? (Computation of the 90-day time period does not include time consumed by residents in preparing any administrative appeal.) (N/A if agency is exempt from this standard.)	yes
	If the agency determines that the 90-day timeframe is insufficient to make an appropriate decision and claims an extension of time (the maximum allowable extension is 70 days per 115.252(d)(3)), does the agency notify the resident in writing of any such extension and provide a date by which a decision will be made? (N/A if agency is exempt from this standard.)	yes
	At any level of the administrative process, including the final level, if the resident does not receive a response within the time allotted for reply, including any properly noticed extension, may a resident consider the absence of a response to be a denial at that level? (N/A if agency is exempt from this standard.)	yes
115.252 (e)	**Exhaustion of administrative remedies**	
	Are third parties, including fellow residents, staff members, family members, attorneys, and outside advocates, permitted to assist residents in filing requests for administrative remedies relating to allegations of sexual abuse? (N/A if agency is exempt from this standard.)	yes
	Are those third parties also permitted to file such requests on behalf of residents? (If a third party files such a request on behalf	yes

	of a resident, the facility may require as a condition of processing the request that the alleged victim agree to have the request filed on his or her behalf, and may also require the alleged victim to personally pursue any subsequent steps in the administrative remedy process.) (N/A if agency is exempt from this standard.)	
	If the resident declines to have the request processed on his or her behalf, does the agency document the resident's decision? (N/A if agency is exempt from this standard.)	yes
115.252 (f)	**Exhaustion of administrative remedies**	
	Has the agency established procedures for the filing of an emergency grievance alleging that a resident is subject to a substantial risk of imminent sexual abuse? (N/A if agency is exempt from this standard.)	yes
	After receiving an emergency grievance alleging a resident is subject to a substantial risk of imminent sexual abuse, does the agency immediately forward the grievance (or any portion thereof that alleges the substantial risk of imminent sexual abuse) to a level of review at which immediate corrective action may be taken? (N/A if agency is exempt from this standard.)	yes
	After receiving an emergency grievance described above, does the agency provide an initial response within 48 hours? (N/A if agency is exempt from this standard.)	yes
	After receiving an emergency grievance described above, does the agency issue a final agency decision within 5 calendar days? (N/A if agency is exempt from this standard.)	yes
	Does the initial response and final agency decision document the agency's determination whether the resident is in substantial risk of imminent sexual abuse? (N/A if agency is exempt from this standard.)	yes
	Does the initial response document the agency's action(s) taken in response to the emergency grievance? (N/A if agency is exempt from this standard.)	yes
	Does the agency's final decision document the agency's action(s) taken in response to the emergency grievance? (N/A if agency is exempt from this standard.)	yes
115.252 (g)	**Exhaustion of administrative remedies**	
	If the agency disciplines a resident for filing a grievance related to	yes

	alleged sexual abuse, does it do so ONLY where the agency demonstrates that the resident filed the grievance in bad faith? (N/A if agency is exempt from this standard.)	
115.253 (a)	**Resident access to outside confidential support services**	
	Does the facility provide residents with access to outside victim advocates for emotional support services related to sexual abuse by giving residents mailing addresses and telephone numbers, including toll-free hotline numbers where available, of local, State, or national victim advocacy or rape crisis organizations?	yes
	Does the facility enable reasonable communication between residents and these organizations, in as confidential a manner as possible?	yes
115.253 (b)	**Resident access to outside confidential support services**	
	Does the facility inform residents, prior to giving them access, of the extent to which such communications will be monitored and the extent to which reports of abuse will be forwarded to authorities in accordance with mandatory reporting laws?	yes
115.253 (c)	**Resident access to outside confidential support services**	
	Does the agency maintain or attempt to enter into memoranda of understanding or other agreements with community service providers that are able to provide residents with confidential emotional support services related to sexual abuse?	yes
	Does the agency maintain copies of agreements or documentation showing attempts to enter into such agreements?	yes
115.254 (a)	**Third party reporting**	
	Has the agency established a method to receive third-party reports of sexual abuse and sexual harassment?	yes
	Has the agency distributed publicly information on how to report sexual abuse and sexual harassment on behalf of a resident?	yes
115.261 (a)	**Staff and agency reporting duties**	
	Does the agency require all staff to report immediately and according to agency policy any knowledge, suspicion, or	yes

	information regarding an incident of sexual abuse or sexual harassment that occurred in a facility, whether or not it is part of the agency?	
	Does the agency require all staff to report immediately and according to agency policy any knowledge, suspicion, or information regarding retaliation against residents or staff who reported an incident of sexual abuse or sexual harassment?	yes
	Does the agency require all staff to report immediately and according to agency policy any knowledge, suspicion, or information regarding any staff neglect or violation of responsibilities that may have contributed to an incident of sexual abuse or sexual harassment or retaliation?	yes
115.261 (b)	**Staff and agency reporting duties**	
	Apart from reporting to designated supervisors or officials, do staff always refrain from revealing any information related to a sexual abuse report to anyone other than to the extent necessary, as specified in agency policy, to make treatment, investigation, and other security and management decisions?	yes
115.261 (c)	**Staff and agency reporting duties**	
	Unless otherwise precluded by Federal, State, or local law, are medical and mental health practitioners required to report sexual abuse pursuant to paragraph (a) of this section?	yes
	Are medical and mental health practitioners required to inform residents of the practitioner’s duty to report, and the limitations of confidentiality, at the initiation of services?	yes
115.261 (d)	**Staff and agency reporting duties**	
	If the alleged victim is under the age of 18 or considered a vulnerable adult under a State or local vulnerable persons statute, does the agency report the allegation to the designated State or local services agency under applicable mandatory reporting laws?	yes
115.261 (e)	**Staff and agency reporting duties**	
	Does the facility report all allegations of sexual abuse and sexual harassment, including third-party and anonymous reports, to the facility’s designated investigators?	yes

115.262 (a)	**Agency protection duties**	
	When the agency learns that a resident is subject to a substantial risk of imminent sexual abuse, does it take immediate action to protect the resident?	yes
115.263 (a)	**Reporting to other confinement facilities**	
	Upon receiving an allegation that a resident was sexually abused while confined at another facility, does the head of the facility that received the allegation notify the head of the facility or appropriate office of the agency where the alleged abuse occurred?	yes
115.263 (b)	**Reporting to other confinement facilities**	
	Is such notification provided as soon as possible, but no later than 72 hours after receiving the allegation?	yes
115.263 (c)	**Reporting to other confinement facilities**	
	Does the agency document that it has provided such notification?	yes
115.263 (d)	**Reporting to other confinement facilities**	
	Does the facility head or agency office that receives such notification ensure that the allegation is investigated in accordance with these standards?	yes
115.264 (a)	**Staff first responder duties**	
	Upon learning of an allegation that a resident was sexually abused, is the first security staff member to respond to the report required to: Separate the alleged victim and abuser?	yes
	Upon learning of an allegation that a resident was sexually abused, is the first security staff member to respond to the report required to: Preserve and protect any crime scene until appropriate steps can be taken to collect any evidence?	yes
	Upon learning of an allegation that a resident was sexually abused, is the first security staff member to respond to the report required to: Request that the alleged victim not take any actions that could destroy physical evidence, including, as appropriate,	yes

	washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating, if the abuse occurred within a time period that still allows for the collection of physical evidence?	
	Upon learning of an allegation that a resident was sexually abused, is the first security staff member to respond to the report required to: Ensure that the alleged abuser does not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating, if the abuse occurred within a time period that still allows for the collection of physical evidence?	yes
115.264 (b)	**Staff first responder duties**	
	If the first staff responder is not a security staff member, is the responder required to request that the alleged victim not take any actions that could destroy physical evidence, and then notify security staff?	yes
115.265 (a)	**Coordinated response**	
	Has the facility developed a written institutional plan to coordinate actions among staff first responders, medical and mental health practitioners, investigators, and facility leadership taken in response to an incident of sexual abuse?	yes
115.266 (a)	**Preservation of ability to protect residents from contact with abusers**	
	Are both the agency and any other governmental entities responsible for collective bargaining on the agency’s behalf prohibited from entering into or renewing any collective bargaining agreement or other agreement that limits the agency’s ability to remove alleged staff sexual abusers from contact with any residents pending the outcome of an investigation or of a determination of whether and to what extent discipline is warranted?	yes
115.267 (a)	**Agency protection against retaliation**	
	Has the agency established a policy to protect all residents and staff who report sexual abuse or sexual harassment or cooperate with sexual abuse or sexual harassment investigations from retaliation by other residents or staff?	yes

	Has the agency designated which staff members or departments are charged with monitoring retaliation?	yes
115.267 (b)	**Agency protection against retaliation**	
	Does the agency employ multiple protection measures, such as housing changes or transfers for resident victims or abusers, removal of alleged staff or resident abusers from contact with victims, and emotional support services for residents or staff who fear retaliation for reporting sexual abuse or sexual harassment or for cooperating with investigations?	yes
115.267 (c)	**Agency protection against retaliation**	
	Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor the conduct and treatment of residents or staff who reported the sexual abuse to see if there are changes that may suggest possible retaliation by residents or staff?	yes
	Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor the conduct and treatment of residents who were reported to have suffered sexual abuse to see if there are changes that may suggest possible retaliation by residents or staff?	yes
	Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Act promptly to remedy any such retaliation?	yes
	Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor any resident disciplinary reports?	yes
	Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency:4. Monitor resident housing changes?	yes
	Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor resident program changes?	yes

	Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor negative performance reviews of staff?	yes
	Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Monitor reassignment of staff?	yes
	Does the agency continue such monitoring beyond 90 days if the initial monitoring indicates a continuing need?	yes
115.267 (d)	**Agency protection against retaliation**	
	In the case of residents, does such monitoring also include periodic status checks?	yes
115.267 (e)	**Agency protection against retaliation**	
	If any other individual who cooperates with an investigation expresses a fear of retaliation, does the agency take appropriate measures to protect that individual against retaliation?	yes
115.271 (a)	**Criminal and administrative agency investigations**	
	When the agency conducts its own investigations into allegations of sexual abuse and sexual harassment, does it do so promptly, thoroughly, and objectively? (N/A if the agency/facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations. See 115.221(a).)	yes
	Does the agency conduct such investigations for all allegations, including third party and anonymous reports? (N/A if the agency/ facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations. See 115.221(a).)	yes
115.271 (b)	**Criminal and administrative agency investigations**	
	Where sexual abuse is alleged, does the agency use investigators who have received specialized training in sexual abuse investigations as required by 115.234?	yes
115.271 (c)	**Criminal and administrative agency investigations**	
	Do investigators gather and preserve direct and circumstantial	yes

	evidence, including any available physical and DNA evidence and any available electronic monitoring data?	
	Do investigators interview alleged victims, suspected perpetrators, and witnesses?	yes
	Do investigators review prior reports and complaints of sexual abuse involving the suspected perpetrator?	yes
115.271 (d)	**Criminal and administrative agency investigations**	
	When the quality of evidence appears to support criminal prosecution, does the agency conduct compelled interviews only after consulting with prosecutors as to whether compelled interviews may be an obstacle for subsequent criminal prosecution?	yes
115.271 (e)	**Criminal and administrative agency investigations**	
	Do agency investigators assess the credibility of an alleged victim, suspect, or witness on an individual basis and not on the basis of that individual’s status as resident or staff?	yes
	Does the agency investigate allegations of sexual abuse without requiring a resident who alleges sexual abuse to submit to a polygraph examination or other truth-telling device as a condition for proceeding?	yes
115.271 (f)	**Criminal and administrative agency investigations**	
	Do administrative investigations include an effort to determine whether staff actions or failures to act contributed to the abuse?	yes
	Are administrative investigations documented in written reports that include a description of the physical evidence and testimonial evidence, the reasoning behind credibility assessments, and investigative facts and findings?	yes
115.271 (g)	**Criminal and administrative agency investigations**	
	Are criminal investigations documented in a written report that contains a thorough description of the physical, testimonial, and documentary evidence and attaches copies of all documentary evidence where feasible?	yes
115.271	**Criminal and administrative agency investigations**	

(h)		
	Are all substantiated allegations of conduct that appears to be criminal referred for prosecution?	yes
115.271 (i)	**Criminal and administrative agency investigations**	
	Does the agency retain all written reports referenced in 115.271(f) and (g) for as long as the alleged abuser is incarcerated or employed by the agency, plus five years?	yes
115.271 (j)	**Criminal and administrative agency investigations**	
	Does the agency ensure that the departure of an alleged abuser or victim from the employment or control of the facility or agency does not provide a basis for terminating an investigation?	yes
115.271 (l)	**Criminal and administrative agency investigations**	
	When an outside entity investigates sexual abuse, does the facility cooperate with outside investigators and endeavor to remain informed about the progress of the investigation? (N/A if an outside agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.221(a).)	yes
115.272 (a)	**Evidentiary standard for administrative investigations**	
	Is it true that the agency does not impose a standard higher than a preponderance of the evidence in determining whether allegations of sexual abuse or sexual harassment are substantiated?	yes
115.273 (a)	**Reporting to residents**	
	Following an investigation into a resident’s allegation that he or she suffered sexual abuse in an agency facility, does the agency inform the resident as to whether the allegation has been determined to be substantiated, unsubstantiated, or unfounded?	yes
115.273 (b)	**Reporting to residents**	
	If the agency did not conduct the investigation into a resident’s allegation of sexual abuse in an agency facility, does the agency	yes

	request the relevant information from the investigative agency in order to inform the resident? (N/A if the agency/facility is responsible for conducting administrative and criminal investigations.)	
115.273 (c)	**Reporting to residents**	
	Following a resident's allegation that a staff member has committed sexual abuse against the resident, unless the agency has determined that the allegation is unfounded, or unless the resident has been released from custody, does the agency subsequently inform the resident whenever: The staff member is no longer posted within the resident's unit?	yes
	Following a resident's allegation that a staff member has committed sexual abuse against the resident, unless the agency has determined that the allegation is unfounded, or unless the resident has been released from custody, does the agency subsequently inform the resident whenever: The staff member is no longer employed at the facility?	yes
	Following a resident's allegation that a staff member has committed sexual abuse against the resident, unless the agency has determined that the allegation is unfounded, or unless the resident has been released from custody, does the agency subsequently inform the resident whenever: The agency learns that the staff member has been indicted on a charge related to sexual abuse in the facility?	yes
	Following a resident's allegation that a staff member has committed sexual abuse against the resident, unless the agency has determined that the allegation is unfounded, or unless the resident has been released from custody, does the agency subsequently inform the resident whenever: The agency learns that the staff member has been convicted on a charge related to sexual abuse within the facility?	yes
115.273 (d)	**Reporting to residents**	
	Following a resident's allegation that he or she has been sexually abused by another resident, does the agency subsequently inform the alleged victim whenever: The agency learns that the alleged abuser has been indicted on a charge related to sexual abuse within the facility?	yes
	Following a resident's allegation that he or she has been sexually abused by another resident, does the agency subsequently inform	yes

	the alleged victim whenever: The agency learns that the alleged abuser has been convicted on a charge related to sexual abuse within the facility?	
115.273 (e)	**Reporting to residents**	
	Does the agency document all such notifications or attempted notifications?	yes
115.276 (a)	**Disciplinary sanctions for staff**	
	Are staff subject to disciplinary sanctions up to and including termination for violating agency sexual abuse or sexual harassment policies?	yes
115.276 (b)	**Disciplinary sanctions for staff**	
	Is termination the presumptive disciplinary sanction for staff who have engaged in sexual abuse?	yes
115.276 (c)	**Disciplinary sanctions for staff**	
	Are disciplinary sanctions for violations of agency policies relating to sexual abuse or sexual harassment (other than actually engaging in sexual abuse) commensurate with the nature and circumstances of the acts committed, the staff member’s disciplinary history, and the sanctions imposed for comparable offenses by other staff with similar histories?	yes
115.276 (d)	**Disciplinary sanctions for staff**	
	Are all terminations for violations of agency sexual abuse or sexual harassment policies, or resignations by staff who would have been terminated if not for their resignation, reported to: Law enforcement agencies, unless the activity was clearly not criminal?	yes
	Are all terminations for violations of agency sexual abuse or sexual harassment policies, or resignations by staff who would have been terminated if not for their resignation, reported to: Relevant licensing bodies?	yes
115.277 (a)	**Corrective action for contractors and volunteers**	

	Is any contractor or volunteer who engages in sexual abuse prohibited from contact with residents?	yes
	Is any contractor or volunteer who engages in sexual abuse reported to: Law enforcement agencies (unless the activity was clearly not criminal)?	yes
	Is any contractor or volunteer who engages in sexual abuse reported to: Relevant licensing bodies?	yes
115.277 (b)	**Corrective action for contractors and volunteers**	
	In the case of any other violation of agency sexual abuse or sexual harassment policies by a contractor or volunteer, does the facility take appropriate remedial measures, and consider whether to prohibit further contact with residents?	yes
115.278 (a)	**Disciplinary sanctions for residents**	
	Following an administrative finding that a resident engaged in resident-on-resident sexual abuse, or following a criminal finding of guilt for resident-on-resident sexual abuse, are residents subject to disciplinary sanctions pursuant to a formal disciplinary process?	yes
115.278 (b)	**Disciplinary sanctions for residents**	
	Are sanctions commensurate with the nature and circumstances of the abuse committed, the resident’s disciplinary history, and the sanctions imposed for comparable offenses by other residents with similar histories?	yes
115.278 (c)	**Disciplinary sanctions for residents**	
	When determining what types of sanction, if any, should be imposed, does the disciplinary process consider whether a resident’s mental disabilities or mental illness contributed to his or her behavior?	yes
115.278 (d)	**Disciplinary sanctions for residents**	
	If the facility offers therapy, counseling, or other interventions designed to address and correct underlying reasons or motivations for the abuse, does the facility consider whether to require the offending resident to participate in such interventions as a	yes

	condition of access to programming and other benefits?	
115.278 (e)	**Disciplinary sanctions for residents**	
	Does the agency discipline a resident for sexual contact with staff only upon a finding that the staff member did not consent to such contact?	yes
115.278 (f)	**Disciplinary sanctions for residents**	
	For the purpose of disciplinary action does a report of sexual abuse made in good faith based upon a reasonable belief that the alleged conduct occurred NOT constitute falsely reporting an incident or lying, even if an investigation does not establish evidence sufficient to substantiate the allegation?	yes
115.278 (g)	**Disciplinary sanctions for residents**	
	Does the agency always refrain from considering non-coercive sexual activity between residents to be sexual abuse? (N/A if the agency does not prohibit all sexual activity between residents.)	yes
115.282 (a)	**Access to emergency medical and mental health services**	
	Do resident victims of sexual abuse receive timely, unimpeded access to emergency medical treatment and crisis intervention services, the nature and scope of which are determined by medical and mental health practitioners according to their professional judgment?	yes
115.282 (b)	**Access to emergency medical and mental health services**	
	If no qualified medical or mental health practitioners are on duty at the time a report of recent sexual abuse is made, do security staff first responders take preliminary steps to protect the victim pursuant to § 115.262?	yes
	Do security staff first responders immediately notify the appropriate medical and mental health practitioners?	yes
115.282 (c)	**Access to emergency medical and mental health services**	
	Are resident victims of sexual abuse offered timely information	yes

	about and timely access to emergency contraception and sexually transmitted infections prophylaxis, in accordance with professionally accepted standards of care, where medically appropriate?	
115.282 (d)	**Access to emergency medical and mental health services**	
	Are treatment services provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident?	yes
115.283 (a)	**Ongoing medical and mental health care for sexual abuse victims and abusers**	
	Does the facility offer medical and mental health evaluation and, as appropriate, treatment to all residents who have been victimized by sexual abuse in any prison, jail, lockup, or juvenile facility?	yes
115.283 (b)	**Ongoing medical and mental health care for sexual abuse victims and abusers**	
	Does the evaluation and treatment of such victims include, as appropriate, follow-up services, treatment plans, and, when necessary, referrals for continued care following their transfer to, or placement in, other facilities, or their release from custody?	yes
115.283 (c)	**Ongoing medical and mental health care for sexual abuse victims and abusers**	
	Does the facility provide such victims with medical and mental health services consistent with the community level of care?	yes
115.283 (d)	**Ongoing medical and mental health care for sexual abuse victims and abusers**	
	Are resident victims of sexually abusive vaginal penetration while incarcerated offered pregnancy tests? (N/A if “all-male” facility. Note: in “all-male” facilities, there may be residents who identify as transgender men who may have female genitalia. Auditors should be sure to know whether such individuals may be in the population and whether this provision may apply in specific circumstances.)	yes
115.283 (e)	**Ongoing medical and mental health care for sexual abuse victims and abusers**	
	If pregnancy results from the conduct described in paragraph § 115.283(d), do such victims receive timely and comprehensive	yes

	information about and timely access to all lawful pregnancy-related medical services? (N/A if “all-male” facility. Note: in “all-male” facilities, there may be residents who identify as transgender men who may have female genitalia. Auditors should be sure to know whether such individuals may be in the population and whether this provision may apply in specific circumstances.)	
115.283 (f)	**Ongoing medical and mental health care for sexual abuse victims and abusers**	
	Are resident victims of sexual abuse while incarcerated offered tests for sexually transmitted infections as medically appropriate?	yes
115.283 (g)	**Ongoing medical and mental health care for sexual abuse victims and abusers**	
	Are treatment services provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident?	yes
115.283 (h)	**Ongoing medical and mental health care for sexual abuse victims and abusers**	
	Does the facility attempt to conduct a mental health evaluation of all known resident-on-resident abusers within 60 days of learning of such abuse history and offer treatment when deemed appropriate by mental health practitioners?	yes
115.286 (a)	**Sexual abuse incident reviews**	
	Does the facility conduct a sexual abuse incident review at the conclusion of every sexual abuse investigation, including where the allegation has not been substantiated, unless the allegation has been determined to be unfounded?	yes
115.286 (b)	**Sexual abuse incident reviews**	
	Does such review ordinarily occur within 30 days of the conclusion of the investigation?	yes
115.286 (c)	**Sexual abuse incident reviews**	
	Does the review team include upper-level management officials, with input from line supervisors, investigators, and medical or mental health practitioners?	yes

115.286 (d)	**Sexual abuse incident reviews**	
	Does the review team: Consider whether the allegation or investigation indicates a need to change policy or practice to better prevent, detect, or respond to sexual abuse?	yes
	Does the review team: Consider whether the incident or allegation was motivated by race; ethnicity; gender identity; lesbian, gay, bisexual, transgender, or intersex identification, status, or perceived status; gang affiliation; or other group dynamics at the facility?	yes
	Does the review team: Examine the area in the facility where the incident allegedly occurred to assess whether physical barriers in the area may enable abuse?	yes
	Does the review team: Assess the adequacy of staffing levels in that area during different shifts?	yes
	Does the review team: Assess whether monitoring technology should be deployed or augmented to supplement supervision by staff?	yes
	Does the review team: Prepare a report of its findings, including but not necessarily limited to determinations made pursuant to §§ 115.286(d)(1)-(d)(5), and any recommendations for improvement and submit such report to the facility head and PREA compliance manager?	yes
115.286 (e)	**Sexual abuse incident reviews**	
	Does the facility implement the recommendations for improvement, or document its reasons for not doing so?	yes
115.287 (a)	**Data collection**	
	Does the agency collect accurate, uniform data for every allegation of sexual abuse at facilities under its direct control using a standardized instrument and set of definitions?	yes
115.287 (b)	**Data collection**	
	Does the agency aggregate the incident-based sexual abuse data at least annually?	yes
115.287	**Data collection**	

(c)		
	Does the incident-based data include, at a minimum, the data necessary to answer all questions from the most recent version of the Survey of Sexual Violence conducted by the Department of Justice?	yes
115.287 (d)	**Data collection**	
	Does the agency maintain, review, and collect data as needed from all available incident-based documents, including reports, investigation files, and sexual abuse incident reviews?	yes
115.287 (e)	**Data collection**	
	Does the agency also obtain incident-based and aggregated data from every private facility with which it contracts for the confinement of its residents? (N/A if agency does not contract for the confinement of its residents.)	na
115.287 (f)	**Data collection**	
	Does the agency, upon request, provide all such data from the previous calendar year to the Department of Justice no later than June 30? (N/A if DOJ has not requested agency data.)	na
115.288 (a)	**Data review for corrective action**	
	Does the agency review data collected and aggregated pursuant to § 115.287 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training, including by: Identifying problem areas?	yes
	Does the agency review data collected and aggregated pursuant to § 115.287 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training, including by: Taking corrective action on an ongoing basis?	yes
	Does the agency review data collected and aggregated pursuant to § 115.287 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training, including by: Preparing an annual report of its findings and corrective actions for each facility, as well as the agency as a whole?	yes

115.288 (b)	**Data review for corrective action**	
	Does the agency’s annual report include a comparison of the current year’s data and corrective actions with those from prior years and provide an assessment of the agency’s progress in addressing sexual abuse?	yes
115.288 (c)	**Data review for corrective action**	
	Is the agency’s annual report approved by the agency head and made readily available to the public through its website or, if it does not have one, through other means?	yes
115.288 (d)	**Data review for corrective action**	
	Does the agency indicate the nature of the material redacted where it redacts specific material from the reports when publication would present a clear and specific threat to the safety and security of a facility?	yes
115.289 (a)	**Data storage, publication, and destruction**	
	Does the agency ensure that data collected pursuant to § 115.287 are securely retained?	yes
115.289 (b)	**Data storage, publication, and destruction**	
	Does the agency make all aggregated sexual abuse data, from facilities under its direct control and private facilities with which it contracts, readily available to the public at least annually through its website or, if it does not have one, through other means?	yes
115.289 (c)	**Data storage, publication, and destruction**	
	Does the agency remove all personal identifiers before making aggregated sexual abuse data publicly available?	yes
115.289 (d)	**Data storage, publication, and destruction**	
	Does the agency maintain sexual abuse data collected pursuant to § 115.287 for at least 10 years after the date of the initial collection, unless Federal, State, or local law requires otherwise?	yes

115.401 (a)	**Frequency and scope of audits**	
	During the prior three-year audit period, did the agency ensure that each facility operated by the agency, or by a private organization on behalf of the agency, was audited at least once? (Note: The response here is purely informational. A "no" response does not impact overall compliance with this standard.)	yes
115.401 (b)	**Frequency and scope of audits**	
	Is this the first year of the current audit cycle? (Note: a “no” response does not impact overall compliance with this standard.)	yes
	If this is the second year of the current audit cycle, did the agency ensure that at least one-third of each facility type operated by the agency, or by a private organization on behalf of the agency, was audited during the first year of the current audit cycle? (N/A if this is not the second year of the current audit cycle.)	na
	If this is the third year of the current audit cycle, did the agency ensure that at least two-thirds of each facility type operated by the agency, or by a private organization on behalf of the agency, were audited during the first two years of the current audit cycle? (N/A if this is not the third year of the current audit cycle.)	na
115.401 (h)	**Frequency and scope of audits**	
	Did the auditor have access to, and the ability to observe, all areas of the audited facility?	yes
115.401 (i)	**Frequency and scope of audits**	
	Was the auditor permitted to request and receive copies of any relevant documents (including electronically stored information)?	yes
115.401 (m)	**Frequency and scope of audits**	
	Was the auditor permitted to conduct private interviews with residents?	yes
115.401 (n)	**Frequency and scope of audits**	
	Were inmates, residents, and detainees permitted to send confidential information or correspondence to the auditor in the	yes

	same manner as if they were communicating with legal counsel?	
115.403 (f)	**Audit contents and findings**	
	The agency has published on its agency website, if it has one, or has otherwise made publicly available, all Final Audit Reports. The review period is for prior audits completed during the past three years PRECEDING THIS AUDIT. The pendency of any agency appeal pursuant to 28 C.F.R. § 115.405 does not excuse noncompliance with this provision. (N/A if there have been no Final Audit Reports issued in the past three years, or, in the case of single facility agencies, there has never been a Final Audit Report issued.)	yes